



Semi Quantitative Evaluation of Access and Coverage (SQEAC) Survey for IMAM Program



Taking a child's MUAC measurement

Location: Isiolo Sub-county, Kenya
Date of Investigation: March/April 2018
Type of Program: OTP & SFP



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- Mothers and caregivers whom their children were assessed
- Data enumerators and their supervisors
- Action Against Hunger program staff for their active role during the entire process and the smooth logistical support and coordination

ABBREVIATIONS/ACRONYMS

CHMT	County Health Management Team
CNC	County Nutrition Coordinator
GAM	Global Acute Malnutrition
GFD	General Food Distribution
ICCM	Integrated Community Case Management
IMAM	Integrated Management of Acute Malnutrition
LOS	Length of Stay
MUAC	Mid Upper Arm Circumference
OJT	On Job Training
OTP	Outpatient Therapeutic Care
RUSF	Ready to Use Supplementary Food
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SCHMT	Sub County Health Management Team
SFP	Supplementary Feeding Program
SQUEAC	Semi-Quantitative Evaluation of Access and Coverage

EXECUTIVE SUMMARY

Action against Hunger Kenya conducted a SQUEAC assessment in Isiolo Sub County between March and April 2018. This was the second assessment to be done in the Sub County after the one supported by International Medical Corps in December 2013 which indicated a point coverage of **42.4% (31.0%- 54.8%)** using the Bayesian technique. Similarly, a SLEAC Survey conducted in Isiolo County in September 2016 to determine areas of High and Low coverage revealed Isiolo Sub-county to be an area of moderate and low coverage in both OTP and SFP programs –with coverage estimates of 52.9% (27.3-78.5 95% C.I) –and 35.3% (26.2-44.4 95% C.I) Isiolo Sub-county hosts the County Referral Hospital (Level 4), 4 health Centers and 20 dispensaries. Action Against Hunger (AAH) has been supporting the Ministry of Health in scaling up of High Impact Nutrition Interventions (HINI) for improved maternal child health and nutrition (MCNP) in Isiolo Sub-County since August 2015 in 3 thematic areas namely System strengthening, Community resilience and Advocacy under UNCEF funded project

The assessment process involved analysis of program data (quantitative data) and discussions with the community members and the program staff (qualitative data) to establish factors influencing program coverage which enabled identification of areas of low and high coverage (Stage 1). In stage 2 there was hypothesis development and testing, based on facilities with low and high coverage.

Data collection was done through qualitative and quantitative until redundancy is reached. During qualitative data collection, the following methods were used;-, Semi structured interviews, informal group discussions and observations.

Table 1: A Summary of possible Recommendations to Improve IMAM Coverage

No	Recommendation	Justification	Source
1	Bringing services closer to the population through; <ul style="list-style-type: none"> • Establishment of health facilities • Scaling up of IMAM services in these facilities • Scaling up integrated outreach sites 	Distance to health facilities, migration, nomadic lifestyle	Care giver of child in program/mother, Community health Volunteer (CHV), Nurse/Nutritionist, Religious leader, Chief/sub area, Father, Traditional health practitioner/TBA, Mother in law/grandmother, Community lay women
2	Foster behavior change at the community by regular sensitization through community dialogues, strengthening and formation of new mother to mother Support Groups.	Health seeking behavior influenced by illiteracy and cultural beliefs, Knowledge gap on IMAM and stigma	Care giver of child in program/mother, Community health Volunteer (CHV), Nurse/Nutritionist, Religious leader, Chief/sub area, Father, Traditional health practitioner/TBA, Mother in law/grandmother, Community lay women
		Sharing and selling of RUTF/RUTF	Care giver of child in program/mother, Community health Volunteer (CHV), Nurse/Nutritionist, Religious leader, Mother in law/grandmother, Community lay women
3	Advocacy on staff recruitment to the county government and relevant partners Management ensuring that there is	Long waiting time due to workload of health workers and shortage of staff. Absenteeism and closure of	Caregivers, CHVs, health workers, religious leaders.

	no disruption of services at health facilities during health worker's absence	health facilities	
4	Strengthen community health strategy through <ul style="list-style-type: none"> • Capacity building • Incentivizing CHVs • Availability of tools 	Lack of motivation to CHVs leading to poor routine screening, referral system/follow up	Religious leaders and CHVs
5	Strengthen and functionalize community units	Poor linkage between health facilities and CHVs as a result of lack of regular meetings	Care giver of child in program/mother, Community health Volunteer (CHV), Nurse/Nutritionist, Religious leader,
6	Capacity building of health workers on LMIS	Periodic stock out of commodities due to poor forecasting and pipeline breakages	Care giver of child in program/mother, Community health Volunteer (CHV), Nurse/Nutritionist, Traditional health practitioner/TBA, Mother in law/grandmother, NGO/FBO staff
7	Capacity building of health workers through class room training, OJTS and mentorship.	Low capacity of health staff on IMAM leading to poor service delivery and reporting.	Community health Volunteer (CHV), Nurse/Nutritionist

1.0 INTRODUCTION

1.1 ICCM Project Background:

Severely Malnourished Children have a higher risk of death from common childhood illness such as diarrhea, pneumonia, and malaria. Despite acute malnutrition contributing to such high proportion of child mortality, in many poor countries, majority of acutely malnourished children are never brought to health facilities or are brought too late, and most facility-based treatment programs do not reach optimal coverage. This is largely due to the distance barrier and associated costs, which limit reach and optimal follow-up in these areas.

These challenges call for an approach with a strong community component in order to reach sick and malnourished children who face barriers to accessing treatment. Integrated community case management (iCCM) is a strategy that utilizes community health volunteers (CHVs) to diagnose and treat multiple conditions, most commonly pneumonia, diarrhea and malaria, in children under-five years. An integrated approach to addressing the twin problem of disease and malnutrition would make it possible to address the presenting and underlying aspects of a child's illness, but new evidence on the potential impact and practical experiences on integrating community-based management of acute malnutrition as part of an iCCM package is not well documented. As Part of ICCM TAG work plan the SQUEAC survey in Isiolo was conducted to determine single estimate coverage for IMAM program to act as a baseline for ICCM research programming

1.2 Overview of the Assessment Area:

Isiolo Sub-county is one of three sub-counties in Isiolo County and covers an area of 2,894 square kilometers with an estimated population of 185,417 people (6-59 months 31,915). The Sub-County borders Samburu County to the North, Merti and Garbatulla Sub-Counties to the East, Meru North Sub-County to the South and Laikipia County to the West. Isiolo Sub-county has three administrative divisions namely; Isiolo East, Central and Oldonyiro. Isiolo Sub-County is mainly inhabited by Borana, the Somali, Turkana, the Samburu and the Meru communities.

The major economic activities in the sub-county are livestock-based, subsistence farming, and petty trade. The main livelihood zones in the district include pastoral (all species), agro pastoral, casual waged labor, Pastoral, Agro-pastoral and Firewood/Formal employment representing 67%, 26% and 7% respectively¹.

¹ Isiolo County Short Rains Assessment Situation Report-February 2018

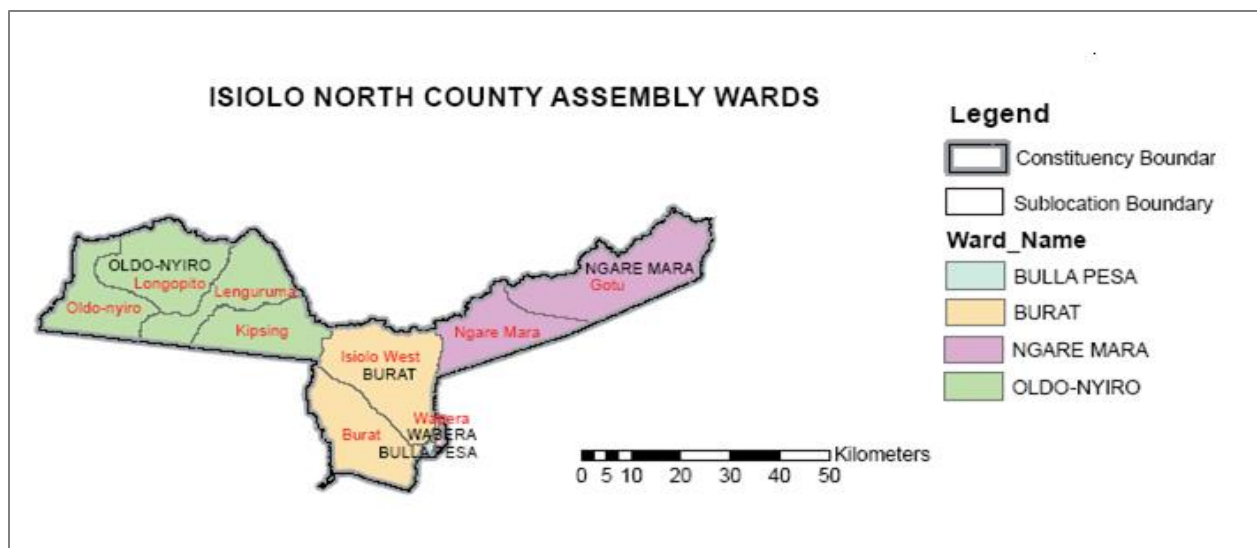


Figure 1: A map showing Isiolo Sub-county Administrative boundaries

The SQUEAC survey was conducted at the peak of the short dry period and onset of the long rains period. At the time of the survey implementation, it was also done after a prolonged industrial action by nurses' country wide, something meant to affect IMAM program coverage. the overall household food security was highly vulnerable due to the failures in crop farming and poor incomes for pastoral households as market functionality has been greatly affected by successive rainfall failure which results to poor livestock body condition and the subsequent migrations to distant grazing areas away from traditional grazing fields. the current GAM and SAM prevalence by weight for height z-score in Isiolo County is 13.8 % (10.9 - 17.3 95% C.I.) and 2.6% (1.6 - 4.2 95% C.I.) respectively a significant improvement compared to a GAM and SAM prevalence of 18.2% (14.6-22.5, 95% CI) and 3.3% (2.1-5.3, 95% CI) in 2018. The improvement is attributed to health and nutrition interventions targeting vulnerable households (Children under 5 years and PLWs): Cash Transfers, Food Vouchers, Integrated Outreach activities and Blanket Supplementary Feeding Program (BSFP) citing recommendations from the Long Rains Assessments Report²

Isiolo sub-county hosts the County Referral Hospital (Level 4), 4 health Centers and 20 dispensaries. The most common diseases for the general population in the county include; diseases of the respiratory system, malaria, skin disease, urinary tract infections and rheumatism. Prevalence among the children under five years include; diseases of the respiratory system, pneumonia, malaria, intestinal worms and skin diseases (NDMA Bulletin, March 2018.)

Action Against Hunger (AAH) has been supporting the Ministry of Health in scaling up of High Impact Nutrition Interventions (HINI) for improved maternal child health and nutrition (MCNP) in Isiolo Sub-County since August 2015 in 3 thematic areas namely System strengthening, Community resilience and Advocacy under UNCEF funded project. Since the inception of the program has been able to support 19 health facilities out of the 22 to offer comprehensive HINI

² Isiolo County Integrated SMART Survey, February 2018

package. IMAM program being one of the HINI packages supporting prevention and treatment of malnutrition is integrated in the health system and is managed by the MOH. Screening for malnutrition is done by the CHVs at the community level using MUAC, at the health service delivery points during growth monitoring and outpatient visits. Children 6-59 months identified to be malnourished are then admitted in the IMAM program according to the admission criteria for OTP and SFP programs. The severely malnourished with medical complications are admitted in the referral hospital for stabilization before being discharged to their link health centers and dispensaries.

A coverage assessment conducted in 2012 using SQUEAC methodology to determine IMAM program coverage revealed Isiolo Sub-county to be below the SPHERE standards coverage of 30% and 32% for OTP and SFP programs respectively. Similarly, a SLEAC Survey conducted in Isiolo County in September 2016 to determine areas of High and Low coverage revealed Isiolo Sub-county to be an area of moderate and low coverage in both OTP and SFP programs –with coverage estimates of 52.9% (27.3-78.5 95% C.I) –and 35.3% (26.2-44.4 95% C.I) respectively.

1.3 Objectives of the Survey:

The overall objective of this assessment is to assess the IMAM coverage within the ICCM research implementation sites in Isiolo Sub-county and the negative/positive attributes to this coverage.

Specific Objectives

1. To determine single estimate coverage for IMAM program to act as a baseline for ICCM research programming.
2. Determine barriers and boosters for appropriate recommendations for pragmatic programming.
3. To determine the Single Coverage for SAM and MAM in Isiolo Sub-county using wide area survey
4. To capacity build MOH, ACF and key partners on how to conduct SQUEAC survey.
5. To share lessons learnt and develop recommendations based on findings which will be incorporated in ICCM research programming

2.0 INVESTIGATION PROCESS:

2.1 STAGE 1: Identifying Areas of High and Low

This stage entails collection of and analysis of routine programme data and additional quantitative data that helps identify areas of high and low coverage as well as the reasons for coverage. This data was extracted from OTP and SFP registers in respective health centres. Performance indicators data of was obtained from the DHIS for purposes of comparing programme performance for two consecutive years.

Additional qualitative data is also collected in this stage through interviewing of various key informants and observation in order to build up a picture of why coverage may be high or low.

2.1.1 QUANTITATIVE DATA

Assessment of routine program data from March 2017 to February 2018 was done, including trends in admission, admission by MUAC, admission by health facility, discharges by MUAC, length of stay at default. Performance trends for the same period of two consecutive years (March 2016 - February 2017 and March 2017- February 2018/) was compared to assess performance of the program over these period

2.1.1.1 Program Performance Indicators

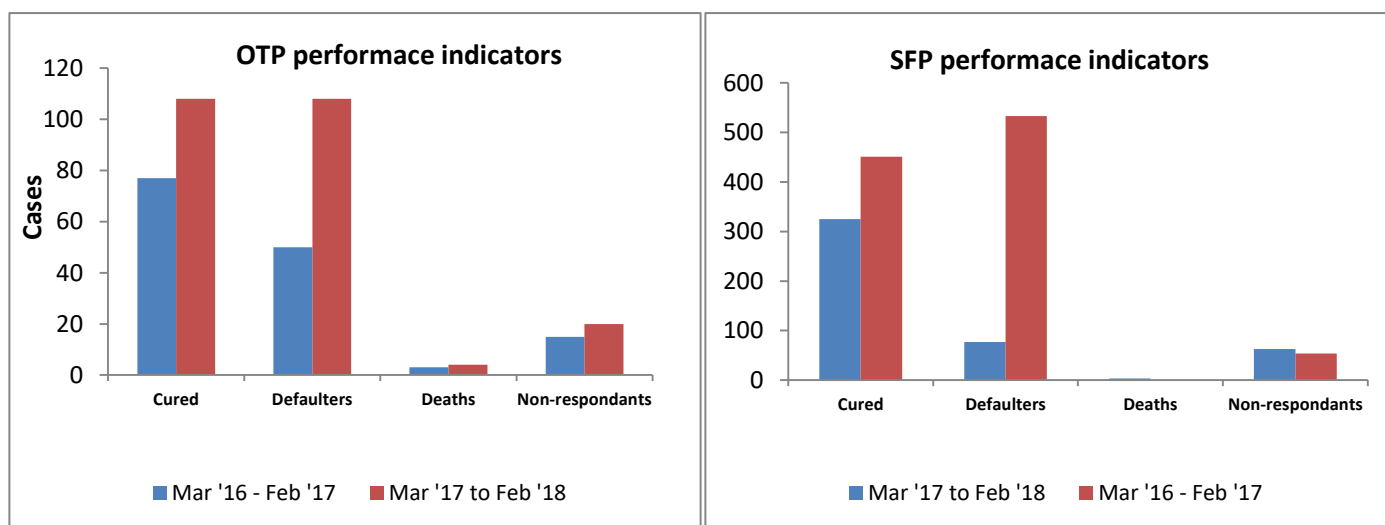


Figure 2: IMAM Program performance indicators in Isiolo Sub-county

In both OTP and SFP programs, there were higher rates of defaulting in 2017 and 2018 compared to a similar period of the previous year attributed to the industrial action taken by nurses

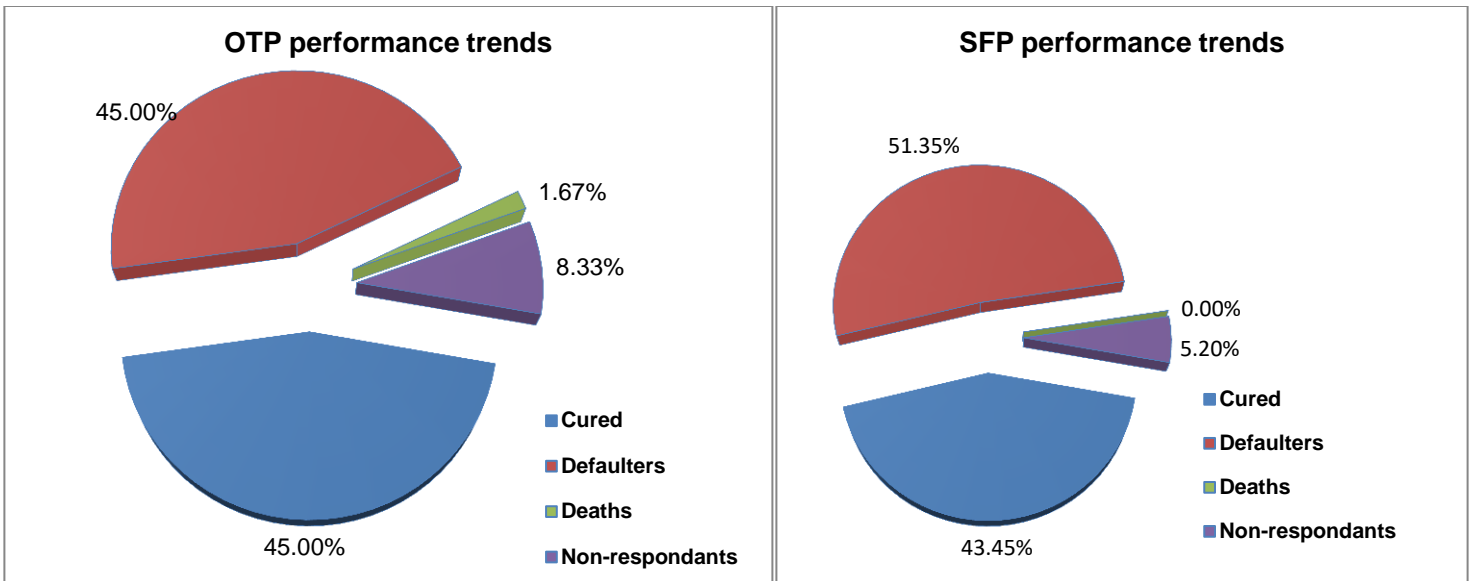


Figure 3: IMAM Program Performance trends (2016 /2017)

High rates of defaulting above the sphere standards of <15% on rural and urban areas can also be observed in both OTP and SFP programs within the one year period.

2.1.1.2 Admission Trends

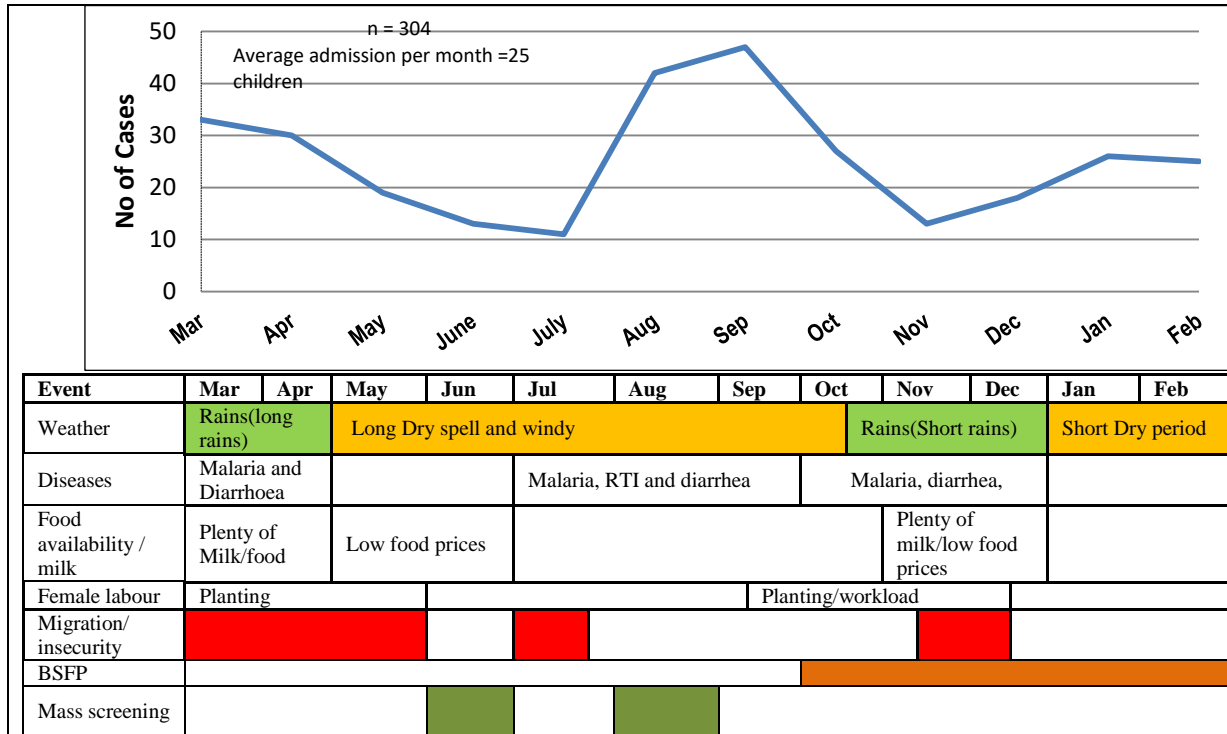
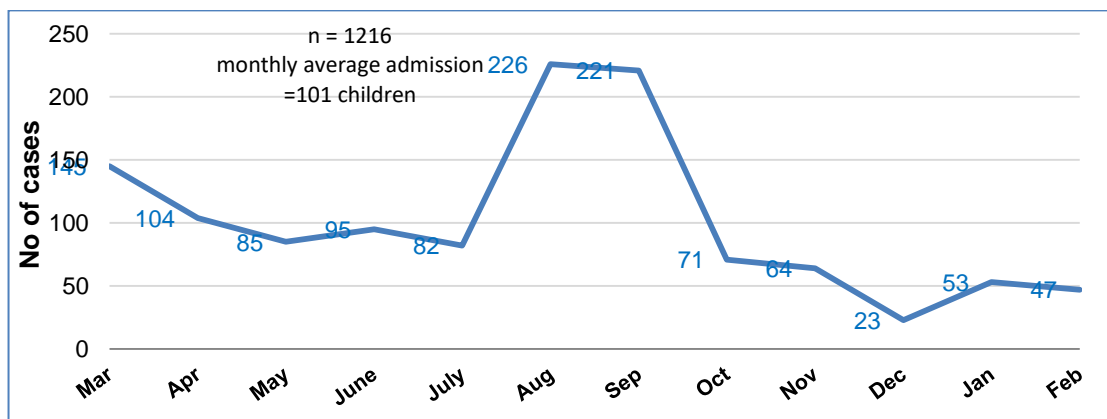


Figure 4: OTP Admission trends in Isiolo Sub-county (March 2017 to February 2018)

Increase in OTP admissions were observed between July to September attributed to the prolonged dry spell and also due to case finding after mass screening. Low admissions in the

program during the month of July were due to nurse’s strike that lead to closure of majority of the dispensaries.



Event	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Weather	Rains(long rains)	Long Dry spell and windy						Rains(Short rains)	Short Dry period			
Diseases	Malaria and Diarrhoea				Malaria, RTI and diarrhea			Malaria, diarrhea,				
Food availability / milk	Plenty of Milk/food	Low food prices						Plenty of milk/low food prices				
Female labour	Planting							Planting/workload				
Migration/ insecurity	[Red]				[Red]					[Red]		
BSFP								[Orange]				
Mass screening				[Green]		[Green]						

Figure 5: SFP Admission trends in Isiolo Sub-county (March 2017 to February 2018)

Increased admission of MAM cases were recorded in August and September 2016 due to the prolonged dry spell and mass screening of under- fives. The increase was also attributed to introduction of CLICK MUAC project that promoted malnutrition screening and self-referral by caregivers at the household level. Fewer admissions observed after the short rain season indicating improved food security (milk and meat from herds) at household level.

Admission by MUAC

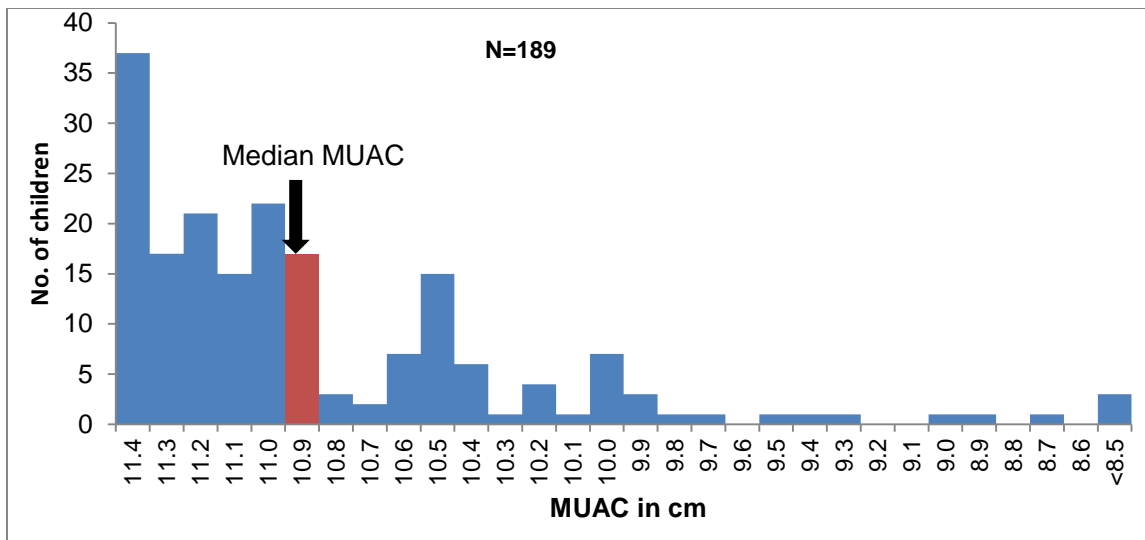


Figure 6: OTP Admission by MUAC in Isiolo Sub-county

Median MUAC at admission was at 10.9cm indicating that the program’s ability to capture SAM children is low. Quite a number of children are admitted with a very low MUAC of below 10.0cm thus a greater likelihood of poor treatment outcomes and longer treatment periods that could lead to defaulting.

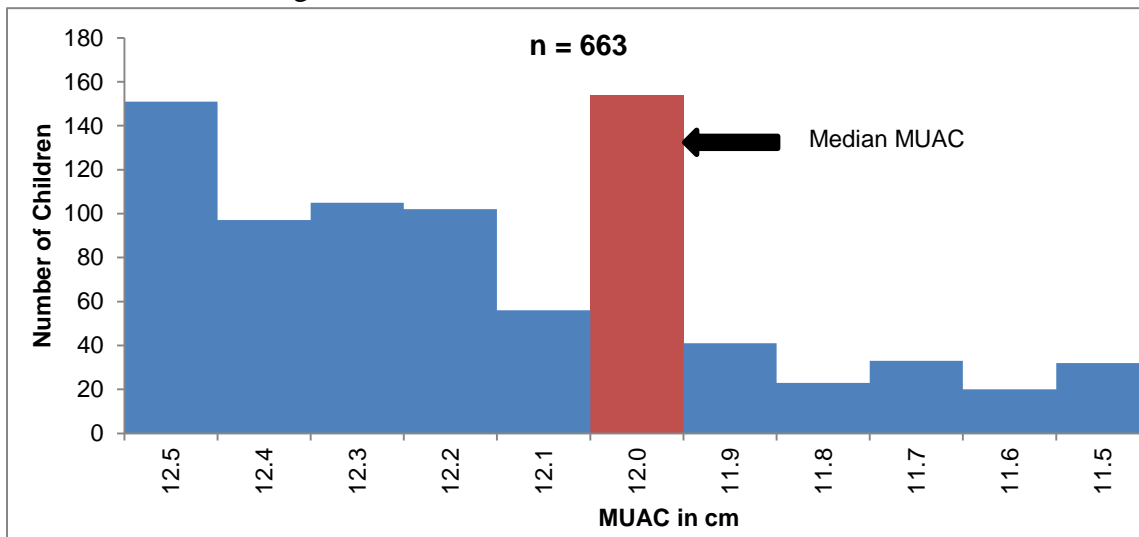


Figure 7: SFP Admission by MUAC in Isiolo Sub-county

The median MUAC at admission was at 12.0cm with large number of admissions having a MUAC above 12.0cm. This signifies that a good number of MAM children are captured in good time. However, quite a number of children are admitted with a MUAC of 12.5cm, indicating poor adherence to protocol.

Defaulting Trends

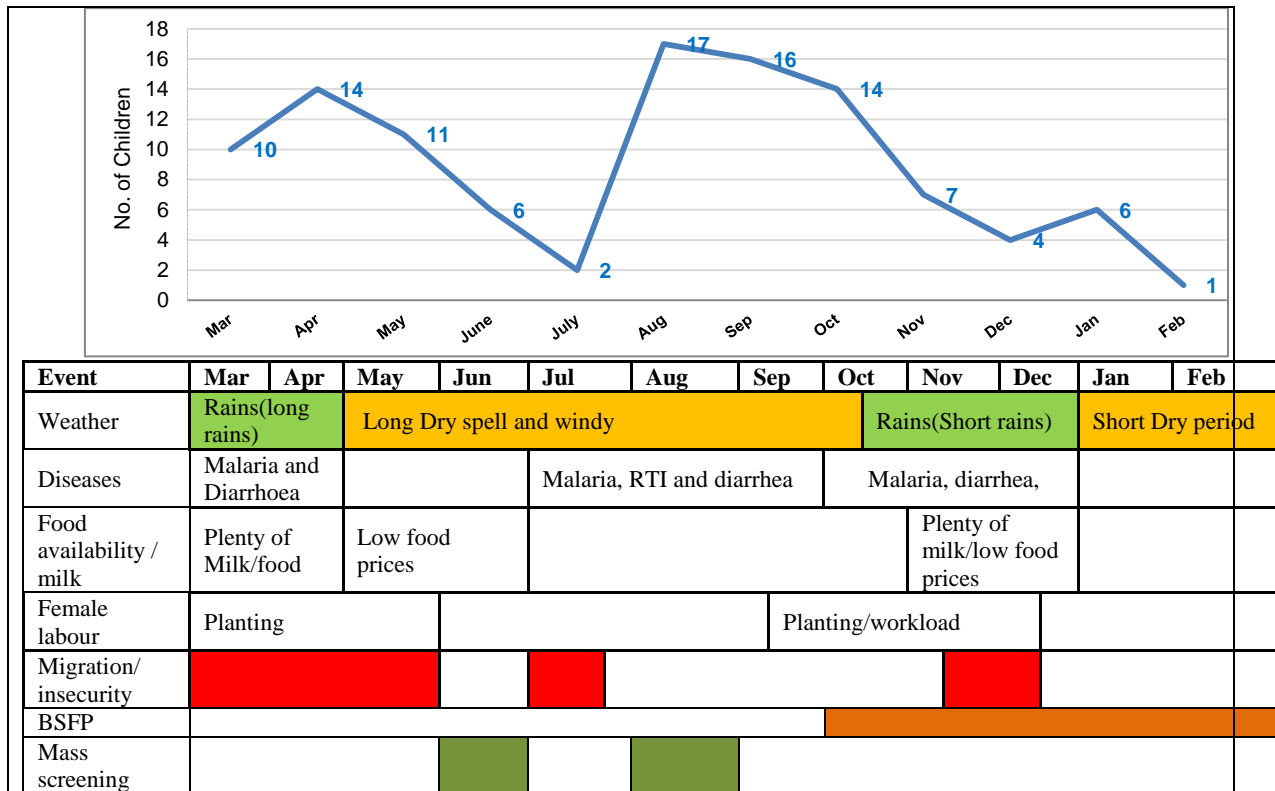


Figure 8: Defaulting Trends in OTP Program

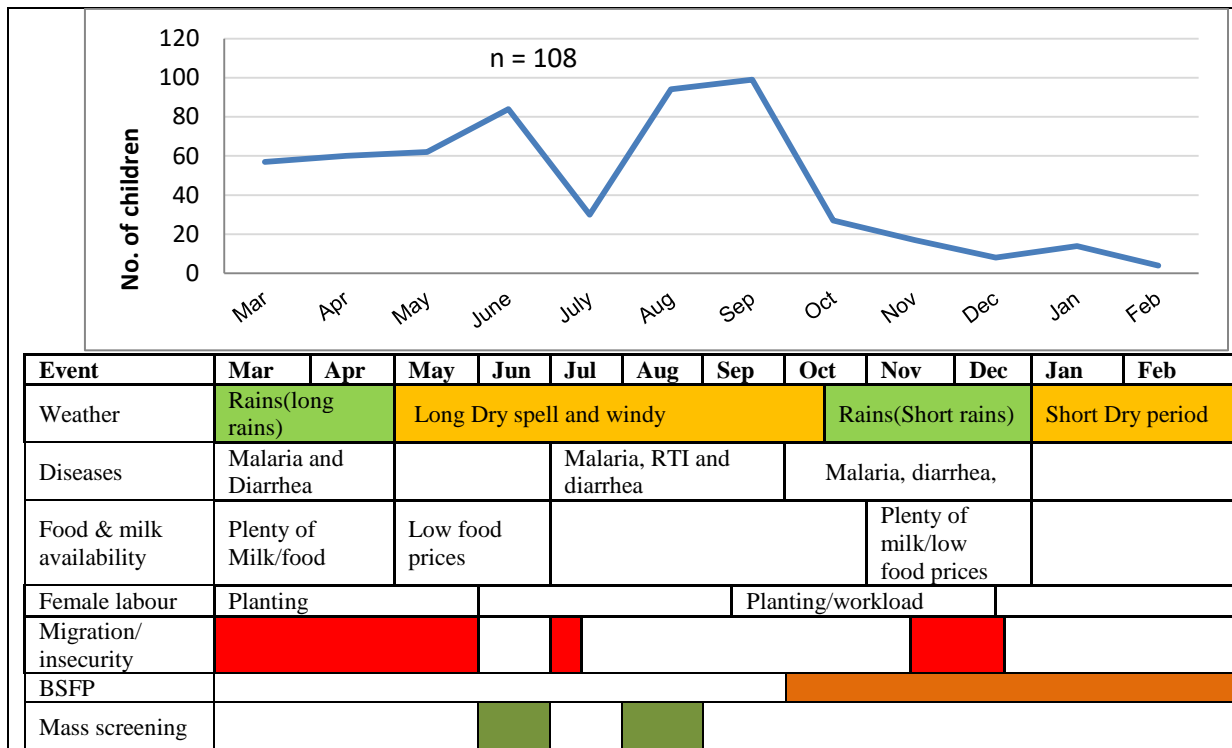


Figure 9: Defaulting Trends in SFP Program

Higher cases of defaulting observed after incidences of insecurity and migration. It could also be a contribution of the health workers strike and poor follow up of cases after mass screening. Incompleteness of records could also be a contributor of the high numbers of defaulting with exit details missing in some beneficiaries registers or not documented immediately after discharge where the transfer outs, discharged as cured are or transferred to SFP are not indicated as so, thus ending up being recorded as a defaulter.

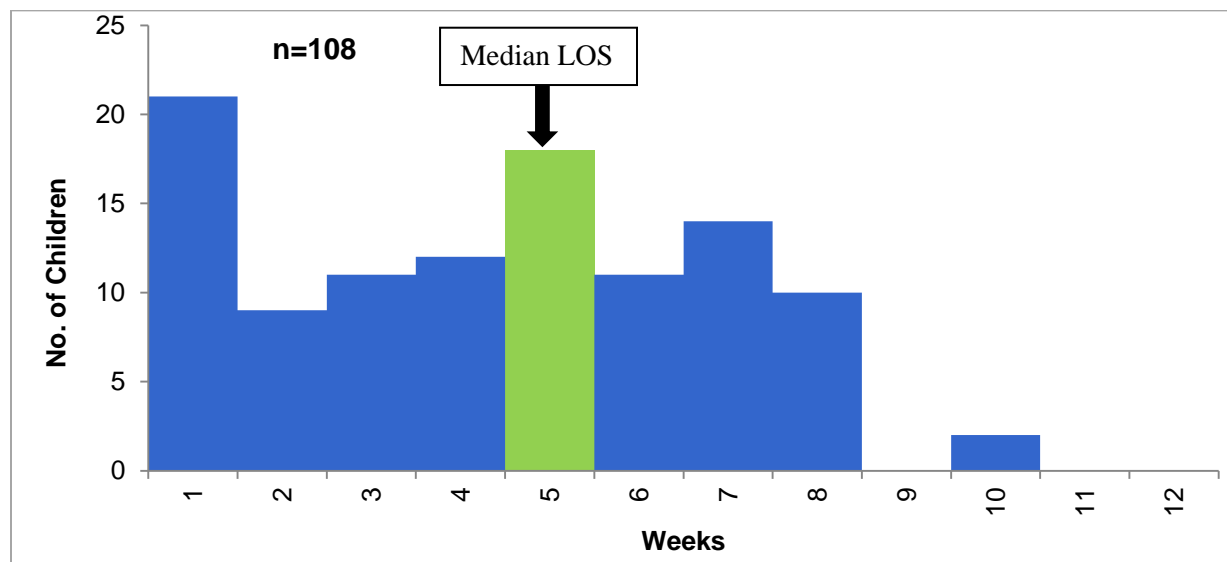


Figure 10: OTP median Length of Stay at default

Majority of the children admitted with a MUAC of 10.8cm (Media admission MUAC) defaulted at a late stage of treatment (5th week). This could be due to caregiver having the perception that the child has been cured after noticing improvement.

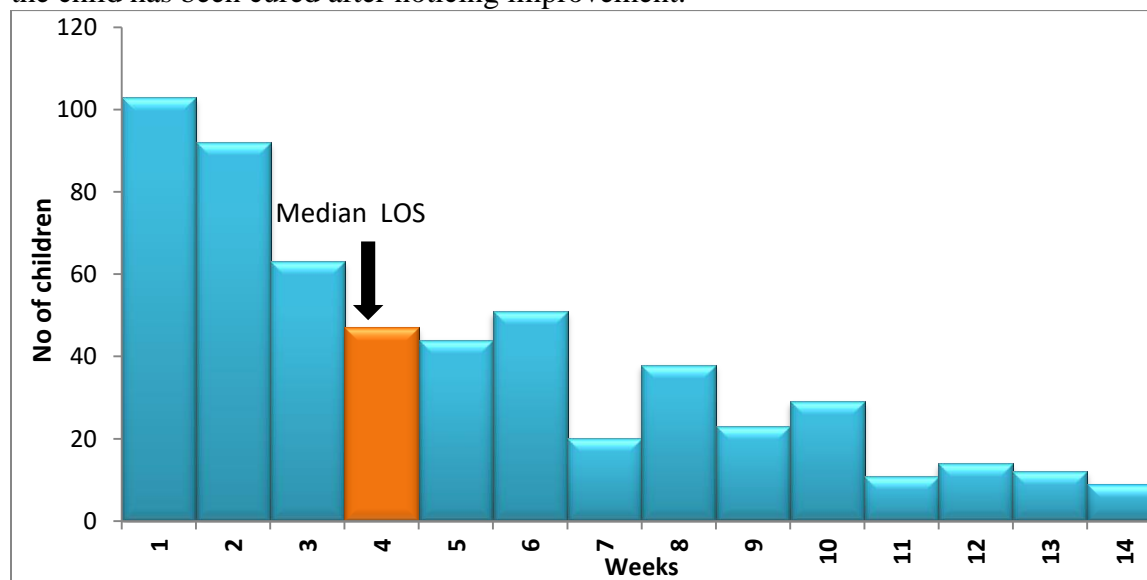


Figure 11: SFP Median Length of Stay at default

Majority of the children were observed to default after the 4th visit. A large number default after the first visit, indicating program’s poor retention strategy. While others were defaulting at 14th week indicating poor adherence to IMAM treatment protocol

Length of Stay

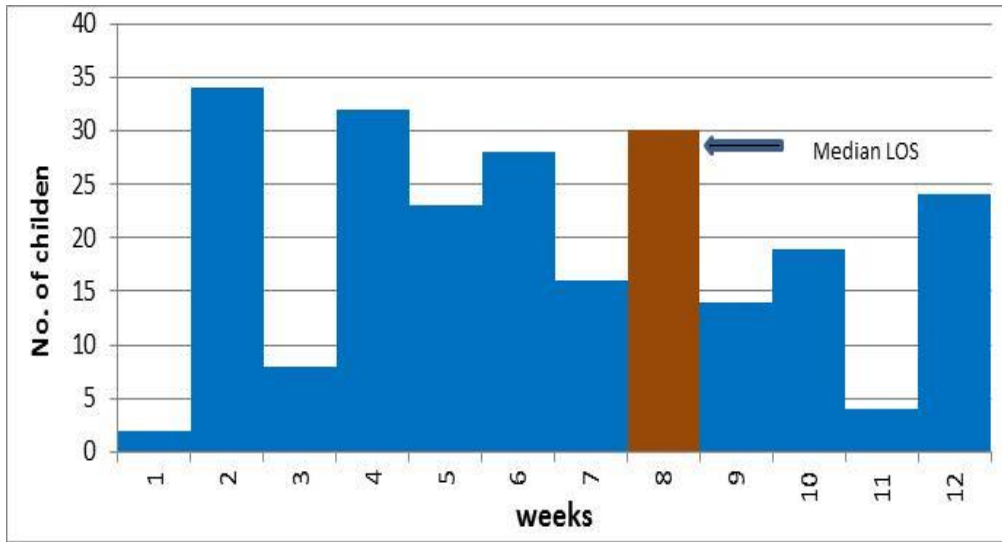


Figure 12: Median Length of Stay at discharge as cured in OTP Program

Majority of SAM cases admitted in the program are treated for a period of 8 weeks before they get cured. The prolonged length of stay could be influenced by the late admission into the program as indicated by a median MUAC of 10.9cm, which is quite late.

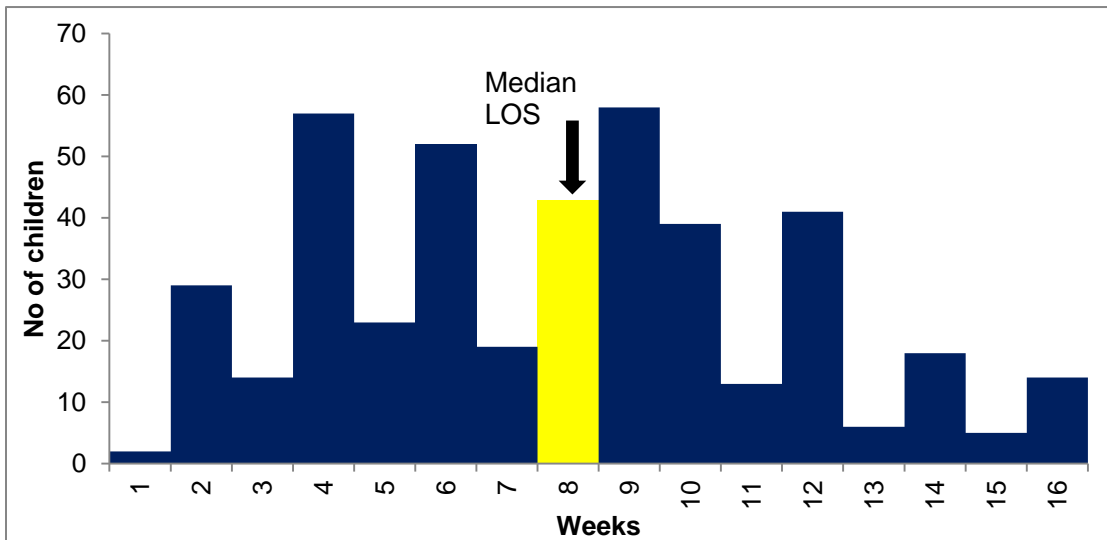


Figure 13: Median Length of Stay at discharge as cured in SFP Program

Majority of the MAM cases are admitted with a MUAC of 12.0cm and are cured within 8 weeks (4th visit), indicating the ability of the program to meet need.

Outcome Trends

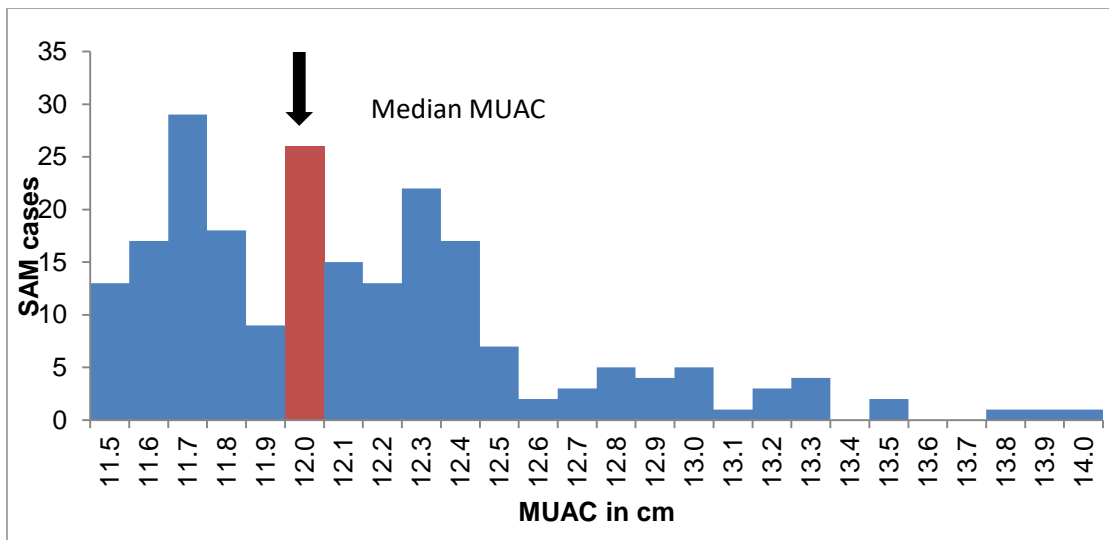


Figure 14: Median MUAC at discharge Cured in OTP Program

Majority of SAM children were discharged as cured at a MUAC of 12.0cm. However, there is a long tail

The MUAC was above the discharge criteria, which indicates overstaying in the program and poor adherence to discharge protocol. This could contribute to caregiver fatigue and defaulting.

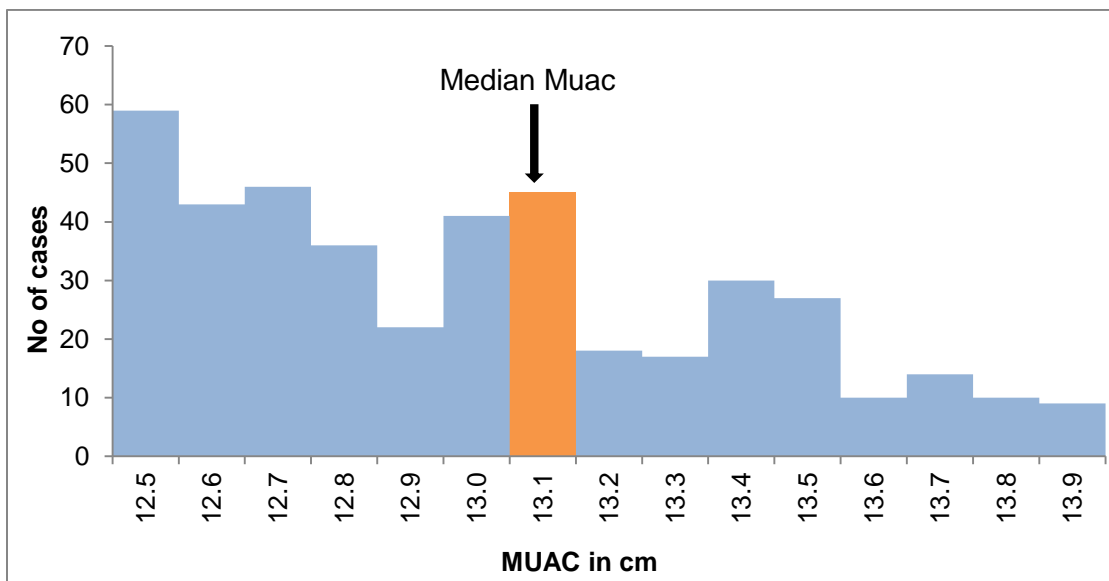


Figure 15: Median MUAC at discharge Cured in SFP Program

The Median MUAC at discharge cured for SFP was at 13.1cm indicating less likelihood of the children to relapse back to malnutrition.

2.1.2 QUALITATIVE DATA

Qualitative data on factors influencing program coverage in Isiolo Sub-county was collected using different methods from various groups and individuals who interact directly or indirectly

with IMAM program. using various methods. Question were asked to respondents until no other information could be obtained. The methods used to collect the qualitative information include;

- a) **Semi structured interviews:** information was collected from health facility in charge/program staff and CHWs, careers of children in program
- b) **Informal group discussions:** by community leaders, TBAs/THPs, pastoralists and care givers in the community.
- c) **Observation**

The sources of the qualitative information were

1. Care giver of child in program/mother
2. Community health Volunteer(CHV)
3. Nurse/Nutritionist
4. Religious leader
5. Chief/sub area
6. Father
7. Traditional health practitioner/TBA
8. Mother in law/grand mother
9. Village elder
10. NGO/FBO staff
11. CHMT
12. Community lay women

2.1.2.1 Data Triangulation Methods Used:

1. **Concept Map** to indicate (logical) positive or negative relationships between data
2. **Boosters, Barriers and Questions:** were used to indicate triangulation achieved with the questions that arose; BBQ showed what were the Boosters, Barriers and the Questions arising from them. The arising questions were further investigated to determine whether they were boosters or barriers
3. Barriers and Boosters affecting OTP and SFP Program were listed separately per program

Table 2: Boosters in OTP Coverage

No	Booster	Explanation	Sources
1	Adequate RUTF supply	Consistent supply of Plumpy Nuts during the period.	2,1,12,3
2	Regular nutrition screening	screening is done at household at once least every two weeks	1,8,4,2
3	Integrated medical services	outreaches also conduct nutrition assessment and treatment	1,8,12,6,2
4	Close proximity to health facility	Health facility within 1km radius in urban centers and 3km radius in rural areas	8,1
5	Good quality of health services	Efficient delivery of required services at the health facility.	1,3,2
6	Awareness of the treatment program	The community members were aware of existence of the program.	4,1,8,5,7,12
7	Active CHVs	CHVs conduct routine screening and are engage in Nutrition and health activities and the village level	12,1,8,4,2,
8	Availability of Medical outreaches	IMAM services were provided at outreach sites	1,8,4,2
9	Male involvement in making decision regarding household	As the household head, fathers were involved in decision making on food availability at the household level.	6,12

	food security		
10	Referrals done by the CHVs from the community to the health facility	The community health volunteers were engaged in referrals of malnourished children from the community to the health facility.	7,3
11	Linkages between TBA and CHV/HF –	the TBAs can identify malnourished cases and refer them to the health facility for treatment	7,12
12	CHV recognition by the community	CHVs are well recognized and accepted by the community.	2
13	CHVs trained on nutrition assessment	CHVs have been trained on assessment and classification of malnutrition.	3

Table 3: Barriers to OTP Coverage

No	Barrier	Explanation	Sources
1	Illiteracy of caregivers	Some caregivers have no capacity to understand the signs of malnutrition and its management.	1, 8
2	Long distance to H/F (above 2km for urban centers and 5km for rural areas)	Some households were located very far from the health facilities, making it difficult to access these services as required.	8,6,1,5,7,1 2,2,4,3
3	Stigma	self-stigmatization and by other members of the community	8,4,6,1,2
4	Knowledge gap on malnutrition	little or no knowledge about malnutrition	8,4,6,5,7,1 2,1,2,3,
5	Stock outs of commodities at the health facility	Some health facilities experienced shortages of RUTF during the reference period.	8,1,2,3
6	Ignorance by caregiver	preference y caregiver to commit to other activities other than seeking care for the malnourished child	8,6,7,12,1, 2
7	Migration	Movement to other area disrupts treatment	8,6,1,12
8	Long waiting time at h/f	Long ques at the health facilities discouraged some of the caregivers keep coming back at the health facilities for treatment.	8,1,12
9	Lack of program involvement at the community	No feedback is given at the community after surveys and regarding implementation of the program	4,5,12
10	Insecurity	Inter-tribal clashed lead to households fleeing to areas where they cannot access treatment	6,1
11	High workload by caregivers	Caregivers engaged in household chores and casual labor activities that they lack time to seek health care	1,2,3,4,
1	Staff shortage	Contributed by staff turnover and failure of county to recruit new staff by the county government.	1
13	Negative cultural beliefs	Beliefs and social norms that influence the nutrition and health status of the child negatively.	5,12,3
14	Lack of motivation to CHVs	No incentives for CHVs	2,4
15	Poor referral system/follow up	Lack of linkages during referral from the facilities back to the community.	7,12,3,1
16	Health facility rejections	Children referred from the community were turned back by health care workers at the facility	2
17	Lack of regular meeting between H/F and CHVs	Failure of the community unit to conduct coordination meetings scheduled at least once every month/	2
18	Food insecurity at household level	Lack of food at the household	7
19	Poor health seeking behaviors	Caregivers prioritize other things above the health of the child	7,1,12
20	Sharing of RUTF	Non malnourished children / adults consumed the treatment ratio	1,4

		of the malnourished child enrolled in the program.	
21	Negative attitude towards IMAM program	Some caregivers do not believe that the treatment can cure their children.	1,2
22	Poor child care practices due to Alcoholism	Alcoholic caregivers failing to adequately care for the child leading to malnutrition and high risk of illnesses	2
23	Lack of tools for assessment and referral	Some CHVs lacked MUAC tapes and referral forms.	2

Table 4: Boosters in SFP Coverage

No	Booster	Explanation	Source
1	Skilled CHVs	CHV are well trained and skilled to conduct assessment and referral of malnutrition	2,1,3
2	Good defaulter tracing	Through linkage with health facilities, CHVs trace defaulters at the household	2,3,10
3	Availability of tools for assessment and referrals	MUAC tapes and referral forms available at the community.	2,3
4	CHVs self- motivated	CHVs volunteer willingly to be engaged in nutrition and health activities at the community.	2
5	Documentation and report writing by CHVs	Monthly reporting done by CHVs	2
6	Integration of services –	Nutrition assessment at triage areas at the outpatient help in identification of malnutrition cases	2,3,1,8,10
7	Awareness creation at the community	CHVs conduct nutrition and health education at the community	2,8,1
8	Active case finding done by CHVs at the community	Routine screening and household visits by CHVs	3,2,1
9	Positive attitude of caregivers on IMAM program	Caregivers understand the importance of malnutrition management and are positive towards seeking treatment.	3,1,10,2
10	Regular CHV meetings(Monthly)	CHVs holding monthly meetings with CHEWs and health care workers	3,2
11	Supervision done at least once every quarter	Supportive supervision done by county and sub-county management team.	3
12	Quality services at the facility	Good quality of health services at the health facilities	3,8,1
13	Good referral system from the community to the health facility by CHVs	Referrals done by CHVs from the community to the facility.	2,1,12,5
14	Recognition of IMAM services by caregivers and other community members	Caregivers are aware about IMAM program	2,1,12
15	Good health seeking behavior	Caregivers seek health care	1,8
16	Close proximity to H/F	Health facility within 1km radius in urban centers and 3km radius in rural areas	1
17	Outreaches	Availability of outreaches	1,12
18	Capacity building done by NGO	Partners support community Units in training and sensitization to build capacity of health workers and volunteers	10,3
19	Follow up of case in treatment and the lost cases done by CHVs	Follow-up of cases done by CHVs at the community.	10
20	Motivation by NGO	Incentives given to CHVs by supporting partners.	10,2,12
21	Availability of treatment	Sufficient stocks of treatment commodities at health	3,7,10

	commodities (RUSF) at the facility	facilities.	
22	Trained health care worker	Health workers have been capacity built on IMAM	2,8,5,12,3
23	Good communication channel	Health workers and CHVs can communicate well, and regularly for information sharing.	3
24	Minimum waiting period	Efficiency in flow of services at health facilities such that the caregivers do not wait for long period	1

Table 5: Barriers in SFP Coverage

No	Barrier	Explanation	Source
1	Heavy workload health workers	Caregivers engaged in household chores and casual labor activities that they lack time to seek health care	2,3,1
2	Distance to H/F (above 2km for urban centers and 5km for rural areas)	Some households were located very far from the health facilities, making it difficult to access these services as required.	2,9,3,1,12,8,10
3	Lack of incentives to CHVs	Little or no payment or motivation tokens to CHVs	2,3,10
4	No feed back to the community after data collection during surveys	Little or no feedback to the community on survey findings.	5,8
5	Staff shortage	Contributed by staff turnover and failure of county to recruit new staff by the county government.	5,8,9,1,10
6	RUSF perceived as food	Households view the treatment commodities as food, not a drug, leading to sharing.	1,9,8
7	Knowledge gap on malnutrition signs and treatment	Caregivers not aware on how malnutrition presents in the young children and how it can be treated.	8,3,7,12,
8	No explanation to caregivers during treatment	Caregivers are taken through the treatment process with little or no knowledge about what the child is being treated for.	8,1,2
9	Stigma	self-stigmatization and by other members of the community	12,2,1
10	Migration	Movement to other area disrupts treatment	3
11	Ignorance about IMAM services	Lack of knowledge on malnutrition management services at the facilities.	3,8,1,2,12
12	Low capacity building of staff	Some of health workers not trained on IMAM	3,2
13	Shortage of commodities	Periodic shortages at the health facility.	2,7,8,3,1,10
14	Negative cultural beliefs	Beliefs and social norms that influence the nutrition and health status of the child negatively.	2,1,12,7
15	Absenteeism of health workers / closure of health facilities	Some health facilities closed or health workers not available for prolonged periods	2,1
16	CHVs not appreciated by the community	Some community members disregard the voluntary work done by CHVs.	2
17	Poor linkage/ between Health facilities and CHV	Breakage of communication channel between health worker and CHV.	3
18	Alcoholism	Alcoholic caregivers	1,12
19	Community over dependency on hand outs	Community depends on relief food and	2,12
20	Poor referral procedures	Lack of linkages	2,8,1,3,12,
21	Sharing of treatment commodities	Non malnourished children / adults consumed the treatment ratio of the malnourished child enrolled in the program.	1,2,3,12
22	Natural calamities/barriers	E.g. seasonal rivers, mountains that completely cut off an area from access to health facility.	2,8,10
23	Insecurity	Inter-tribal clashed lead to households fleeing to areas where	2

		they cannot access treatment	
24	Selling of RUSF	Some caregivers sell the treatment ration given.	2,8
25	Long waiting time at the health facility	Inter-tribal clashed lead to households fleeing to areas where they cannot access treatment	8
26	Lack of identification materials for CHVs	CHVs lack badges or coats that they could identify them as CHVs in the community.	2
27	Poor attitude of health workers to caregivers during treatment	Some caregivers feel like they are treated rudely at the health facilities	1
28	Insufficient assessment and referral tools for CHVs	Some CHVs lacked MUAC tapes and referral forms.	10
29	Poor service integration		10
30	Influence by secondary caregiver	Negative influence on childcare y grandmothers or mother in laws	1
31	Poor reporting systems	Breakages of reporting channels failure to report	10

Concept Map

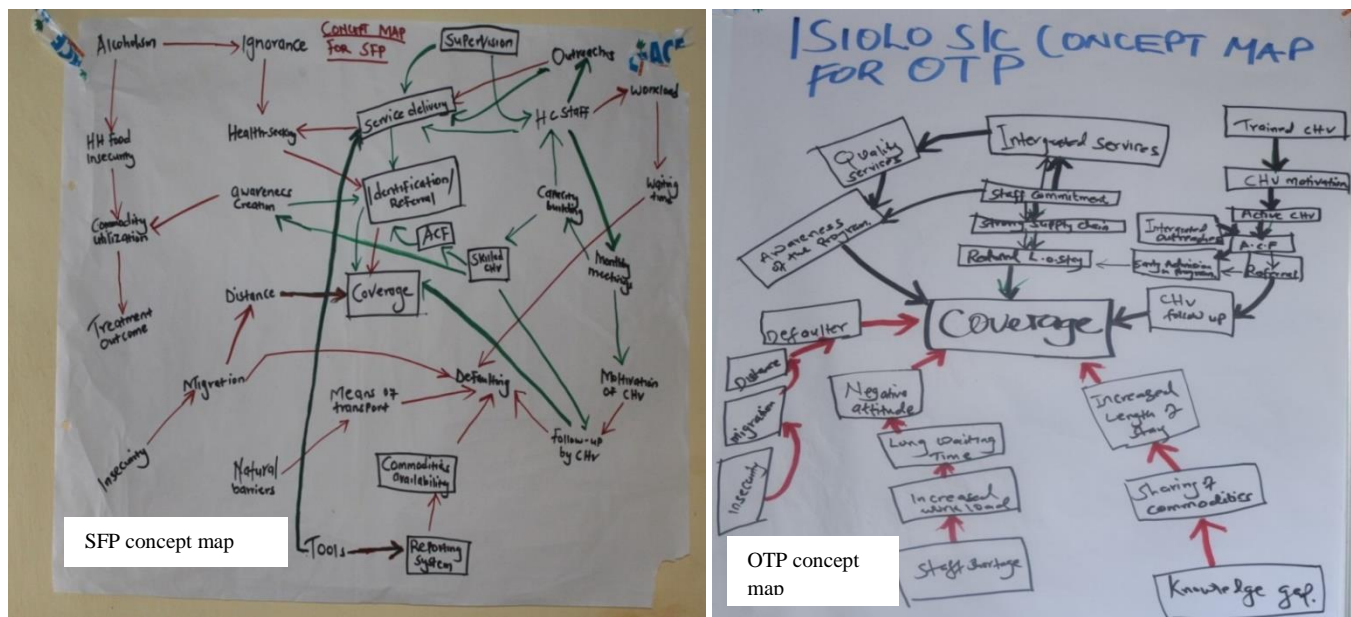


Figure 16: Concept Maps for OTP and SFP in Isiolo Sub-county

2.2 STAGE 2: Hypothesis Testing and Verification

In this stage information collected from the previous stage helps to formulate hypotheses on coverage which will be tested and proved to be either satisfactory or unsatisfactory.

Evidence in Stage 1 indicated that IMAM program in Isiolo Sub-county has defaulting rates of 45% and 54% in OTP and SFP respectively. The rates are above the SPHERE standards thresholds of 15% despite frequent defaulter tracing being conducted at the household level by CHVs. The data also helped identify areas with higher defaulting rates and those with low defaulting rates and this was used to develop hypotheses for both OTP and SFP programs

Hypothesis statements;

- There is low coverage (<40%) in areas with high rates of defaulting and poor routine screening (active case finding and follow-up) by CHVs
- Hypothesis of high coverage (>40%) in villages low defaulting rates with consistent routine screening and good defaulter tracing mechanism

2.2.1 Study Description

2.2.1.1 Small Study

A small study was thus conducted to understand the reasons for defaulting in both areas of high and low coverage. A total of 33 defaulters (12 from OTP and 21 from SFP) from 24 villages were visited and interviewed on the reasons why they had defaulted from the program. The reasons for defaulting are highlighted in *Figures 17 and 18*.

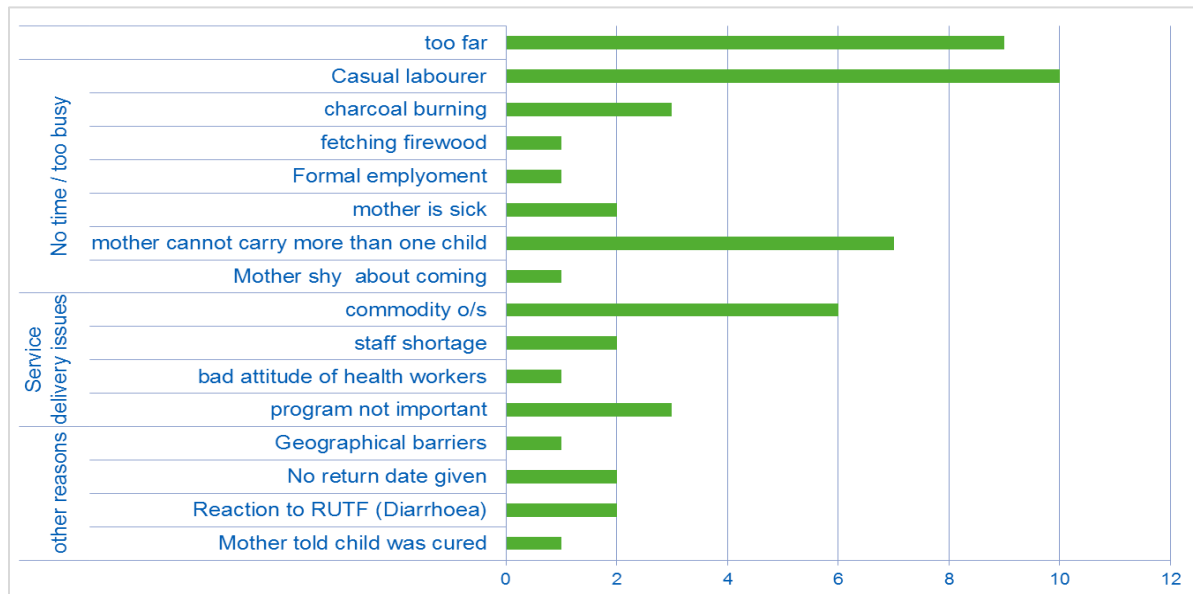


Figure 17: OTP main reasons for defaulting

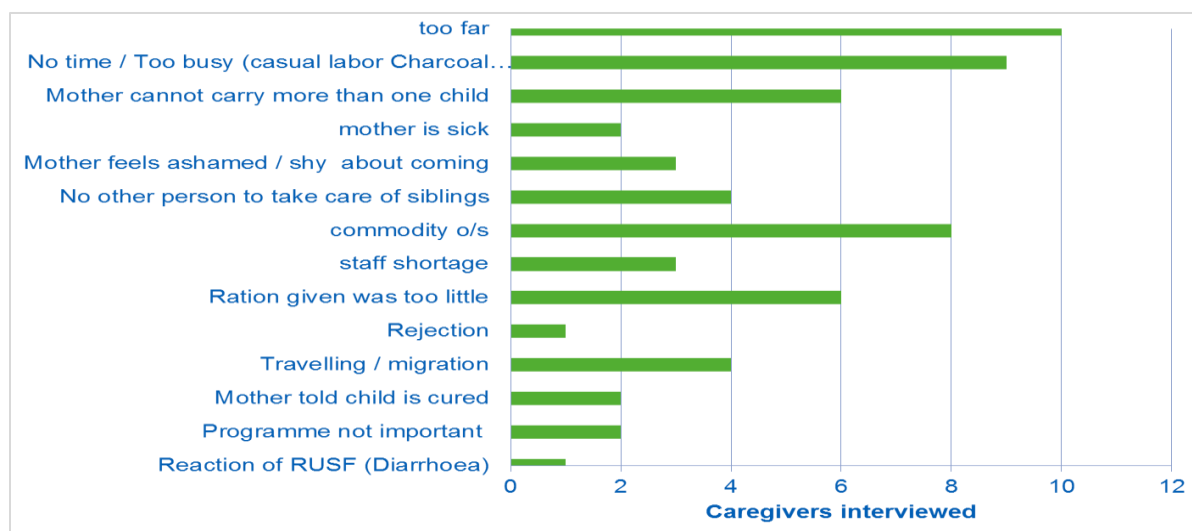


Figure 18: SFP main reasons for defaulting

Distance was found to be the major influencer of defaulting in both OTP and SFP programs hence affecting program coverage. Engagement in casual labor and commodity running out of stock at the health facilities also contributed to defaulting. In SFP, some caregivers also felt that the treatment ratio given was too little to justify going back to the health facility, which indicates poor understanding by the caregivers on the importance of malnutrition management.

2.2.1.2 Small Area Survey

In order to confirm or reject the hypothesis, a small area survey was conducted, applying the simplified LQAS (Lot Quality Assurance Sampling) methodology.

The formula $d = \lceil n \cdot p / 100 \rceil$ was used where

n = sample size

p = standard set (50% -SPHERE standards for rural setup)

d= threshold value

Table 6: Case Definition

Definition	Age category	Cut offs
SAM case	Child aged between 6 – 59 months	MUAC <115mm, and/or Bilateral oedema
SAM recovering	Child aged between 6 – 59 months Presently in OTP (verify with RUTE/Card)	MUAC ≥ 115mm; No Bilateral Oedema
MAM case	Child aged between 6 – 59 months	MUAC ≥115 - <125mm
MAM recovering	Child aged between 6 – 59 months, presently in SFP (verify with RUSF/Card)	MUAC ≥ 125mm
Case not covered	Child aged between 6 – 59 months who qualifies to be SAM or MAM case, but is not admitted in either program.	

2.2.2 Qualitative Data (Hypothesis Verification) Results

Table 7: OTP High Coverage Hypothesis

THRESHOLD = 40%										
Hypothesis of high coverage in areas with low defaulting										
Sub-county	HF	OTP % defaulting	Village	SAM Case	SAM Case covered	SAM Case NOT covered	Recovering SAM	Total SAM + recovering SAM	Total covered (SAM or recovering)	
Isiolo	kipsing	25	Naingura	0	0	0	1	1	1	
Isiolo	Narapuu	28.5	Iebarisherik	0	0	0	2	0	2	
Isiolo	Ngaremara	33.3	Atuntun	0	0	0	1	1	1	
Total				0	0	0	4	2	4	
d= n * (p/100)				d=			2*(40/100)	= 0.8		
round off to 1 child										
since 4>1, hypothesis of high coverage is confirmed.										

Table 8: OTP Low Coverage Hypothesis

THRESHOLD = 40%										
Hypothesis of low coverage in areas with high defaulting										
Sub-county	HF	OTP % defaulting	Village	SAM Case	SAM Case covered	SAM Case NOT covered	Recovering SAM	Total SAM + Recovering SAM	Total covered (SAM or recovering)	
Isiolo	Oldonyiro	76.5	Parkurk	2	0	2	0	2	0	
Isiolo	ACK	58	Mabatini	1	1	0	1	2	2	
Isiolo	Cathoic	80	Mwangaza C	0	0	0	1	1	1	
Total				3	1	2	2	5	3	
d= n * (p/100)				d=			5*(40/100)	2		
since 3>2, hypothesis of low coverage is confirmed.										

Table 9: SFP High Coverage Hypothesis

THRESHOLD = 40%								
Hypothesis of high coverage in areas with low defaulting								
HF	% defaulting	Village	MAM Case	MAM Case covered	MAM Case NOT covered	Recovering MAM	Total MAM + recovering MAM	Total covered (MAM or recovering)
Narapuu	10.9	Namelock	1	0	1	8	9	8
GK Prison	8.1	Kariokor	5	1	4	2	7	3
Oldonyiro	6.9	Narasha	3	2	1	0	3	2
Total			9	3	6	10	19	13
		$d = n * (p/100)$			$d = 19*(40/100)$	7	round down	
		since $13 > 7$, the hypothesis of high coverage is confirmed						

Table 10: SFP Low Coverage Hypothesis

THRESHOLD = 40%								
Hypothesis of low coverage in areas with high defaulting								
HF	% defaulting	Outreach village	MAM Case	MAM Case covered	MAM Case NOT covered	Recovering MAM	Total MAM + Recovering MAM	Total covered (MAM or recovering)
Eremet	99.4	Eremet	9	6	3	8	17	14
Kipsing	51.3	Lengurma	9	5	4	0	9	5
Ngaremara	55.9	Ngaremara	7	4	3	3	10	7
Total			25	15	10	11	36	26
		$d = n * (p/100)$			$d = 36*(40/100)$	14	round down	
		since $26 > 14$, the hypothesis of low coverage is confirmed						

From the analysis done, heterogeneity in coverage was confirmed, meaning that areas with high defaulting rates have poor active case finding and defaulter tracing mechanisms, while areas with low defaulting have CHVs actively doing active case finding and defaulter tracing that contributing to high program coverage.

2.3 Forming the Prior

It was derived from;

- **Simple barriers & boosters:** this involved listing of the Boosters and Barriers arising from triangulated evidence
- **Weighted barriers & boosters:** the Boosters and Barriers derived from well-triangulated evidence in stages 1 and 2 were weighted depending on the impact they have on IMAM program coverage
- **Histogram:** Histogram drawn with Credible coverage limits derived from triangulated evidence
- **Bayes Prior Plot:** Use of the Bases calculator and manual calculation

Shape parameters: Describe α and β shape parameters (Bayes Calculator or manual calculation)

2.3.1 Weighting of Boosters and Barriers

Table 11: Weighting of OTP Boosters

BOOSTER	SOURCE	Unweighted score	Weighted score
Adequate RUTF supply	2,1,12,3,1,1,1,1,1,12	1	3
Regular nutrition screening/case finding	1,8,4,2,1,1,1,4	1	2
Integrated services at health facility level	1,8,12,6,2,1,1,1,1,8,12,12	1	4
Proximity to health facility	8,1,1	1	1
Awareness of the treatment program	4,1,8,5,7,12,4,4,1,1,1,12	1	4
Quality services (Cure rate)	8,1,1,3,2	1	2
Active CHVs	12,1,8,4,2,1,1,12	1	2
Medical outreaches	1,8,4,2,1	1	1
Male involvement in decision making on IMAM program	6,12	1	1
Referrals	7,3	1	1
Linkages among CORPs	7,12	1	1
CHV recognition by the community	2	1	1
Trained CHVs	2,1	1	1
Total		13	24

Table 12: Weighting of OTP Boosters

BARRIERS	SOURCE	Unweighted score	weighted score
Illiteracy and cultural beliefs	1,8,5,12,3	1	1
Distance to H/F	8,6,1,5,7,12,2,4,3,12,12,4,2	1	4
Migration/nomadic lifestyle	8,6,1,12	1	2
Stigma	8,4,6,1,2,1	1	2

Knowledge gap	8,4,6,5,7,12,1,2,3,	1	4
Poor health seeking behaviors	7,1,12,8,4,6,1,1,2	1	3
Stock outs	8,1,2,3	1	2
Work load	1,2,3,4,4,1,3,2	1	3
Staff shortage	1	1	3
Long waiting time at the H/F	8,1,12	1	3
Lack of tools	2	1	1
Poor routine screening, referral system/follow up	7,12,3,1	1	3
Lack of program involvement	4,5,12	1	2
Ignorance on use of RUTF	8,6,7,12,1,2,4,2,12	1	3
Insecurity	6,1	1	1
Rejection and staff attitude	2,2	1	1
High workload by caregivers	1,2,3,4,	1	2
Care giver illness	1	1	1
Cultural beliefs	5,12,3	1	1
Lack of motivation to CHVs	2,4,2,2,2,4	1	3
Poor communication between CORP and the H/F	4,1,2,2,1,3	1	3
Lack of regular meeting between H/F and CHVs	2,2,2	1	3
Food insecurity	7	1	3
Negative attitude	1,2	1	1
Alcoholism	2	1	2
Total		25	57

Table 13: Weighting of SFP Boosters

BOOSTERS	SOURCE	SIMPLE	WEIGHTED
Health seeking behavior		1	2
Good health seeking behavior	1,8,1		
Awareness about malnutrition and malnutrition signs		1	3
Awareness creation	2,2,8,1,2,2		
Recognition of IMAM services	2,1,1,12		
Availability of the service		1	3
Close proximity to H/F	1,12		
Outreaches	10,3		
Identification/strategy & enrollment		1	3
Integration of services	2,3,1,8,10,3		
Self-motivation	2,2		
Active case finding	3,2,1,12,1,2		
Communication system with CHVs		1	1
Regular CHV meetings(Monthly)	3,2,3		
Communication system with community		1	1
Good communication channel	1		
Referral/transfer & Follow up strategy		1	2
Good referral system	2,1,12,2,5,12,		
Follow up by CHVs	10,2,12,2		

Capacity to provide a quality service (from health staff)		1	3
Skilled CHVs	2,2,1,1,1,1,1,2,3,1,3,2		
Availability of tools	2,2,2,2,3,		
Documentation and report writing	2,2		
Supervision	3,3,3,		
Quality services	3,8,1,1,1,1,3,1		
Capacity building by NGO	10		
Availability of commodities	2,8,5,12,3		
Trained health care worker	3,3		
Minimum waiting period	1,1,1,		
Appreciation of the service:		1	2
Positive attitude (children get cured after treatment)	3,1,1,10,12,1		
Retention strategy		1	1
Motivation by NGO	3,7,10		
Good defaulter tracing mechanism	2,3,2,10,3		
Total		10	21

Table 14: Weighting of SFP Barriers

BARRIERS	SOURCE	SIMPLE	WEIGHTED
Identification/strategy & enrollment		1	1
Poor service integration (outreaches not integrated)	10		
Lack of identification materials for CHVs	2		
Referral/transfer & Follow up strategy		1	3
Lack of incentives to CHVs	2,3,10		
Poor referral procedures	2,8,1,3,12,		
Capacity to provide a quality service		1	2
Heavy workload	2,3,1		
Staff shortage	5,8,9,1,10		
Low capacity building of staff	3,2,3,3,2		
Shortage of commodities	2,7,2,8,1,3,1,3,10		
Long waiting time	8		
Insufficient tools	10		
Poor reporting systems	10		
Absenteeism/closed H/F	2,1,1		
Appreciation of the service:		1	1
CHVs not appreciated by the community	2,		
Poor attitude	1		
Retention strategy		1	2

Poor linkage between HF and CHV	3		
Communication system with community		1	1
Poor attitude of health workers	1		
Totals		10	19

2.3.2 Histogram

Histograms are drawn or derived with credible coverage limits derived from triangulated evidence. Using the obtained data from the various sources, barriers and booster, the survey team identified the most unlikely coverage values. The percentage of the number of people from the team proposing the coverage values was marked on the chart and a bar graph plotted from these figures. The highest percentage of the team suggested the coverage values of 56% for SFP and 46% for OTP as the most likely values for coverage.

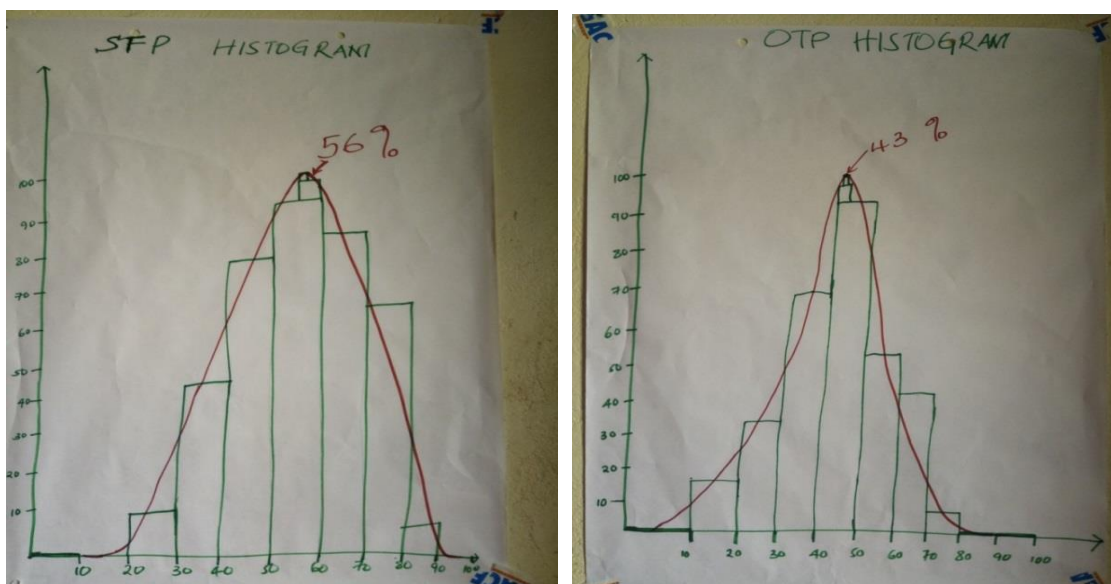


Figure 19: Figure 16: OTP and SFP Program Histograms indicating belief in Isiolo Sub-county Coverage

Histogram = 56%

BBQ simple

Boosters = 10, Barriers = 10

Average = $\{10 + (100 - 10)\} / 2 = 50\%$

BBQ Weight

Boosters = 21, barriers = 19

Average = $\{21 + (100 - 19)\} / 2 = 51\%$

Concept Map

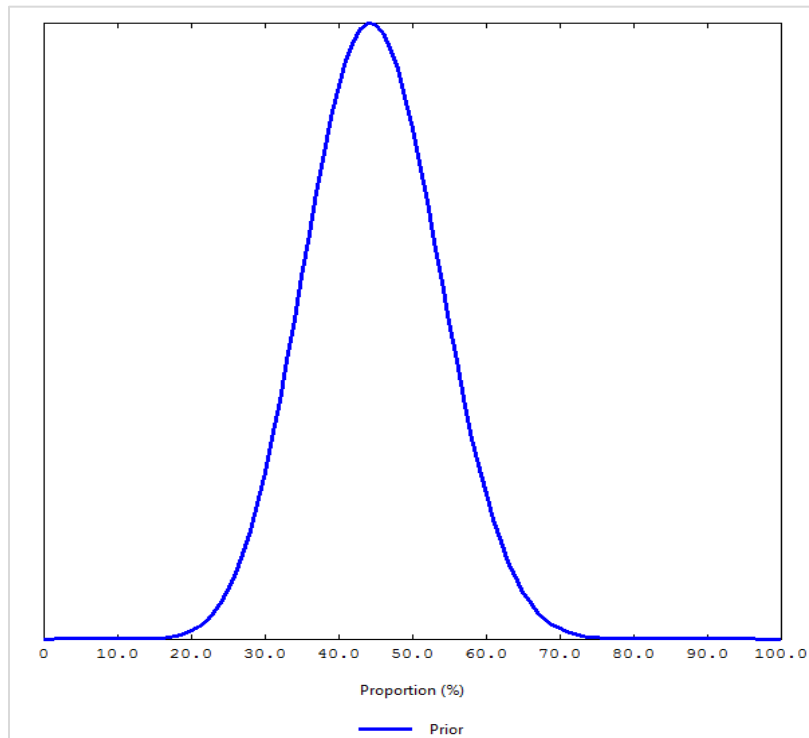
Positive links = 20; Negative links = 24

Average = $\{20 + (100 - 24)\} / 2 = 48.0\%$

Prior: $(56.5 + 50 + 51 + 48) / 4 = 51.3\%$

2.3.3 Bayes Plot of the Prior

OTP PRIOR



Alpha = 13.8
Beta = 17.1
Mode = 0.44
Precision = 13%

Sample size = 29

Figure 20: A Bayes Plot of OTP Prior

Histogram = 43%

BBQ simple

- Boosters = 13 , barriers = 25
- Average = $\{13 + (100 - 25)\} / 2 = 44\%$

BBQ Weighted

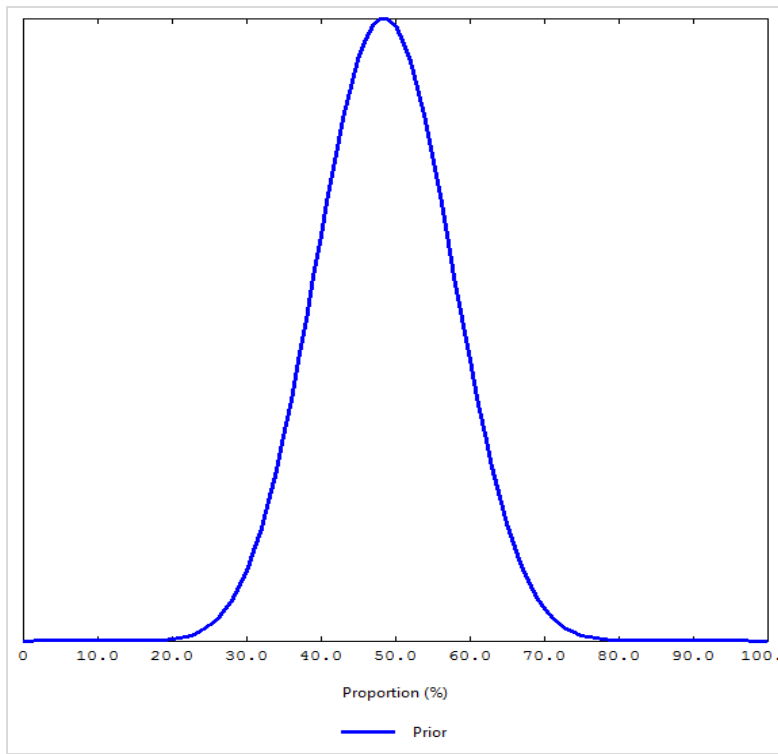
- Boosters = 24 , barriers = 57
- Average = $\{24 + (100 - 57)\} / 2 = 34\%$

Concept map

- Positive links = 18; Negative links = 11
- Average = $\{18 + (100 - 11)\} / 2 = 53.5\%$

Prior: $(43 + 44 + 34 + 53.5) / 4 = 43.6\%$

SFP PRIOR



Alpha = 15.2
Beta = 16.1
Mode 0.51
Precision = 13%

Sample size = 30

Figure 21: A Bayes Plot of SFP Prior

2.4 STAGE 3: WIDE AREA SURVEY

2.4.1 Calculating the number of Villages and Sampling

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

$$n_{\text{villages}} = \left[\frac{n}{\text{average village population}_{\text{all ages}} \times \frac{\text{percentage of population}_{6-59 \text{ months}}}{100} \times \frac{\text{SAM prevalence}}{100}} \right]$$

Where n is the sample size obtained from the Bayes plot. The total number of villages was 117 and the average population is 699.79, percentage population of under-fives in the county is 16.9%. Prevalence of SAM 1.8% and MAM was 3.8% (SMART Survey 2018)

Number of villages:

OTP	SFP
$n_{\text{villages}} = 29 / (699.79) * (16.9/100) * (1.8/100)$ = 13 (round up)	$n_{\text{villages}} = 30 / (699.79) * (16.9/100) * (3.8/100)$ = 6 (round up)

Out of the full list of 117 villages, 19 villages (13+6) were sampled using spatially stratified systematic sampling. A sampling interval of 6 was used (117/19), and the first village selected randomly between 1 and the sixth village. Active and adaptive methodology was used to actively search for SAM cases, with intention to find all or nearly all cases in the sampled villages. Door to door visits were used to find SAM and MAM cases in the sampled villages. Questionnaires for the caregivers of cases NOT in the program were administered during the wide area survey.

2.4.2 Likelihood and Posterior Calculation

Table 15: Likelihood and Posterior Calculation

Case description	SAM cases	MAM cases
Cases in program	14	51
Cases not in program	9	34
Recovering cases in program	7	71
NUMERATOR	21	122
DENOMINATOR	32	172

2.4.3 Bayes Coverage Estimates

Single coverage estimator was used to estimate the overall **OTP** program coverage. Using the Bayes Coverage Estimate Calculate, coverage of **55.5% (43.0% - 67.4%)** was obtained. The posterior is narrower than the prior, indicating that the wide area survey reduced uncertainty on the coverage of the program. There is considerable overlap between the prior and likelihood indicating no conflict between prior and likelihood (z- test value of 0.0944)

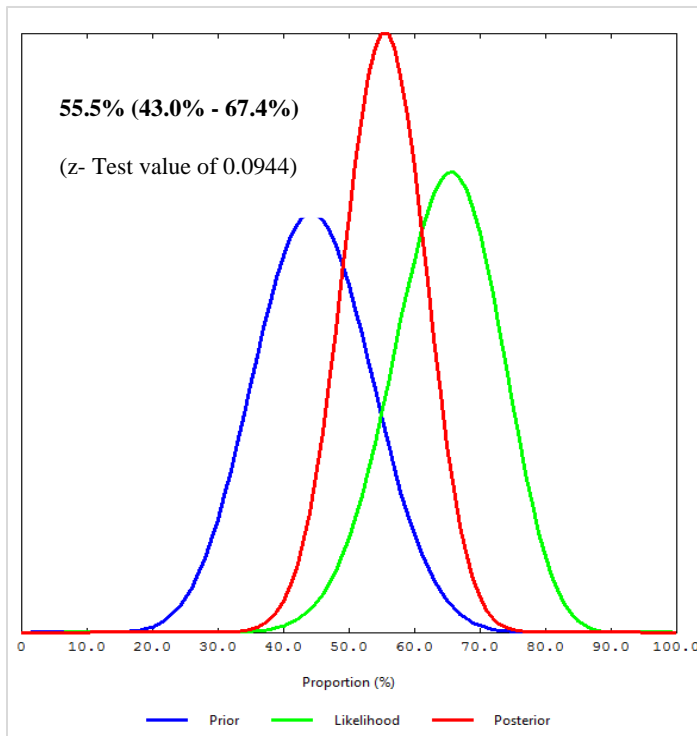


Figure 22: OTP Posterior for Isiolo Sub-county

Single coverage estimator used to estimate the overall **SFP** program coverage. Using the Bayes Coverage Estimate Calculate, coverage of 67.7% (**60.9% - 73.8%**) was obtained. The posterior is narrower than the prior, indicating that there was underestimation of coverage using belief. The wide area survey reduced uncertainty on the coverage of the program.

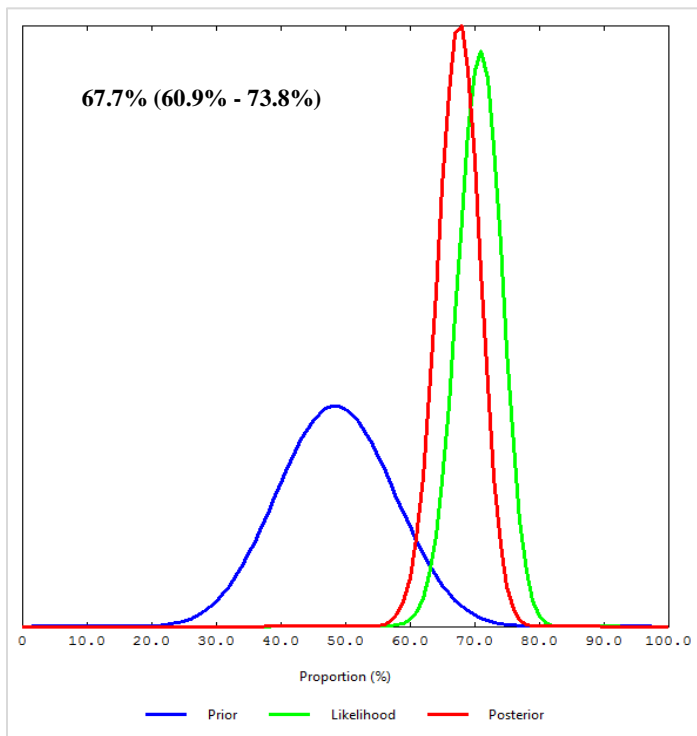


Figure 23: SFP Posterior for Isiolo Sub-county

3.0 DISCUSSION AND RECOMMENDATIONS

3.1 Discussion

The coverage assessment conducted in Isiolo sub-county showed single coverage estimate of 55.5% (**43.0% - 67.4%**) for **OTP** and coverage of 67.7% (**60.9% - 73.8%**) for **SFP**. The recommended coverage in the SPHERE standards for a rural population is more than 50%. The result indicates that case coverage for both SAM and MAM are above the required standards. This could point to various intervention programs that may have contributed to improved situation. From the analysis done, areas with low defaulting have CHVs actively doing active case finding and defaulter tracing that contributing to high program coverage. The increase was also attributed to interventions such as CLICK MUAC project that promoted malnutrition screening and self-referral by caregivers at the household level. Fewer admissions was also observed after the short rain season indicating improved food security (milk and meat from herds) at household level.

However, a lot needs to be done to strengthen program effectiveness and maintain coverage levels. In terms of assessment by MUAC some children are admitted with a very low MUAC of below 10.0cm thus a greater likelihood of poor treatment outcomes and longer treatment periods that could lead to defaulting. Evidence in Stage 1 indicated that IMAM program in Isiolo Sub-county has defaulting rates of 45% and 54% in OTP and SFP respectively. The rates are above the SPHERE standards thresholds of 15% despite frequent defaulter tracing being conducted at the household level by CHVs.

Distance, engagement in casual labor and commodity running out of stock at the health facilities were found to be the major influencer in both OTP and SFP programs hence affecting program coverage. Therefore, there is need to increase program outreaches and improve in involvement of other key family members to reduce the barriers sited and increase the boosters.

3.2 Recommendations and Action Plans

Table 16: Recommendations to Improve IMAM Program Coverage in Isiolo Sub-county

No	Recommendation	Justification	Source
1	Bringing services closer to the population through; <ul style="list-style-type: none"> • Establishment of health facilities • Scaling up of IMAM services in these facilities • Scaling up integrated outreach sites 	Distance to health facilities, migration, nomadic lifestyle	Care giver of child in program/mother, Community health Volunteer (CHV), Nurse/Nutritionist, Religious leader, Chief/sub area, Father, Traditional health practitioner/TBA, Mother in law/grandmother, Community lay women

2	Foster behavior change at the community by regular sensitization through community dialogues, strengthening and formation of new mother to mother Support Groups.	Health seeking behavior influenced by illiteracy and cultural beliefs, Knowledge gap on IMAM and stigma	Care giver of child in program/mother, Community health Volunteer (CHV), Nurse/Nutritionist, Religious leader, Chief/sub area, Father, Traditional health practitioner/TBA, Mother in law/grandmother, Community lay women
		Sharing and selling of RUTF/RUTF	Care giver of child in program/mother, Community health Volunteer (CHV), Nurse/Nutritionist, Religious leader, Mother in law/grandmother, Community lay women
3	Advocacy on staff recruitment to the county government and relevant partners Management ensuring that there is no disruption of services at health facilities during health worker's absence	Long waiting time due to workload of health workers and shortage of staff. Absenteeism and closure of health facilities	Caregivers, CHVs, health workers, religious leaders.
4	Strengthen community health strategy through <ul style="list-style-type: none"> • Capacity building • Incentivizing CHVs • Availability of tools 	Lack of motivation to CHVs leading to poor routine screening, referral system/follow up	Religious leaders and CHVs
5	Strengthen and functionalize community units	Poor linkage between health facilities and CHVs as a result of lack of regular meetings	Care giver of child in program/mother, Community health Volunteer (CHV), Nurse/Nutritionist, Religious leader,
6	Capacity building of health workers on LMIS	Periodic stock out of commodities due to poor forecasting and pipeline breakages	Care giver of child in program/mother, Community health Volunteer (CHV), Nurse/Nutritionist, Traditional health practitioner/TBA, Mother in law/grandmother, NGO/FBO staff
7	Capacity building of health workers through class room training, OJTS and mentorship.	Low capacity of health staff on IMAM leading to poor service delivery and reporting.	Community health Volunteer (CHV), Nurse/Nutritionist

Table 17: Action Plan

No	Objectives	Strategy	Activity	Monitoring	Evaluation	Frequency	Responsibility
1.	To Improve SAM/MAM case identification treatment	Scaling up of integrated outreaches	Mapping out of outreach sites	Reports of forums for mapping out sites	Total mapped sites	Monthly	CNC Sub counties Implementing partner SCPHN
			Conducting integrated outreaches routinely	Outreach reports	Number of reports	Quarterly	
		Strengthening and scaling up of IMAM surge	Refresher training, sensitization and OJT	Number of trainings	Timely and quality health services	Monthly	CNO CNC CSFP
			Establish IMAM surge in facilities with no IMAM surge	Training reports	Number of cases in IMAM program supported by outreaches	Quarterly	
			Capacity build facility with IMAM surge	Updating of IMAM surge dashboard	Total number of health facilities implementing IMAM surge	Annually	
		2.	To improve service delivery at health facility	Increased resource allocation for nutrition programs in the county	Advocate for recruitment of nurses, nutritionists and CHEWS	Number of a health facilities with adequate staff	Number of health facilities providing timely and quality services
Procurement of nutritional commodities and equipment	Regular quantification and supply of commodities				Number of health facilities with adequate commodities and tools	Quarterly	County pharmacist
Classroom training of health workers on IMAM and LMIS	Training reports			Number of trained health workers	Number of facilities with no commodity supply chain breakage (correct placing of orders)	Monthly	CHMT (CNC) S/CHRIO S/CNC, S/CHRIO, Pharmacist Implementing partner
				Quarterly			
	OJT			Sessions reports	Number of health facilities reporting HINI package and LMIS		
	DQAs/RDQA			Number of DQA reports	Number of health facility providing quality health services		

3.	To strengthen community health strategy	Form and functionalize community units	Recruitment of CHVs in CUs without CHVs	CUs with at least 1 CHV covering 20 Households	Number of CU which are functional and CHVs reporting every month to HF	Monthly	C/SCSFP C/SHRO CNC Implementing Partners
			Training of CHVs on relevant modules (module 8, basic modules and ICCM (case identification classification referrals, treatment follow-ups and reporting)	Training reports. Monthly reports by CHVs (514 – household registers) Updated chalk boards (516)	Number of CHV trained. Number of CU with CHVs with capacity to identify, classify refer, treat follow-up and report	Quarterly	
						Annually	
		Strengthening the functional community units	Sensitization forums at the community (community dialogues and Action days)	Number of Dialogue and action days Reports	Number of CUs with regular dialogues and action days	Monthly	C/SCSFP C/SHRO CNC Implementing Partners
			Advocacy on CHVs incentive from the county government and partners	Continued advocacy on resource allocation in strengthening CUs	Increased resource allocation to strengthening community health strategy	Quarterly	
			Provision of working tools – MOH 100, 513,514, 515, and 516	Supportive supervision of CUs	Number of supportive supervision visits	Annually	
			Monthly meetings of CHVs and routine monitoring of CHVs	Number of meetings and Minutes	Actions points in minutes addressed		
			Refresher training for CHVs	Training reports	Monthly review meeting and reporting (timely and quality reports)		
			Coordination meeting to share feedback	Number of meetings and minutes	Action points addressed		
4.	To promote positive behavior change	Operationalize SBCC strategy	Dissemination at County /Sub county, health facilities and community levels	Dissemination reports/minutes	SBCC strategy disseminated	Monthly Quarterly Annually	CNC C/SCSFP CNO CHP implementing partners
			Development of Work plans and	Operationalize work plans and monitor their operation	Developed work plans and monitoring framework		

			implementations plans		operationalized		
		Strengthening support group	Participation of communities in health days (malezi bora, breast feeding week, handwashing days, toilet days and water days)	Active support groups with regular meetings	Improved nutritional practices	Monthly Quarterly Annually	CNC C/SCSFP CNO CHP implementing partners
			Participate in community dialogues	Number of mothersto mother support groups	Improved nutritional practices at community level		
			Form support groups (mother to mother, psycho social – HIV, TB and other vulnerable groups) at community level to pass information or promote positive behavior	Number of reports and minutes	Action points addressed		
		Implementatio n of recommendati on from different surveys (SMART, KAP)	Foster partnership and building of alliances (Multi sectorial platforms)	Number of Multi Sectorial platforms (MSP)	Recommendations from surveys are jointly implemented	Monthly Quarterly Annually	CNC C/SCSFP CNO CHP implementing partners
			Improve coordination through development of implementation and response plan	Number of coordination meetings held (Nutritional specific) CNTF CIWG, response coordination forums	Implementation of action plans Regular meetings Action points addressed	Monthly Quarterly Annually	CNC C/SCSFP CNO CHP implementing partners
			Resource mobilized for joint implementation	Costed Work plans and response plans developed and operationalised Resources allocated for the implementation for the recommendation from various surveys	Adequate resource available		

4.0 ANNEXES

Annex 1: List of People Trained during the SQUEAC Survey

No .	FIRST NAME	SURNAME	GENDE R (M/F)	POSITION	ORGANI SATION	EMAIL ADDRESS
1	Saida	Abdirahman	F	CNC	MOH	saidaabdirahman@yahoo.com
2	Florence	Gitonga	F	SCNO	MOH	katflorence7@gmail.com
3	Salo	Boru	F	Deputy SCPHN	MOH	
4	Jamila	Sora	F	SCCSFP	MOH	jamilasora@yahoo.com
5	Janet	Mwenda	F	HRIO	MOH	janetmwenda334@gmail.com
6	Kioko	Kiamba	M	Nutrition officer	AAH	nutoff1-is@ke-actionagainsthunger.org
7	Leila	Baare	F	Enumerator	MOH	laylaahajj@gmail.com
8	Habiba	Katomobola	F	Enumerator	MOH	habibakatomobla@gmail.com
9	Martha	Labarakwe	F	Enumerator	MOH	labaratayo@gmail.com
10	Eric	Mujira	M	Enumerator	MOH	ericmujirah@gmail.com
11	Amina	Lengrinas	F	Enumerator	MOH	everlineamina92@gmail.com
12	Dansoye	Bonaya	F	Enumerator	MOH	dansabonaya92@gmail.com
13	Buke	Dabasso	F	Project Manager	AAH	iccmppm-is@ke-actionagainsthunger.org
14	Leah	Nyambura	F	Project Officer	AAH	iccmoff-is@ke-actionagainsthunger.org

Annex 2: Chronogram of Training and Assessment

IMAM COVERAGE ASSESSMENT- SQUEAC METHODOLOGY

ISIOLO SUBCOUNTY

MARCH 2018

TASK	No. of Days
Preliminary activities Quantitative data collection to be done before classroom training	
Classroom training - Training on SQUEAC Methodology and Community Assessment – quantitative and qualitative tools - Local terminology and seasonal calendar (done in the field)	3
Stage One: Determining areas of high and low coverage Field data collection (Quantitative and Qualitative Data Collection) -Complementary quantitative data collection and Analysis -Seasonal calendar analysis, Interviewing of key informants; OTP and SFP -Identification of potential Barriers and Boosters of coverage	2
Data Synthesis and Hypothesis Testing: preparation for Small Area Survey	1
Stage Two: confirmation of Hypothesis Confirming areas of high and low coverage - Small studies, small surveys, and small-area surveys (according to hypothesis) and data analysis for Small Area Survey	3
Stage Three: estimation of overall coverage - Provide an estimate of overall program coverage using Bayesian techniques	4
Presentation of Results, Recommendations, Conclusion and closure	1
Total days	15

Annex 3: Questionnaires _KII, IDI, FGD

Survey Questionnaire for caretakers with cases NOT in the programme – OTP / SFP (circle)

Team No: _____

Sub-county: _____ HF: _____ Village: _____

Child Name: _____

1. DO YOU THINK YOUR CHILD IS SICK? IF YES, WHAT IS HE/SHE SUFFERING FROM? _____

2. DO YOU THINK YOUR CHILD IS MALNOURISHED?

- a. YES NO

3. DO YOU KNOW IF THERE IS A TREATMENT FOR MALNOURISHED CHILDREN AT THE HEALTH CENTRE?

- YES NO (stop)

4. a. WHY DID YOU NOT TAKE YOUR CHILD TO THE HEALTH CENTRE?

- Too far (How long to walk?hours)
 No time / too busy

4b. Specify the activity that makes them busy this season _____

- The mother is sick
 The mother cannot carry more than one child
 The mother feels ashamed or shy about coming
 No other person who can take care of the other siblings
 Service delivery issues (specify)
 The amount of food was too little to justify coming
 The child has been rejected. When? (This week, last month etc) _____
 The children of the others have been rejected
 My husband refused
 The mother thought it was necessary to be enrolled at the hospital first
 The mother does not think the programme can help her child (prefers traditional healer, etc.)
 Other reasons: _____

5. WAS YOUR CHILD PREVIOUSLY TREATED FOR MALNUTRITION AT THE HC? Which programme? SFP OTP/SC (circle)

- YES NO (=> stop!)

6. If yes, why is he/she not treated now?

- Defaulted, When?.....Why?.....
 Discharged cured (when?)
 Discharged non-cured (when?)
 Other: _____

(Thank the mother/carer)

Annex 4: Key Guiding Questions during Qualitative Data Collection

SQUEAC Investigation Process Qualitative work – Topics for discussion

Key guiding question for key informant interviews and focus group discussions

1. COMMUNITY - LAY PEOPLE

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

UNDERSTANDING/ PERCEPTION OF SEVERITY OF MALNUTRITION IN THEIR COMMUNITY

1. What are the common health problems that children experience here?
2. Which are the most frequent? Rank.
3. Are any more frequent at certain times of the year? When? Why?
4. Which are the most serious? Rank. Why?

If malnutrition mentioned ask:

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

HEALTH SEEKING BEHAVIOUR

8. What do you do when your child has this (insert name of most common illnesses) problem?
 - a. Probe fully for different illnesses
9. What factors determine which treatment / approach you use for a particular illness?
Probe on:
 - a. Cost, Access, Father permission, Habit/familiarity

If clinic/hospital mentioned:

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

If malnutrition not already mentioned ask/show pictures:

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

AWARENESS OF IMAM SERVICE

17. Do you know of a place where this condition can be treated?
18. How did you hear about it?
 - a. Who told you? When? What do you know about it?
19. What are children given for this condition?

If people think the RUTF is a food ask:

- a. What sort of food is it?
- b. What do you call it?

- c. Who can eat it?
 - d. What foods do you give your children to make them health/strong?
20. Do you know children receiving this treatment?

PERCEPTIONS OF IMAM

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

If people say it is good ask:

- a. *What is good about it?*
22. Have you noticed a change in the children who are being treated?
23. What improvements would you like to see to the service?

If people say it isn't good ask:

- a. *What is wrong with it?*
24. What do people not like about the service?
25. How can we change it? What suggestions do you have

AWARENESS OF CHV (CASE FINDER) AND HIS/HER ACTIVITIES

26. How are children identified for treatment?
- a. What tool is used?
 - b. Have you seen anyone doing this in your community?

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

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

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

COVERAGE QUESTION

27. Do you know children who have this condition but who are not going to the health centre for treatment? Why?
28. Do you know of any children who have stopped going for treatment?
- a. Why is this? What would encourage them to return?
29. Do you know of children who have been to the clinic and have not been given the treatment?
- If yes,*
- a. Why not? What were they told? How did they feel?

BARRIERS

30. What factors might prevent children from being able to access treatment? Why? How can we overcome these obstacles?
31. What messages/suggestions would you like us to pass to the people running the IMAM service?

2. Key community figures (local village/religious leaders)

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

- Understanding of malnutrition
- Health seeking behaviour

KNOWLEDGE AND UNDERSTANDING OF IMAM

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

ROLE / AWARENESS RAISING

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

PERCEPTIONS OF IMAM

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

BARRIERS/COVERAGE QUESTION

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

STIGMA

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

COMMUNICATIONS

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

IMPROVEMENTS

15. How can we improve the service?
16. Do you have any messages for those who run the service?

3. TRADITIONAL HEALER / OTHER HEALER

TREATMENT AND PERCEPTION OF MALNUTRITION

Start the discussion by asking:

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

If not mentioned show picture of malnourished children and ask:

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

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

KNOWLEDGE AND UNDERSTANDING OF IMAM

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

4. CARERS OF BENEFICIARIES

Individual case history

HISTORY OF THE ILLNESS

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

HEALTH SEEKING BEHAVIOUR

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

INFORMATION SOURCE FOR THE OTP

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

AWARENESS OF/CONTACT WITH CHV (CASE FINDER)

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

UNDERSTANDING OF THE SERVICE

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

STANDARD OF SERVICE

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

OPINION OF THE SERVICE

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

ABSENCE/DEFAULTING

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

COVERAGE QUESTION

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

Group discussion with carers

INFORMATION SOURCE FOR THE OTP

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

AWARENESS OF/CONTACT WITH CHV (CASE FINDER)

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

STANDARD OF SERVICE

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

OPINION OF THE SERVICE

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

DISTANCE

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

COVERAGE QUESTION/DEFAULTING

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

CASE REFERRAL

- c. Have you told anyone else to bring their child to the clinic?
- d. Why/why not?

PERCEPTION OF IMAM

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

STIGMA

19. Is there a stigma attached to malnutrition in your village? Are there parents who hide their children? For what reason?

If stigma exists:

20. How does the stigma affect you personally? In what way?

FEEDBACK

17. Have you any messages you want us to give to the people running the service

COMMUNITY HEALTH VOLUNTEERS (CHV)

ROLE

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

EXPLANATION GIVEN TO MOTHERS

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

REFERRAL AND FOLLOW UP

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

REJECTION

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

COVERAGE QUESTION

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

COMMUNICATIONS

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

OPINION OF THE OTP

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

MOTIVATION

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

IMPROVEMENTS

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

5. OTP STAFF

IMAM INVOLVEMENT AND CHALLENGES

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

CALENDAR

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

REFERRAL

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

REFERRAL AND FOLLOW UP

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

REJECTION

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

DEFAULTING

12. How many children are absent for more than 1 week during the course of treatment?

- a. Why do you think this is?
- 13. How many children default?
 - a. Why do you think this is?
- 14. Is there a system to follow up on defaulters? How does it work? How could we encourage children to return for treatment?
- 15. What barriers prevent mothers from bringing their children to the OTP?

COVERAGE QUESTION

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

COMMUNICATIONS

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

OPINION OF THE SERVICE

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

WORK LOAD

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

IMPROVEMENTS

- 24. Challenges? Problems? Improvements?
- 25. What messages do you want us to pass to the people organising IMAM?

7. FIELD AGENT (if NGO)

ROLE AND ACTIVITIES

Tell me about the activities you did last week?

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

COMMUNICATIONS

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

FOLLOW UP / HOME VISITS

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

OPINION OF OTP

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

8. PROGRAMME STAFF

ROLE AND ACTIVITIES

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

COMMUNICATIONS

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

OVERVIEW OF THE SERVICE

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

BARRIERS

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

ADDITIONAL QUESTIONS (adapt according to the audience)

Terminology:

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

Key people:

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

Calendars:

- Ask the community to help you develop seasonal calendars for:
 - The hunger gap
 - Agricultural labor (periods of intense activity)
 - Child illness (ARI, malaria, fever, diarrhea etc.)