Semi Quantitative Evaluation of Access and Coverage (SQUEAC) of the Pokot Central Integrated Management of Acute Malnutrition (IMAM)

12th Nov – 29th Nov 2019

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Acronyms

CEPI	County Expanded Program off Immunization
CHMT	County Health Management Team
CHS	Community Health Strategy
CHV	Community Health Volunteer
CIDP	County Integrated Development Plan
CNTF	County Nutrition Technical Forum
CU	Community Unit
DPHN	Deputy Public Health Nurse
HINI	High Impact Nutrition Intervention
IDI	In-depth Interview
IGA	Income Generating Activity
IGD	Informal Group Discussion
IMAM	Integrated Management of Acute Malnutrition
KCRS	Kenya Red Cross Society
KEMSA	Kenya Medical Supplies Agency
KII	Key Informant Interviews
LLB	Linda Lishe Bora
MAM	Moderate Acute Malnutrition
MNPs	Micronutrient Powders
MOH	Ministry of Health
MTMSGs	Mother to Mother Support Groups
MUAC	Mid Upper Arm Circumference
NGO	Non-Governmental Organization
OJT	On the Job Training
OTP	Outpatient Therapeutic Program
RUSF	Ready to Use Supplementary Feeds
RUTF	Ready to Use Therapeutic Feeds
SAM	Severe Acute Malnutrition
ScHMT	Sub-county Health Management Team
SFP	Supplementary Feeding Program
SLEAC	Simplified Lot Quality Evaluation of Access and Coverage
SMART	Standardized Monitoring and Assessment of Relief and Transitions
SQUEAC	Semi-Quantitative Evaluation of Access and Coverage
TBA	Traditional Birth Attendant
TCA	To come again
UNICEF	United for Children
URTI	Upper Respiratory Tract Infections
WASH	Water Sanitation and Hygiene
WHZ	Weight for Height Z-score

Executive Summary

Pokot sub County has a population projection of 164,610 and a population density estimate of 64 persons per Km^2 (CIDP 2018-2022).It has two distinct livelihood zones namely; Pastoral and Agro pastoral. Pokot Central is prone to cross border conflicts manifested in cattle raids and conflicts over resources.

Action Against Hunger in collaboration with the Ministry of Health through a UNICEF funding have been implementing High Impact Nutrition Interventions (HINI) packages in West Pokot County since 2011. It is currently implementing Nutrition and WASH programs in three Sub Counties namely: Pokot central, south and North.

A SQUEAC assessment was conducted in Pokot Central in November 2019 following a recommendation from SLEAC assessment conducted in September 2019, which classified the Sub County as low in coverage for both OTP and SFP.

The overall objective of the assessment was to assess the overall coverage for OTP and SFP in Pokot Central Sub County. The specific objectives were:

1. Identify boosters and barriers of access to SAM and MAM interventions of the:
    - Outpatient Therapeutic Program
    - Supplementary Feeding Program
2. Establish Single coverage for OTP and SFP in Pokot Central Sub County
3. Generate practical recommendations that would lead to better access and coverage of the nutrition program.
4. Build the capacity of Ministry of Health and Partners in conducting coverage surveys using SQUEAC methodology.

The November 2019 rains and landslides in West Pokot County interfered with the assessment, as most areas were rendered inaccessible due to cut off roads. This meant that only stage one of the SQUEAC methodology was completed before the disaster. Nevertheless, the detailed investigation during stage one would allow identification of the boosters and barriers to access and treatment for acutely malnourished children. The quantitative and qualitative data collected revealed that there was low cure rates and high defaulter rates across both programs majorly attributed to frequent commodity stock-outs, inconsistent and discontinuity of outreaches by partners, distance to health facilities and ignorance of effectiveness of the program by the caregivers. Minimal defaulter tracing mechanisms or lack thereof, mainly facilitated by absence of or non-functional CUs crowns this. With only stage one completed, the sub-county health managers in collaboration with the health and nutrition partners were able to develop

recommendations, and the necessary actions to address the barriers to access and treatment in IMAM program *(see Table 1)*.

Table 1: Summary of Key Barriers and Boosters to OTP and SFP and possible Interventions

Barrier	**Recommendations**	**Actions**
1. Use alternative treatment seeking avenues	-Advocating for proper health seeking practices	-Advocacy meetings through community dialogues, *kokwo*
2. Minimal defaulter tracing	-Strengthen the link between the community and the health facility.	-CHV referrals, through household visits -Supporting CHVs monthly meetings -Develop a proper defaulter tracing mechanism
3. Unmotivated CHVs	-Plan activities to keep the CHVs motivated and engaged. -Operationalize community units	-Link CUs with IGAs -Refresher trainings of CHVs on IMAM programs(module 8) -Conduct a CU functionality assessment -Scale up more CUs to be linked with all facilities especially facilities implementing IMAM
4.Lack of ownership by of the IMAM program by the Health workers and the community	-Advocacy's on IMAM program -Integration of IMAM programs in to other treatment activities by health workers	-Conduct community dialogue days on IMAM program. -Regular health talks on IMAM program -Involving key community informants and key influencers in advocacy meetings -Increase the frequency of the CHMT to ensure the IMAM programming in incorporated into other treatment
5.Insufficient staffing and staff absenteeism	-MOH to increase the number of nurses and nutritionists at facility level	-Lobby for more nutritionists and nurses to be employed so as to reduce workload

1.0 Introduction

1.1 Background Information

Overview of Central Pokot Sub-county

Central Pokot is one of the Sub-counties in West Pokot County with a population projection of 164,610 and a population density estimate of 64 persons per kilometer square according to the 2018-2022 CIDP. The Sub-county borders Elgeyo Marakwet to the South, Baringo to the East, Turkana South to the North and Pokot South to the South East and it covers an area of 2109.7 Km^2. It has two distinct livelihood zones namely; Pastoral and Agro pastoral. The predominant inhabitants of the sub-county are the Pokots. Pokot Central is prone to cross border conflicts manifested in cattle raids and conflicts over resources. The sub-county relies more on the long rains that are supposed to be experienced between March and June annually.

Figure 1: A map of West Pokot County livelihood zones

Nutrition Situation

Central Pokot Sub-county has 28 health facilities, 20 among which are implementing Integrated Management of Acute Malnutrition (IMAM) including one stabilization center (Sigor Sub-county Hospital). The Sub-county has 12 health facilities whose staff are trained in IMAM; among them are three (3) nutritionist and four (4) nutrition volunteers. It has four functional CUs out of 13 consisting 25 CHVs each attached to the villages within the CUs catchment population. The CHVs are trained in management of acute malnutrition. Facility nurses, nutritionist, nutritionist volunteers and CHVs usually deliver IMAM services. Continuous On the Job Training (OJT) is done at the health facilities to improve the capacity of IMAM service providers. Protocols for the management of SAM and MAM cases are usually

followed as per the national guidelines and the main admission criteria for IMAM programs are WHZ, MUAC or edema.

Action Against Hunger has been supporting MoH in the implementation and scale up of HINI packages and strengthening the health systems in the Sub-county. The organization currently implements HINI packages and WASH programs in the entire West Pokot County. Between September 2019 and February 2020, Kenya Red Cross and Action Against Hunger have supported 5 and 24 integrated bi-monthly outreaches in Pokot central, respectively, in an effort to increase access to health and nutrition services in malnutrition hot spots and hard to reach areas.

1.2 Rationale for the coverage Survey

The most recent SQUEAC for Pokot Central Sub-County was conducted in 2014 and it revealed coverage estimate to be 32.5% (16.9%-53.5%) and 30.4% (18.3%-45.8%), for OTP and SFP programs respectively. These were below the minimum SPHERE standard of 50% for rural programs. Since then, a SQUEAC assessment has not been conducted to show progress in the programming activities.

A SLEAC Survey conducted in September 2019 in the entire West Pokot County, Pokot Central Sub County was classified as a low coverage area (≤ 20%) [1]in both OTP and SFP programs. From the findings, it was recommended that an in-depth SQUEAC assessment to be conducted in Central Pokot Sub County in order to identify the barriers and boosters for the low coverage. The coverage assessment was also to give recommendations that would increase access to OTP and SFP in the County. Central Pokot Sub County having two livelihood zones; Pastoral and Agro pastoral livelihood zones would therefore give a good representation of the entire county thus the results can be inferred to the entire County.

1.3 Objectives of the Survey

Main objective was to assess the overall coverage for OTP and SFP in Pokot Central Sub County while the specific objectives were:

1. To identify boosters and barriers of access to SAM and MAM interventions of the:
    - Outpatient Therapeutic Program
    - Supplementary Feeding Program
2. To Establish Single coverage for OTP and SFP in Pokot Central Sub County
3. Generate practical recommendations that would lead to better access and coverage of the nutrition program.
4. Build the capacity of Ministry of Health and Partners in conducting coverage surveys using Semi Quantitative Evaluation of Access and Coverage

[1]West Pokot SLEAC Survey Report 2019

2.0 Methodology

Overview of the Methodology Approach for Central Pokot SQUEAC Survey

The SQUEAC methodology uses a two- staged screening test model:

Stage 1: Identification of areas of low and high coverage and the reasons for coverage failure. Data collection methods included; analysis of routine program data, key informant interviews at field and health facility levels, focus group discussions and informal discussions.

Stage 2: Confirmation of the location of areas of high and low coverage and the reasons for coverage failure identified above using small studies, small surveys and area surveys.

However, if appropriate and if required an additional stage may be performed.

Stage 3: Overall estimation of program coverage through combination of prior and likelihood (wide area survey estimates) and through Bayesian techniques.

However, this assessment applied only Stage 1 as the subsequent stages could not kick off due to impassability of survey areas caused by the rains and landslides in West Pokot County. This could also not be done at a later date since the project supporting this activity had come to a close at the time when the flooding situation had improved.

3.0 Results of the SQUEAC Survey

3.1 Stage 1: Identifying Areas of Low and High Coverage

In stage one both quantitative and qualitative data was collected from routine programs; SC, OTP and SFP admissions and exit outcomes overtime and program performance. It revealed that there were persistent low cure rates and high defaulter rates across IMAM program majorly attributed to frequent stock outs, inconsistent and discontinuity of outreaches by partners, distance to health facilities and ignorance of effectiveness of the program by the caregivers. This is crowned by minimal or no defaulter tracing mechanisms especially in areas with no or non-functional CUs.

3.1.1 Quantitative data

This data was obtained from monthly stock summary (MoH 734) and OTP and SFP beneficiaries registers for 3 years (November 2016 – October 2019) to include data overtime, MUAC, Z-scores and oedema at admissions and exit indicators; cure, defaulter, non-response and death rates. Admissions and exit graphs were plotted against the seasonal calendar for the Sub-county to compare the trend of the program data.

3.1.1.1 Inpatient Management of Acute Malnutrition

The only stabilization center in Pokot Central (Sigor Sub-county Hospital) recorded a few more admissions between November 2018-October 2019 (12) than the previous year November 2017-October 2018 (7). All the admissions were direct admissions from the Outpatient department with no referrals from OTP. This meant that the SAM cases found at the OTP sites did not develop complications/worsen once admitted into the program. At the time of this assessment, three (3) had already been discharged to OTP, three (3) to SFP and four (4) had been discharged (to home) as cured (Figure 2).

3.1.1.2 Out-Patient Therapeutic Program (OTP) in Central Pokot

OTP Admissions by MUAC (Nov ‘18-Oct ‘19)

Timely case-finding and early admissions into IMAM are an indication of good coverage. Upon analysis of the quantitative data, the Median MUAC was 11.1cm indicating that most SAM cases were timely identified and admitted. However, some few cases with MUAC less than 11.0cm indicate late case identification in Central Pokot Sub-county.

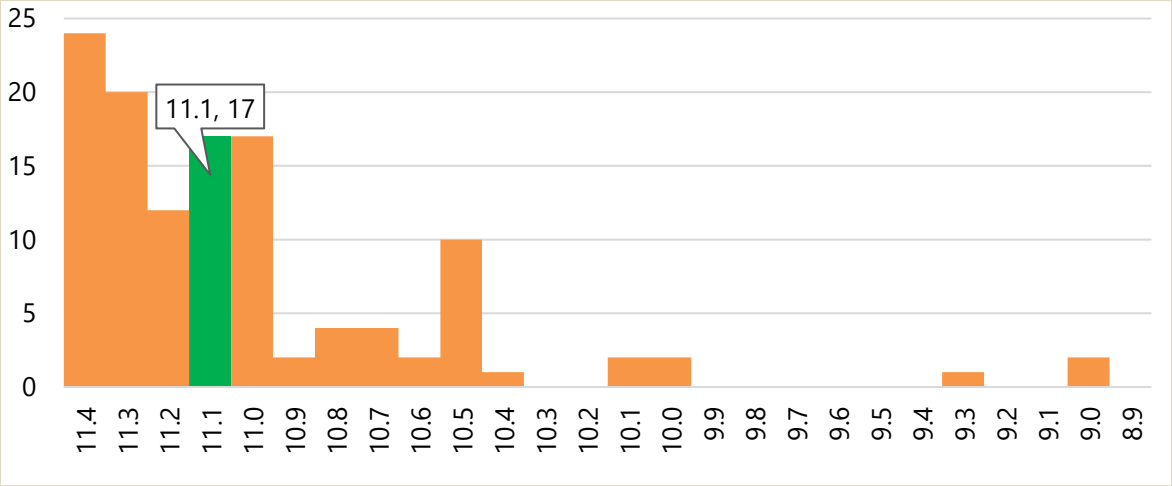
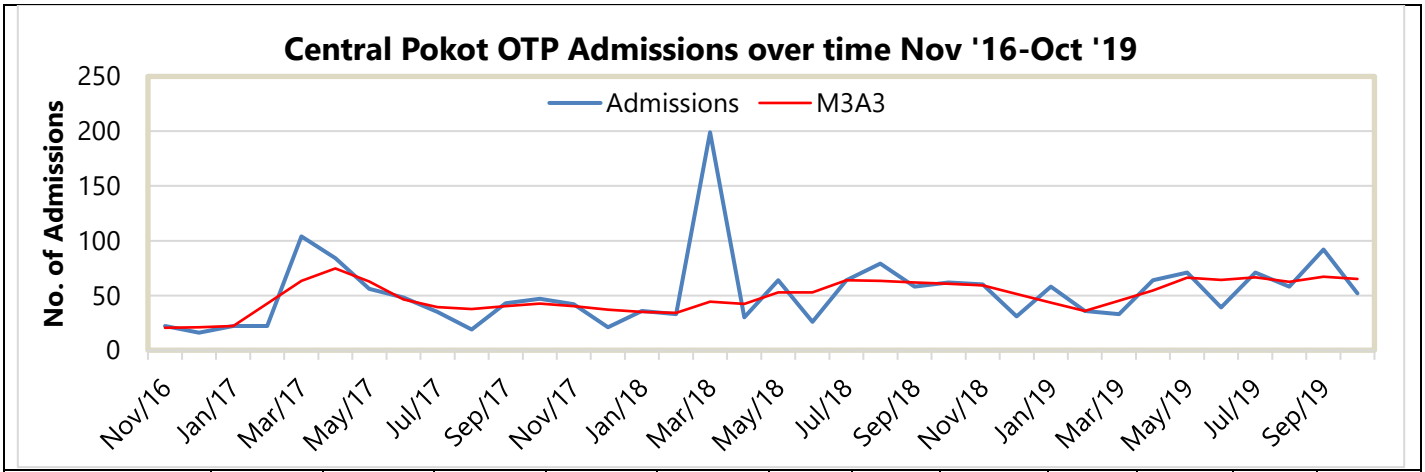


Figure 2: OTP Admissions by MUAC Nov'18-Oct'19

OTP Admissions Overtime

From the assessment, there was an observed increase in admissions in March 2018 which coincide with partner supported mass screening and referral exercise in Pokot Central. The peak in admissions in March 2018 is attributed to the Cash transfer that came with the LLB (Linda Lishe Bora) where by the target beneficiaries had to first be current beneficiaries of the IMAM program (OTP, SFP) (Figure 3).



	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
LLB					2018							
Scale-up outreaches							2019			2019	2019	2019
SLEAC											2019	
Mass screening					2017		2017					
Planting						Yes	Yes				Yes	
Gold mining	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Climate	Dry	Dry	Dry	Dry	Dry		Rainy	Rainy	Rainy			
Migration	Pasture	Pasture	Pasture	Pasture	Pasture							
Nurses strike				2019	2019	2019		2017	2017			
RUTF stock out												

Figure 3: OTP Admissions Over time

OTP Admissions by MUAC, Z-Score, Oedema (NOV '18-OCT '19)

Facilities in Pokot Central use all the criteria for admission into the program. There were more Z-score admissions than MUAC admissions November 2018 to October 2019 with of the Z-score admissions coming from Masol Ward, which is characteristic of a pastoral community (Figure 3).

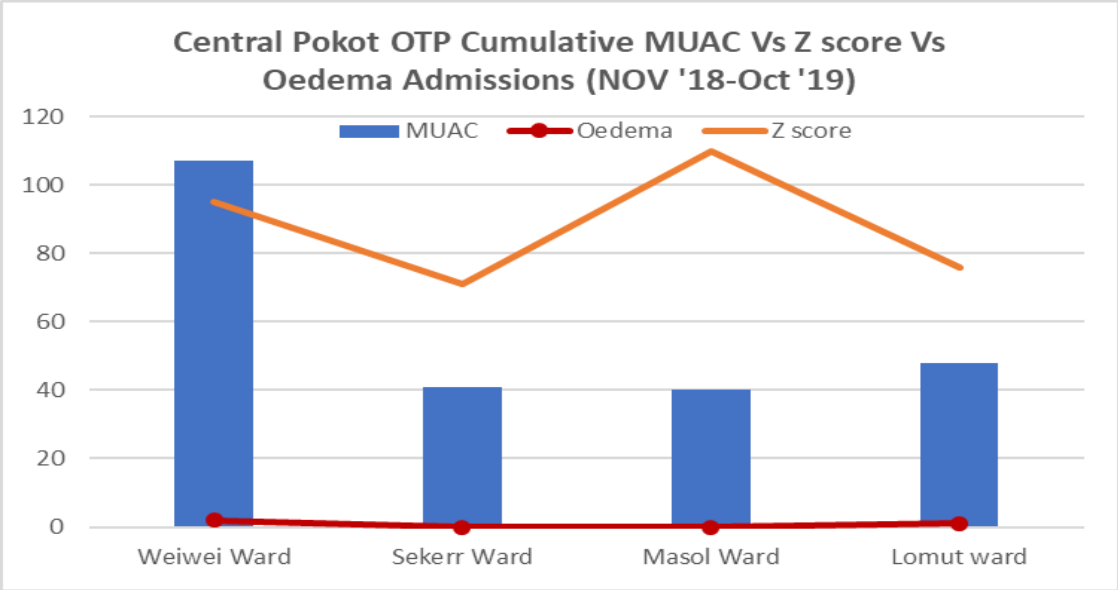
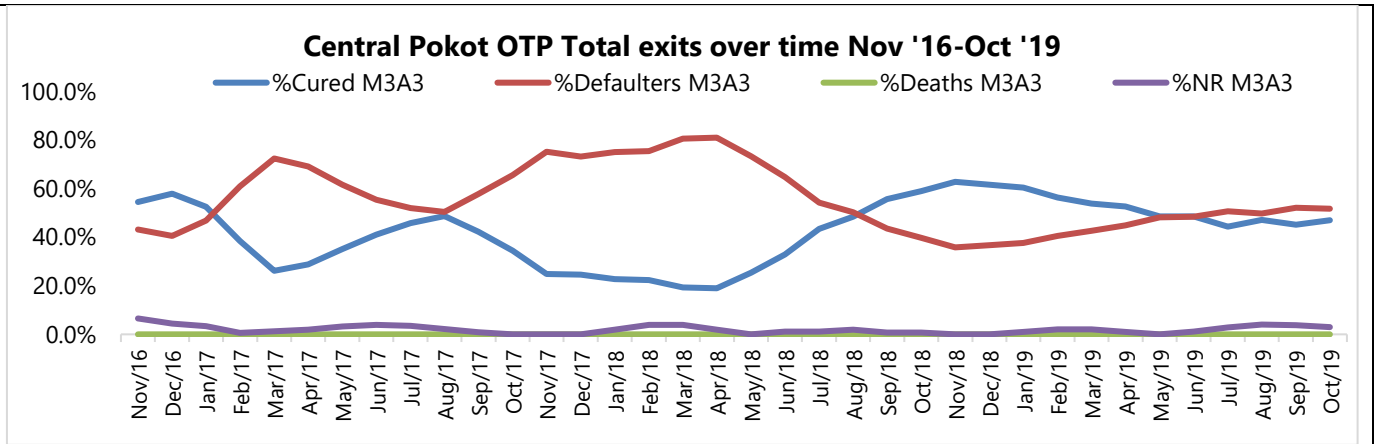


Figure 4: OTP cumulative MUAC as compared to Z-score and Oedema admissions

OTP Exits Overtime (Performance Indicators)

The cure rates and defaulter rates were below and above the sphere standards of 75% and 15% respectively with an exception of cure rates in April 2018 (Figure 5).



	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
LLB					**2018**							
Scale up-outreaches							**2019**			**2019**	**2019**	**2019**
SLEAC											**2019**	
Mass screening					**2017**		**2017**					
Planting						**Yes**	**Yes**				**Yes**	

Gold mining	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Climate	**Dry**	**Dry**	**Dry**	**Dry**	**Dry**		**Rainy**	**Rainy**	**Rainy**			
Migration	**(Pasture)**	**(Pasture)**	**(Pasture)**	**(Pasture)**	**(Pasture)**							
Nurses strike				**2019**	**2019**	**2019**		**2017**	**2017**			
RUTF Stock out						**2019**	**2019**	**2019**	**2019**	**2019**	**2019**	**2019**

Figure 5: OTP Total Exits Nov'16-Oct'19

There were persistent defaulters in the entire assessment period (November 2016-October 2019) which is attributed to massive admissions during LLB exercise who quickly defaulted from the program after the cash transfer ended. The gradual increase in cure rate as from April 2018 could be attributed to the cash transfer conducted in March 2018 targeting households with IMAM beneficiaries. This might have reduced sharing of the RUTF with the availability of cash to purchase diverse food for household members. The trend was however short-lived by the nurses strike that saw health facilities without professional medical practitioners in 2019.

Length of stay for cured MUAC Admissions (Nov '17-Oct '19)

The median average length of stay among the cured MUAC OTP admissions between November 2017 and October 2018 was 4 weeks. It increased to 6 weeks between November 2018 and October 2019. This insinuates that the children may not be staying too long in the program before being exited as cured. However, there were few long length of stays recorded which include 12 and 16 weeks which is attributed to sharing of rations at household level (Figure 6).

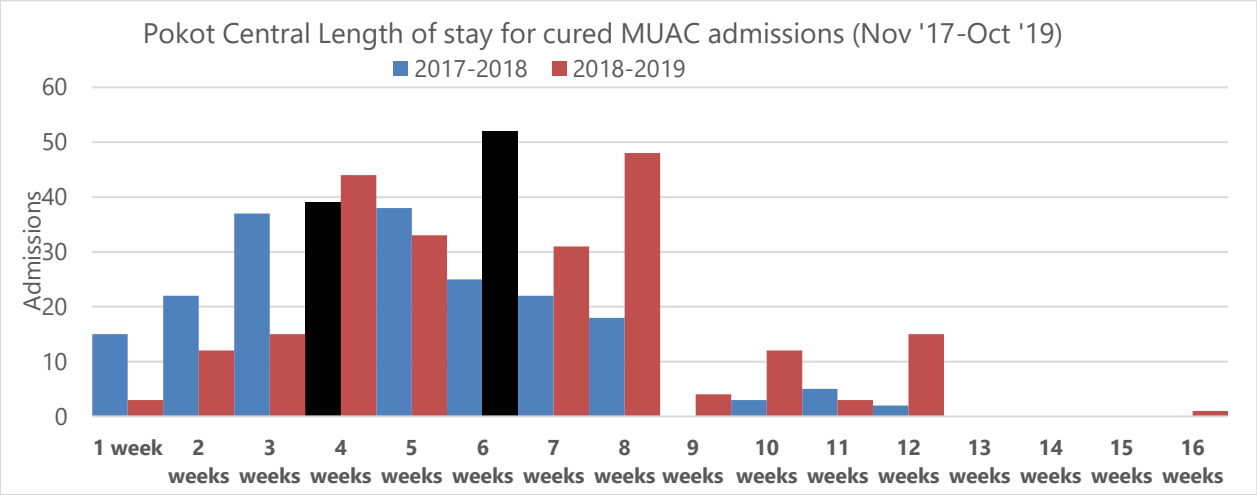


Figure 6: Length of stay for cured OTP MUAC admissions

Cumulative Number of Weeks Facilities Had No RUTF Stock (NOV '18-OCT '19)

According to the stock cards summary MOH 734 that were found in the facilities, 8 facilities (Kokwotendwo, Sostin, Nyang'aita, Marich, Lomut, Simpol, Onoch and Chesta) had experienced Stock-outs in the between November 2018 to October 2019. Kiseran health facility data was not available at the time of the assessment. Six (6) other facilities; Wakor, Onoch, Arpollo, Tamkal, Takaywa, Sarmach and Masol had no stock cards that could be reviewed. Kokwotendwo had 20 weeks stock out throughout April to August 2019 since there was no professional health worker

in charge of the facility at that time while the CHVs attached to the health facility were offering IMAM services (Figure 7).

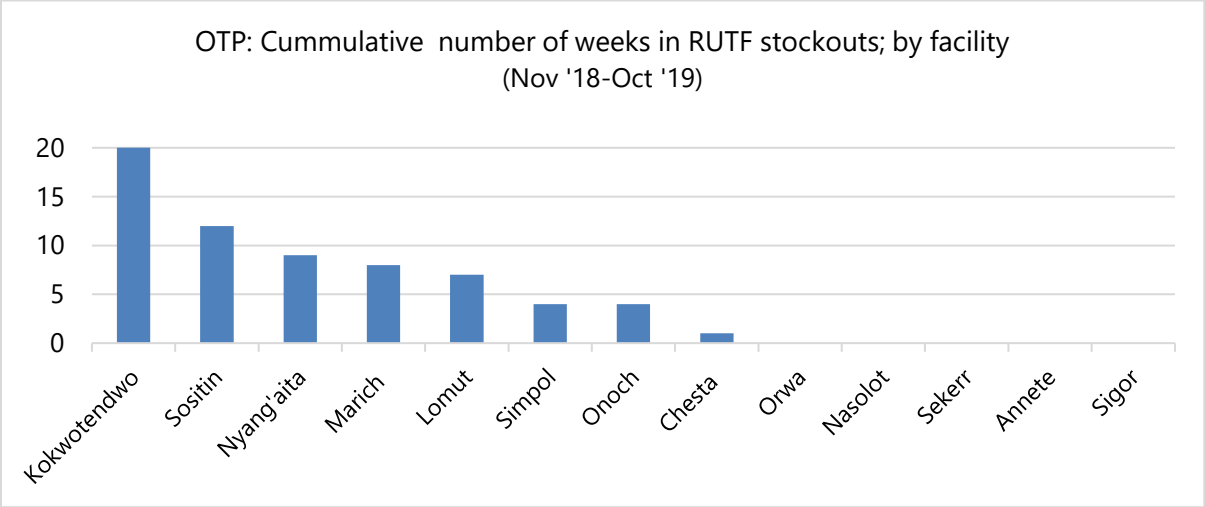
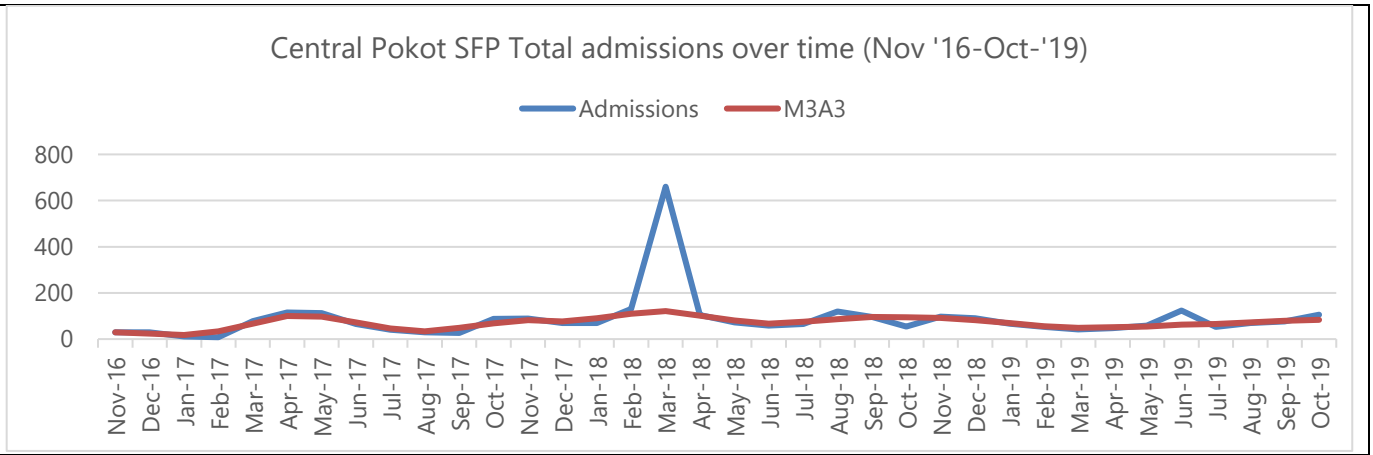


Figure 7: Cumulative number of Weeks between Nov 2018 and Oct 2019 health facilities had no RUTF stock

3.1.1.3 Supplementary Feeding Program (SFP) in Central Pokot

Admission over Time

There was a peak in SFP admissions in March 2018, which was in line with the Linda Lishe bora program that entailed cash transfer; targeting households with malnourished children. A slight increase in admissions was also observed in June 2019 attributed the SMART survey that entailed active screening and referrals conducted in the course of the assessment (Figure 8).



	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
LLB					2018							
Scale up-outreaches							2019			2019	2019	2019
SLEAC											2019	
Mass screening					2017		2017					
Planting						Yes	Yes				Yes	
Gold mining	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Climate	Dry	Dry	Dry	Dry	Dry		Rainy	Rainy	Rainy			

Migration	**(Pasture)**	**(Pasture)**	**(Pasture)**	**(Pasture)**	**(Pasture)**							
Nurses strike				**2019**	**2019**	**2019**		**2017**	**2017**			
RUSF Stock out						**2019**	**2019**	**2019**	**2019**	**2019**	**2019**	**2019**

Figure 8: SFP Admissions in Central Pokot

SFP Admissions Based on MUAC (NOV '18-OCT '19)

The median MUAC at admission based on the criteria was 12.0cm with November 2017-October 2018 recording more admissions compared to the other years. However, there was also a long tail of admissions going into 11.5cm indicative of late admissions attributed to poor health seeking behaviors and use of alternative treatment seeking avenues. The children are likely to take long period of time before they can exit as cured beneficiaries (Figure 9).

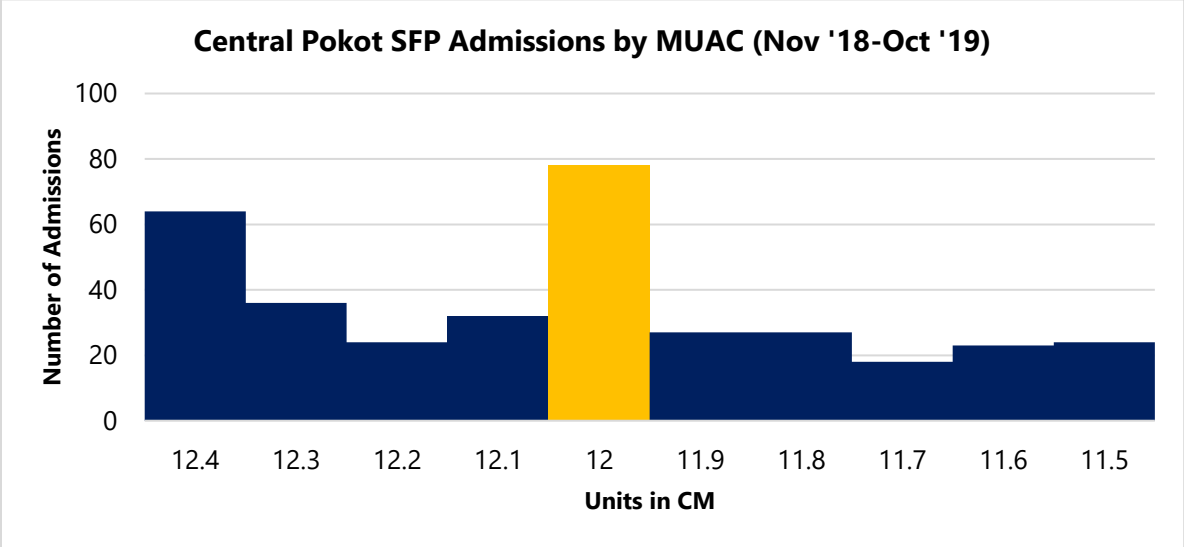


Figure 9: SFP Admissions by MUAC (Nov '18-Oct '19 by MUAC)

SFP Total Admissions per Health Facility

Nyang'aita dispensary had the most admissions for SFP between November 2018 and October 2019 attributed to the sensitization of Family MUAC to a mother-to-mother support group in the CU. Sarmach health facility had no SFP admissions between November 2018 and October 2019 due to RUSF stock out (Figure 10).

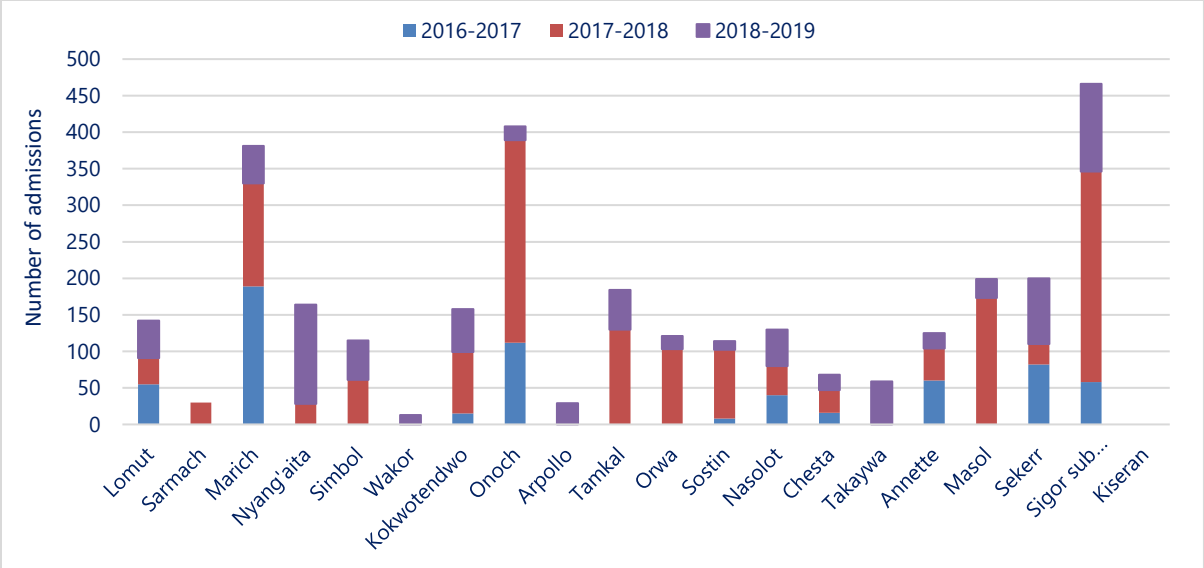
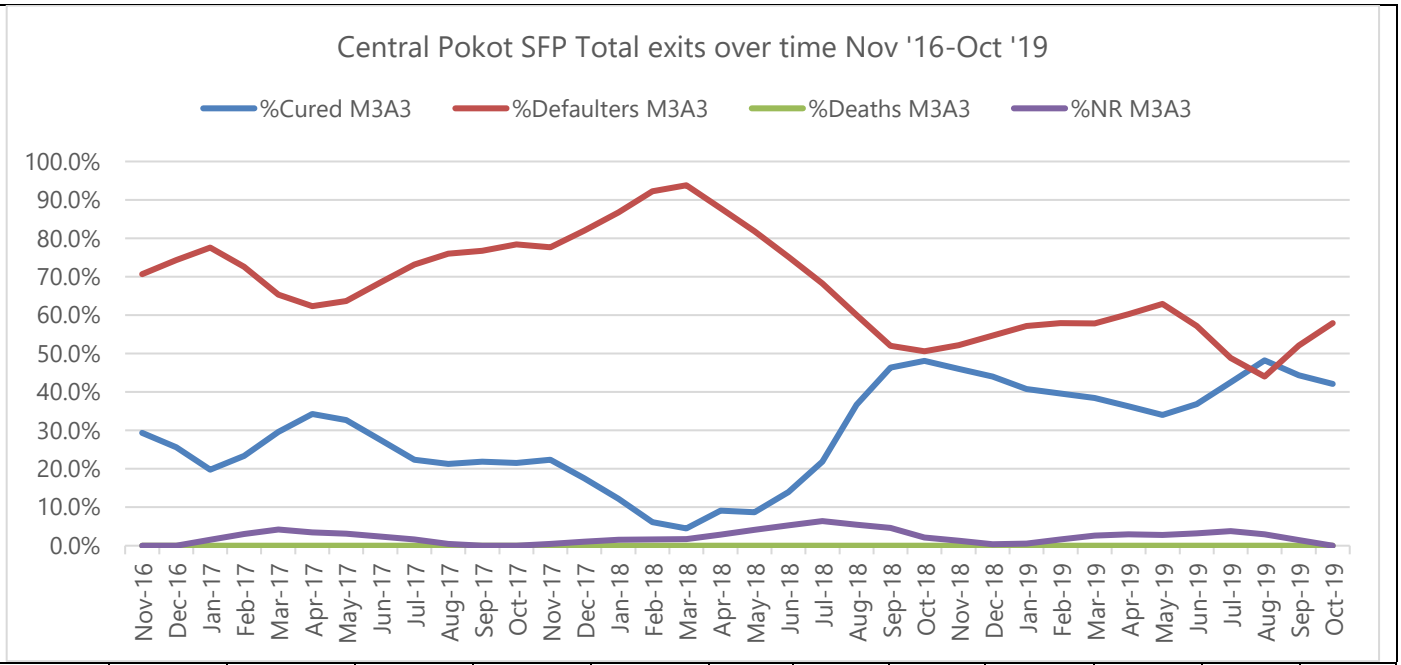


Figure 10: SFP Total Admissions per Facility

SFP Exits Overtime

The cure rate and defaulter rate was below the sphere standard of 75% and 15% across the periods. The increased defaulting in March 2018 is attributed to the completion of the cash transfer under Linda Lishe Bora where nearly all beneficiaries who had been newly registered for the exercise, defaulted The nurses strike experienced early 2019 affected service delivery in the facilities among them IMAM programming hence increased defaulting (Figure 11).



	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
LLB					**2018**							
Scale up-outreaches							**2019**			**2019**	**2019**	**2019**

SLEAC											**2019**	
Mass screening					**2017**		**2017**					
Planting						**Yes**	**Yes**				**Yes**	
Gold mining	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Climate	**Dry**	**Dry**	**Dry**	**Dry**	**Dry**		**Rainy**	**Rainy**	**Rainy**			
Migration	**(Pasture)**	**(Pasture)**	**(Pasture)**	**(Pasture)**	**(Pasture)**							
Nurses strike				**2019**	**2019**	**2019**		**2017**	**2017**			
RUSF Stock out						**2019**	**2019**	**2019**	**2019**	**2019**	**2019**	**2019**

Figure 11: SFP Exits in Central Pokot overtime

The high default rate was attributed to little or no defaulter tracing according to the triangulated qualitative data. There was an observed slight peak in cure rate in August 2019, which is attributed to the scale up of integrated outreaches in the hard to reach areas.

Number of Weeks Facilities Had No RUSF Stock (Nov '18-Oct '19)

The sub-county experienced RUSF stock out in 10 health facilities between November 2018 and October 2019. Most of the stock-outs were mainly from April 2019 all through to October 2019. Through a sub-county directive, the SFP beneficiaries were received the CSB rations that is usually given to PLWs in the SFP (Figure 12).

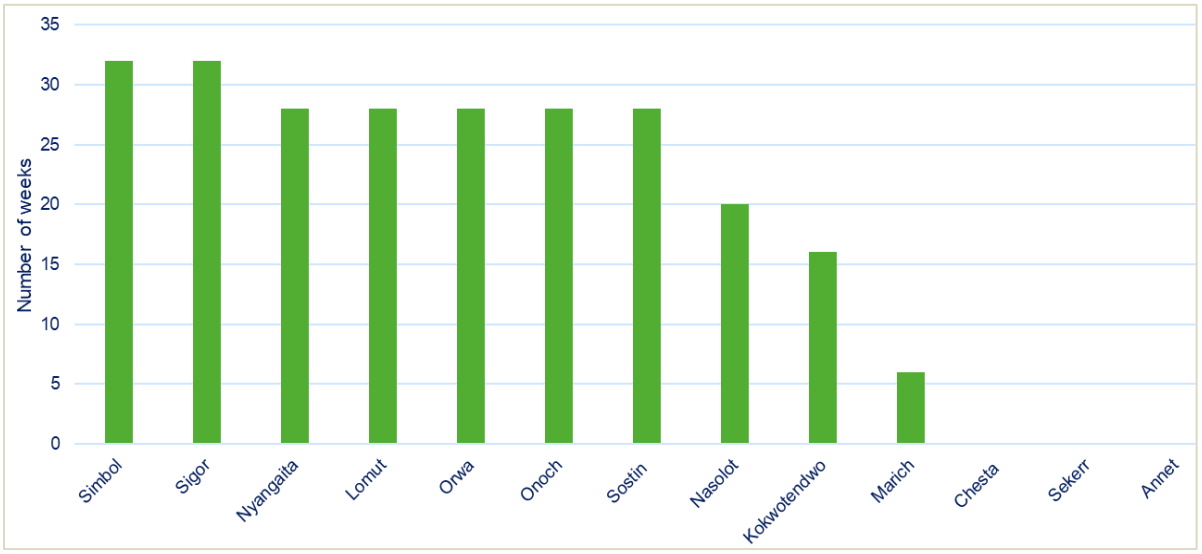


Figure 12: Number of Weeks Facilities had RUSF stock outs

3.1.1.4 Documentation

Documentation and reporting are essential aspects in process monitoring of IMAM program. According to both quantitative and qualitative data, it was revealed that there were unduly filled OTP/SFP registers. These include: missing follow up detail, missing discharge criteria and exit details, lack of referral slips as well as lack of ration cards. Some health facilities had no details of CHVs activity records and where they had very few referral cases were made even in areas with functional community units. After further investigation, it was established that on the job trainings, joint support supervision as well as routine data reviews were conducted however,

updating of program registers was sometimes delayed or overlooked and only returned to normalcy later. This was attributed to frequent transfers of already trained staffs on IMAM within the county.

3.1.2 Qualitative Data

3.1.2.1: Overview of the process: Triangulation by source and method

Qualitative data was collected from different sources with an aim of confirming the already collected quantitative data. This data was then crosschecked with the assessment team for validity and confirmation as well as establishing barriers and boosters for both SFP and OTP.

Table 2: Triangulation by Source and Method

SOURCE	KEY	METHOD	SOURCE	KEY	METHOD
Sub Area (Nyumba kumi)	A	KII	Traditional healer	N	KII
CHV	B	IDI	TBA	O	KII
Doctor	C	KII	Shopkeeper	P	KII
Chief	D	KII	Caregivers of non-beneficiaries	Q	IGD,IDI
Sub-Chief	E	KII	Fathers of non-beneficiaries	R	IGD
Caregivers of beneficiaries	F	IDI, IGD	Nurse	S	KII
Father of beneficiary	G	IDI	Registers	T	Observation
Caregiver of defaulter	H	IDI	Data collection team	U	IGD
Father of defaulter	I	IDI	Caregivers of cured	V	IDI
Facility Security guard	J	KII	MoH 734	W	Observation
Pastor	K	KII	Sub County Nutritionist	X	IDI
Village elder	L	IDI	Nutritionists	Y	IDI, KII
Grandmother of beneficiary	M	IDI	Nutrition program staff	z	KII

3.1.2.2 OTP and SFP Boosters and Barriers

Key barriers to OTP/SFP Programs

Table 3: Key barriers to OTP/SFP Programs

	Barrier	Short summary	Sources	Method
1	Lack of ownership of the IMAM program by most health workers at facilities	-The CHV runs the program in most facilities to include updating the registers and dispensing the RUTF to the caregivers of the beneficiaries. - One CHV said that during their monthly facility meeting, the health workers ask him to give a presentation of "his program". -Nurse said they work together with CHVs on the IMAM program activities as sometimes they have a lot of work in the jurisdiction so they let the CHV handle the program(admissions and discharge) as they support when there is need - Data collection team observed during first phase of stage 1 that most health workers (nurses) were not aware of the program record details. - Sub-county nutritionist said that some nurses have confessed that they are on contract terms and feel they are being given a lot of work without increased pay; nor assurance of job security. Sub county highlighted that most IMAM programs in the area are being managed by CHVs.	CHVs, Nurses, Sub county, caregiver of defaulter	IDIs, KIIs, Observation
2	Un-incentivized CHVs	- CHVs, in the Community units wish to be given some support such as "lunch" and "transport" to enable them to effectively do the community work; most are inactive. - Nurses stated that CHVs at the village level say that they are the breadwinners in their families and as much as they like the community work, they find it discouraging to walk long distances for hours and get back home with nothing to show for it. Most nurses have seen CHVs choosing other activities that bring them some income as opposed to the work of the CU that does not give them the same. This limits follow up of IMAM clients in the community -A Nurse said when she reported to the facility (Nasolot) she saw a list of CHVs in the book but have never seen them in person. *"Wanaona afadhali kuchunga ng'ombe yao juu angalau hapo watapata pesa"* (they see it is better to engage in cattle herding because at least that will give them some money. - Sub-area, sub-chief and Chief highlighted that CHV activities stopped in their areas due to pull out of support from NGOs for lunch and transport allowances.	Nurses, CHVs, Sub area, Chief	IDI, KII,IDG
3	Limited active community screening	-Caregivers of defaulter children said they has not had any contact with any CHV in the village.	CHVs, Nurse, caregivers of beneficiaries,	IDG, IDI,KII

		- CHV stated that there is a disconnect between Community-Unit CHVs and facility-based CHVs as they feel the one in the facility may be getting some support which they in the village do not. The community unit CHVs would screen and refer malnourished children to the health facilities. -Nurses, facility based CHVs and nutritionists said that most of their program beneficiaries are identified when they come for outpatient treatment had never seen referral from the community for more than 6 month.	caregivers of defaulters, mkasa, chief, nutrition program staff	
4	Distance	- A caregiver of defaulter said that if child is unwell, it does not matter how far she will have to go, the caregiver will take child to the hospital. - Caregiver of defaulter said she walked 3 hours with her child to seek medical treatment for her child who she later found out was malnourished. Her village is 7km away from the facility - Caregiver of cured said that she lives near the facility as she could see the facility from her house. -Facility security guard said that some caregivers will choose to go for gold first being that the village with the gold mining avenues is halfway placed to the IMAM facility. - Caregiver of beneficiary in *Adodo* Village of Nasolot said the place is not far for her, about 5km walking. - Facility security guard said that houses close to the facility find it easier to visit the facility than those farther away. - A Nurse said they conduct outreaches on biweekly basis because of the distance travelled by caregivers of beneficiaries in farthest villages.	Nurse, Facility security guard, Caregiver of defaulter, CHVs, Nurses	IDI
5	Topography/ terrain as a barrier	- CHV said, *"topography of the area makes it difficult for CHVs to do home visits to IMAM beneficiaries and tracing of defaulters".* - CHV said some caregivers live down the valley so the volunteers are not able to follow them up. - Caregiver of defaulter requested for services to be brought closer to the community by taking the plumpynut to where they are so they do not have to come up and down the hills for services. - Traditional healer said that the facility is on the valley while the village is on top of the hill so coming down to and coming up from the facility with a baby, *"Nyarptai"* is too challenging for mothers, and some just choose to go to the traditional healer who lives among them. As a solution, she said unless the CHVs carry the nutrition commodities up the hill to give the caregivers, beneficiaries would continue defaulting. Caregivers of defaulter from that area echoed the same suggestion. -Facility based CHV and Nurse said KEMSA will sometimes leave Kokwotendwo stock delivery at Onoch due to bad road and sometimes will not reach the Kokwotendwo facility, as there is no one to take them up the hill. -Data collection team found 8 boxes of Micronutrient Powders (MNPs) meant for Kokwotendwo offloaded at Onoch nearly three (3) months back.	CHV, Nurse, caregiver of defaulter,	Observation , IDIs

		-Data collection team noted that some villages (such as "*Adodo*" village in *Nasolot* catchment) are completely cut off from accessing the health facility during the rainy season due to flooded seasonal rivers "*laga*".		
6	RUTF/RUSF stock outs	- Some health facilities, about 5 facilities, had records that indicated a period of at least four weeks without stock before the next delivery; between November 2018 and October 2019. - The Sub-county Nutritionist and the other nutritionists said that KEMSA delivers stock once every quarter; sometimes some health facilities run out of stock and they redistribute the supplies between facilities while awaiting delivery of their requests. - A Sub-chief mentioned that the program helps a lot when nutrition commodities are available but during stock-out the program really declines; *"Inasaidia sana lakini zikikosa dawa, hushuka sana na watu wanakataa kuja".* -Caregivers of beneficiaries from *Parkut* and *Chepar* villages appreciate IMAM program in *Arpollo* Dispensary very much. However, at the time of this assessment they had stopped visiting the facility due to stock out.	MoH 734, nutritionist, Sub-county, caregiver of beneficiary, father of beneficiary, nurse	Observation , IDIs
7	Minimal defaulter tracing	- CHVs and Nutrition program staff said that CHVs have not incentivized since 2015 hence have not been tracing defaulters; the link between the facility and community through CHVs has become weak. Through UNICEF Funded Emergency Response project, there were plans to have 2 CHVs per facility to be facilitated towards finding November defaulters. - CHVs and nurses said that defaulter tracing is only conducted once the children are discharged as defaulters not before. -Nurse said that some CHVs are pastoralists and move from time to time in the dry season to unknown location. This affects defaulter tracing and home visits within the activity of the CUs. - Sub-county said that facilities in the area do not do close follow up of absentees in the program on time. Therefore, some defaulting may only have been noted in different months as opposed to actual months. - Nurse mentioned that only the active CHVs in CUs assist in tracing defaulters but just within their village jurisdiction as it is impossible to move to other villages due to lack of transport or lunch facilitation.	Sub-county, nurse, CHVs, OTP/SFP registers	IDIs
8	Temporary migration	-CHV said that sometimes families move from *Sigor* to *Masol* area in search of livelihood because these areas are along the "Muruny" river (nicknamed Marich or Weiwei river). The CHV said that villages along the river line (within *Sigor* area) such as *Karaptel*, *Kasetiang*, *Sonjiro*, *Ngaram* and *Korellach* are each about 2km and on a slightly sloppy terrain from the facility.	CHV	IDI
9	Some caregivers feel that Non-	- Caregiver of defaulter said they had been used to coming on a specific day of week for IMAM but when it changed to any weekday (Mon-Fri), they would come to the facility for the IMAM service and wait for long periods with no one to serve them. They would then leave and possibly delay their next visit.	CHV, Caregiver of defaulter,	IDIs

	specific IMAM days not working well	-Nutritionist said that the week preceding the assessment the nutrition colleagues had gone to conduct the outreach activities in the facility catchment, hence no nutritionist was available in the health facility to attend to the beneficiaries. -CHV said that initially they would admit any day but give TCAs of their facility specified distribution days. Currently with the non-specific days of nutrition commodity distribution, some caregivers of beneficiaries feel that the TCAs are not being respected. -CHV said that the days mentioned are possibly when the nutritionist had other activities such as outreach, outside of the hospitals, and thus nobody might have been there to offer the services. -Nutritionist said that they do assess and admit into program any day (Monday to Friday) and the TCA is set in relation to their specific admission date.	nutritionist, nurse	
10	Insufficient Information shared on the progress of the beneficiaries	- Nutritionist said that there is usually minimal time for individual talk on the IMAM program, malnutrition and proper use of the commodities given to the caregivers awaiting screening and admission for IMAM services. This is the reason for some caregivers' unwillingness to see their children indicated as "cured" as the caregivers are not fully informed on causes of malnutrition, importance of compliance to the treatment regimen and the exit criteria before being admitted. - Caregiver of cured said she would wish to understand why some beneficiaries are given more RUTF than others. - Caregiver of beneficiary said no information is usually given on the progress of the child after screening. - CHV said they tell the mothers reasons for admission and use of RUTF/RUSF with adherence to prescribed sachets daily. - Caregiver of defaulter said that there is some education and counselling at the facility on condition of child with a bit on the program. She added that she did not receive any guidance on how to use the commodity. - Caregiver of beneficiary and Grandmother of beneficiary said CHV explained how to use the RUTF and that only the child should use the commodity. - Grandmother of beneficiary said that the CHV said she should give the child 1 sachet in the morning another at lunch and another at supper. Then when they are finished, she should get back for some more.	Nutritionists, caregiver of beneficiary, caregiver of defaulter, CHV, grandmother of beneficiary	IDIs
11	Use of alternative treatment seeking avenues: some poor health	- A Caregiver of defaulter said when the child does not get well, she takes him to a traditional healer to be given ash and gain strength; *"mtoto asipopona, nampeleka kwa mama fulani wa dawa anapewa jivu ndivyo apate nguvu".* -Caregiver of a beneficiary said that some parents seek herbs and traditional healing as first treatment for malnutrition.	Caregiver of defaulter, Father of beneficiary, caregiver of beneficiary,	IDG,IDIs

	seeking behaviors	-Caregiver of cured said that she usually takes her child to the hospital whenever he is sick, sometimes to the chemist first or even the Sub-district hospital which is further away. -In Sarmach village, fathers of non-beneficiary said when children get diarrhea they take the regurgitated grass from cow's stomach, boil it, sieve and give child to drink, if the child does not improve in 2-3 days they are taken to the health facility; a practice by many people in that and neighboring villages. -Some caregivers of beneficiaries said fathers do not see the need to have their sick children taken to hospital immediately when they are sick. They prefer traditional herbs first then to hospital only when the child worsens. -Traditional healer said she is first a midwife but also treats common illness but not *"chemosoi"* (a term used around her area for malnutrition- -Traditional healer said her clients have increased and that she will currently receive at least 10 clients on a low week. Most of her clients had already been through hospital treatment and believe that they got their illness from the health facilities. Some of the clients are caregivers of IMAM beneficiaries who have already received *"Nyarptai"* (plumpynut/plump sup) still go for traditional healing when they feel the child is not improving. They would go with the sachets during the consultation and when it is time to feed the child, they would go ahead even if in front of her.	grandmother, traditional healer, caregiver of cured, father of non-beneficiary	
12	Persistent high defaulting	- Data from IMAM registers revealed that nearly all facilities have had above 15% defaulting with about 12 of the 19 facilities (who availed their registers for data collection), showing over 50% defaulter rate (November 2018-October 2019). Notably, November 2017 to October 2018 had nearly twice as many defaulter as November 2018 to October 2019. - CHVs said that reason for defaulting among nearly all defaulters is not known because no home visits have been conducted for nearly all the beneficiaries. -Some nurses said that some defaulter exits were due to delay in restocking (4 weeks or more) that caused the clients to be exited as defaulters awaiting restocking. -Sub-county nutritionist, nurse, CHV, Caregivers of beneficiaries, caregivers of defaulters *Arpollo* dispensary catchment said that sporadic intercommunity clashes at the border of West Pokot and Baringo Counties has contributed to high defaulter rates. -Some nurses noted that scale down of outreach activities such as *"Oruro"* and *"Lochacha"* or lack of nutrition commodities has contributed to beneficiaries defaulting.	OTP registers, CHVs, caregivers of defaulters, nurses, Sub county nutritionist,	Observation , IDIs
13	Maternal workload as reason for defaulting	-Data collection team observed that farming activities are mainly conducted by mothers who move to the agricultural areas for the activity and may be absent for follow up visits. -A caregiver of a defaulter observed to be engaging in gold mining activities said that the caregivers use the *"plumpy"* (RUTF/RUSF) to sooth the children while they leave gold mining activities as they do not cry; *"wakiacha mtoto nyumbani kuendea gold, halii juu anakula plumpy".*	Data collection team, caregiver of defaulter,	IDGs, IDIs

		-Another caregiver of a defaulter said that for the mother who is the breadwinner, she would prefer to go for gold mining activities for IMAM program follow up visits. -A CHV said that some of the caregivers are into alcohol brewing business that is common along the riverine (*"mtoni"*). Alcohol is also sold along the river because the gold miners are the mostly the customers as they are perceived to have quick access to money *"hawa watu wa gold wanapata pesa ya haraka"*, contributing to defaulting. A caregiver of non-beneficiary confirmed this.	CHV, Caregiver of non-beneficiary, Shopkeeper	
14	Sharing of RUTF/RUSF	-Facility security guard said that the households with a beneficiary would sometimes share the commodities especially if they do not have food in the house. A village elder confirmed the same. -Caregiver of cured beneficiary said that she was notified of the undernourished status of the child at the facility by a CHV who informed her that the "N*yarptai*" (RUTF) was not really medicine but not really food, which if given to children who are healthy, they could get ill. - A Sub area *("nyumba kumi")* said, "some households use the program commodities as food, not as treatment, especially the poor families". - A nurse said that households would usually share the commodities due to lack of food. He suggested the need for other programs like the protective rations could help households meet food requirements hence preventing sharing of commodities. -Nurse noted that some caregivers, whose children are screened and not found to be malnourished, insisted on having their children admitted since their neighbor's children are in program, even if they do not meet the criteria. -Traditional healer said that she has tried severally to have a taste of the *plumpy* from the caregivers as she feeds the children in front of her, but they have constantly refused saying they have been told it is only for the children as the doctor at the facilities have informed them. -Good enough there are some caregivers who are strict with the sharing of RUTF/RUSF	Doctor, facility security guard, Sub area, Traditional healer, Fathers of beneficiaries, caregiver of cured, Shopkeeper, Nurse, village elder	IDGs, IDIs, KII
15	Stigma associated with Malnutrition	-The Sub-area for *Onoch* catchment population said that caregivers from *"dini ya msambwa"* religion, in the community, do not believe in conventional treatment of ailments and will often not take their children for treatment. He said the caregivers would mostly hide their children who might show visible signs of malnutrition for fear of being ridiculed. -Sub-chief in Arpollo was concerned that there are caregivers who shy away from the program but has not been able to establish the reason. - Traditional healer said that some caregivers are afraid of taking the children to the health facilities for treatment because they have probably been using the herbs and child might be too malnourished by the time they get there; they are afraid of being scolded by the health workers	Subarea, traditional healer, sub chief	IDI, IGD, KII

Table 4: Key Boosters to OTP and SFP Programs

	Boosters	Short Summary	Source	Methods
1	Supported Integrated outreaches	- Some Nurses said their facilities have functional bi-monthly integrated outreach services including IMAM services serving villages that are more than 5km away from the link facility. - Caregiver of a defaulter said that the outreach activities are not conducted in areas that are far -CHV said that the previously non-functional site "*Kapsoo*" (10Km from Sostin facility) that there were plans to revive it -Sub-county nutritionist said the sub county currently has about 29 integrated outreach sites -Scale up of outreach sites began to be operationalized in September 2019, operating bi-weekly.	Nurse, Sub County nutritionist, caregiver of defaulter, CHV	IDI, KII
2	RUTF/RUSF dispensed at the pharmacy	- Sub-County nutritionist said that a directive was given to the entire County to move the commodities to the pharmacy as the new point of dispensing to enable the community to see the commodity as medicine for the sick child and not share. - Nutritionist, Nurses and CHVs said that the nutrition commodities are dispensed at the pharmacy. -CHV said that the dispensing of the commodities in the pharmacy seemed to have reduced wastage of the commodities whereby, initially the commodity would issued to any child. For instance, when a child cries when in waiting line for screening or when the child was not cooperating and crying a lot. -Data collection team observed the commodities in the same store as the other medication in the IMAM integrated facilities. -Nutritionist mentioned a caregiver of beneficiary who brought positive feedback on reaching the pharmacy for the commodity; being served from the pharmacy makes it look like a medicine	Sub-county nutritionist, nurses, CHVs, data collection team, Nutritionist	Observation, KII, IDI
3	Good link between the Stabilization Center (SC) and OTP	- Nutritionist said more than half of the new OTP clients are those discharged from the Stabilization Center. - Nurse said whenever they receive a child who has malaria and is found to be severely malnourished, they are sent to the stabilization center in the Sub-County hospital for admission and treatment first.	Nutritionist, Nurse, SC register	IDI
4	Good opinion of the program by community	- CHV said that the community likes IMAM program as it helps improve the nutrition status of children and mothers. - Security guard for the facility said he knows some of the beneficiaries who have been cured in the program. He mentioned that caregivers of the cured cases encourage others to take children to the health facility for screening and management of any malnourished case. - Caregiver of beneficiary in *Nasolot Dispensary* encourages others whose children look malnourished to visit the health facility; she uses her child as an example of the benefits of the IMAM program.	caregiver of defaulter, CHV, Facility Security guard, caregiver of beneficiary, Village elders,	IGD,KII

		- Caregiver of a cured beneficiary appreciates the IMAM program because her baby's health has improved. - Caregiver of beneficiary was using herbs on her child was advised by her sister to take the child to the clinic and upon doing so, the child was screened, identified with malnutrition, admitted, treated and discharged as cured. -Sometimes some Caregivers of IMAM beneficiaries are accompanied by other caregivers of children not in program, during the clinic visits and request for their children to also be screened: *"sister nipimie mtoto wangu nimwone ako aje"*. Nutritionist stated that most end up fitting into the program criteria. - Village elder said people like the services, that some community members are aware that the "*plumpy*" is medicine for malnourished children. Men remind their women to take their children for the visits. - Caregiver of an IMAM beneficiary referred to the program another caregiver of a child who was sickly and had first gone through traditional healer and used other herbs without improvement. Upon admission into IMAM program, the child improved - Caregiver of defaulter said that, although distance and maternal workload are the main challenge, most caregivers are pleased with the program in the community. The same was also confirmed by the sub-area and chief, lay mothers interviewed, that very many people like the program as have heard about it through those who have benefitted. Those in the program encourage those not in the program to have their children screened for malnutrition and be enrolled if they qualify. - Caregivers appreciate the services given at the SC by the nutritionist in Sigor.	sub area, chief, Sub Chief	
5	Screening at health facility	- Nurses said most of the new clients are those identified during outpatient medical treatment and are referred for nutrition review and admission according to criteria. - Caregivers of defaulters said that she knew her child was malnourished during a visit to the health facility for medical treatment where a health worker screened the child and explained that the child was malnourished and would be admitted into IMAM Program *(kuskus)* - Nutritionists said that sometimes they receive clients with a note from the consultation room to do nutrition review with screening. - Caregiver of beneficiary said that her child has never been screened at home. The child was sick and she took the child to the doctor who sent her to nutrition review and was admitted - Caregiver of a cured beneficiary got to know about her child being malnourished during a clinic visit where the child was screened for weight and MUAC, by the CHV found at the facility.	Nurse, Caregiver of defaulter, Nutritionists, caregiver of beneficiary, caregiver of cured	IDI
6	Some awareness of some signs of malnutrition	- Chief said he knows of plumpynut-*"chakula ya watoto"* and said it is given to children who have brown hair and big stomachs	Chief, Village elders, Sub Chief,	KII,IDI, FGD

		- Nyang'aita Village elders said that *kikaran* children have brown hair, thin, not active and a big stomach. Knows that the program *nyarptai* the red one *"nyopr"* is for those who are very thin while the yellow one *"nyotolelio"* is for the thin children *"kichangulan"*. - Sub-chief said that he was aware of malnutrition and its treatment program where some children were given plumpynut while others are given *"unga"*; was informed about it in 2016 and 2017 through outreach activities. - A Caregiver of beneficiary in *Nasolot* health facility said that the people in her village (*Adodo*) are not aware of malnutrition unless the child gets sick they come to the health facility.	Caregivers of beneficiary	
7	Some collaboration between the CHVs, Chiefs and village elders in identifying malnutrition	- Some Chiefs could mention the specific days of the week that the program runs since some said they had been aware of the program in their facilities for about 2 years. - A chief went on to say it targets the children who are underweight and the identification is done at the outreach sites/baraza forums/church/*siik* groups/*mganda* groups/community meetings - Some CHVs and chiefs work with the CHVs to mobilize the community on health and nutrition services. - Another chief mentioned that when CHVs want to conduct activities, they inform him then take the "*Mkasa*" for mobilization and some community activities	Chiefs, CHV,	KII
8	Some collaboration between the health workers and CHVs on nutrition matters	-Some CHVs said that the nurses in-charge will often call for a facility meeting after a nutrition training or in-charges meetings to debrief or give feedback to the staff (including CHVs and other support staff). - CHV said that any nutrition issue is discussed by CHVs and facility in-charges. - Nurse said they work together with the CHVs on nutrition programming but due to staff shortage the nurse usually handles other medical issues, allowing the CHVs to assist manage IMAM program under the nurse' watch and offering support where needed. - Nurses said that they hold debrief sessions with CHVs at the facility after any nutrition related training or their monthly in-charges meetings. -Village elder said that the nutrition work is mainly for CHVs and nurses	CHV, Nurse, Village elders	IDI,KII

4.0 Discussion and Conclusion

The Central Pokot SQUEAC survey applied only Stage One as the subsequent stages could not kick off due to impassability of survey areas caused by the rains and landslides in West Pokot County. This could also not be done at a later date since the project supporting this activity had come to a close at the time when the flooding situation had improved.

From the findings of the SQUEAC survey conducted in Pokot Central (stage 1) there was an observed increase in admissions for both OTP and SFP in March 2018 that coincide with partner supported mass screening and referral exercise in the sub-county. The peak in admissions in March 2018 is attributed to the Cash transfer that came with the LLB (Linda Lishe bora) where by the target beneficiaries had to first be current beneficiaries of the IMAM program (OTP, SFP). The exits outcome also revealed that there was persistent low cure rates and high defaulter rates across both programs majorly attributed to frequent commodity stock-outs, inconsistent and discontinuity of outreach activities by partners due to diminished funding, distance to health facilities and ignorance of effectiveness of the program by the caregivers.

The barriers to IMAM program can be attributed to the weak community mobilization component in West Pokot. The weak community-health facilities linkage prior to the emergency response project mainly facilitated by absence or non-functional Community Health Units and community activities in the county contribute to these barriers to program. Little or no motivation of the CHVs to conduct early screening for case finding, beneficiaries' follow up and minimal defaulter tracing mechanisms in the health facilities or lack thereof, has also been associated with low IMAM program coverage in the County. In 2019, West Pokot County terminated contracts of 80% of the health workers in 2019, which nearly immobilized the health systems. As a result, health services had not fully normalized including IMAM services at the health facility and community level at the time of the assessment. Moreover, majority of the newly recruited health workers had not been trained on IMAM services and community linkage hence low coverage.

Stage One of SQUEAC survey in Central Pokot Sub-county helped in identification of barriers to IMAM program uptake and access, which if addressed based on the recommendations put forward by the coverage assessment team, and the sub county management team as shown in table 5 will increase access and coverage in the County.

5.0 Recommendations

Below are some of the recommendation made in the previous SQUEAC conducted in Pokot Central in 2014 as well as their implementation status and the current recommendation based on the identified boosters and barriers.

Table 5: Cross cutting Barriers to Both OTP and SFP and Recommendations (SQUEAC 2014 and 2019)

Recommendations 2014	Current Status of implementation	Recommendations 2019
Upscale existing outreach sites to health facilities	In progress, so far 11 outreach sites have been upgraded to health facilities	Encourage all outreaches to offer integrated services
Ensuring supported outreaches are integrated	In progress, with exception of 18 outreaches supported by THS and a few supported by health rite and rotary doctors.	Lobby for recruitment of nutritionists in Pokot Central considering there is only one nutritionist in the sub county
Need to increase active case finding at community level in order to capture cases that do not make it to the facility.	Not done and this is because of lack of motivation by CHVs	Encourage proper health seeking behaviors among community members through advocacies
Need for program to involve key community leaders in IMAM activities to support community sensitization mobilization and defaulter tracing	This is in progress, done through community dialogues where community leaders play an active role. Key community	Have a strengthened defaulter tracing mechanisms through operationalizing community units
To incentivize CHVs	In progress following the CHS bill	Advocacies targeting the county assembly health committee following the CHS bill.
To sensitize the community on the program and to not misuse the supplements or sharing	In progress through advocacy meetings	Community advocacy meetings through dialogue days to sensitize the community on IMAM program for ownership and discouraging misuse and sharing
The need to strengthen integration of services at the facility levels by health workers	completed	Encourage health workers to offer integrated services and screening for all under-fives who go to the facility.
Intensive mentorship and on the job trainings on IMAM protocols	In progress, this is a routine activity done at most twice in a month. Trainings on IMAM have also been conducted	Refresher training for CHVs on IMAM protocols
To strengthen capacity of health workers on documentation, reporting and follow up of outcomes of clients in OTP and SFP programs	In progress, continuous mentorship through in-charges meetings and support supervision	

The MOH to increase the number of nurses at facility level	In progress	
Increase the frequency of imam treatment days and number of outreaches	completed	
Enhance the capacity of the District Nursing Officer to be able to accurately and timely request for supplies	completed	
Need for program to educate and sensitize the community on IMAM services	In progress through advocacy meetings	
	There were 13 recommendations by the county among them 12 were actioned (92%	

5.0 County Action Plans for the Proposed Recommendations

Table 6: County Action plans for the Proposed Recommendations

Barrier	Source	Recommendations	Actions	Process indicators	Means of Verification	Persons responsible
1. Use alternative treatment seeking avenues	Caregivers, Traditional healers	-Advocating for proper health seeking practices	-Advocacy meetings through community dialogues, *kokwo*	-No. of dialogue days held in relation to sensitization of the community on IMAM program and proper health seeking behaviors.	-Community dialogues days Reports	-CHEWs, chiefs, community strategy focal person,
2. Minimal defaulter tracing	Sub County Nurse, CHVs, OTP/SFP registers	-Strengthen the link between the community and the health facility.	-CHV referrals, through household visits -Supporting CHVs monthly meetings -Develop a proper defaulter tracing mechanism	-No. of minuted monthly meetings conducted -No. of referrals by CHVs	-Minutes from monthly CHVs meetings - Referred cases by CHVs (MOH 100) -Developed defaulter tracing mechanism	Community strategy focal person, CHEWs
3. Unmotivated CHVs	Nurses, CHVs Sub area, Chief	-Plan activities to keep the CHVs motivated and engaged. -Operationalize community units	-Link CUs with IGAs -Refresher trainings of CHVs on IMAM programs(module 8) -Conduct a CU functionality assessment -Scale up more CUs to be linked with all facilities especially facilities implementing IMAM	-No. of CUs reporting on monthly basis -No. of CHVs trained on IMAM (Module 8).	-Monthly reports from C Us (MOH 514) -Training reports for CHVs on module 8. -Functionality assessment report on existing CUs. -CUs developed and linked to IMAM implementing facilities	-County community strategy focal person, Partners,

4.Lack of ownership by of the IMAM program by the Health workers and the community	CHVs, Nurses, Sub County Nutrition officer, caregivers	-Advocacy's on IMAM program -Integration of IMAM programs in to other treatment activities by health workers	-Conduct community dialogue days on IMAM program. -Regular health talks on IMAM program -Involving key community informants and key influencers in advocacy meetings -Increase the frequency of the CHMT to ensure the IMAM programming in incorporated into other treatment	-No. of community dialogue days -No. of health supervision done	-Community dialogues reports -CHMT supervision reports	-County community strategy focal person, Partners
5.Insufficient staffing and staff absenteeism	CHVs, Caregivers	-MOH to increase the number of nurses and nutritionists at facility level	-Lobby for more nutritionists and nurses to be employed so as to reduce workload	-No. of nurses and nutritionists employed	-Continuous advocacy done to the County to implement the county strategic plan which includes hiring of health workers	-County government
6.Chronic commodity stock out	CHVs, Nurse, pastor, Ass. Chief	-Enhancing capacity of health workers to be able to timely and accurately order for supplies	-OJTs on stock management and supply request -Early reporting by health facilities to be able to timely restock and long-term projection of needs. -Follow up on facility stocks	-No. of OJTs conducted on stock management and requests -No. of facilities reporting early	-OJT sessions conducted on early reporting.	-Pharmacy, CNC, Health facility in charges, sub county nutritionists
7.Poor health seeking behaviors and	Pastor, CHV, Caregivers, Chief,	-Need to sensitize the community on the program and importance	-Involve the key community leaders in the dialogues	-No. of community dialogue days	-Community dialogues reports	Community strategy

poor child care practices	Traditional healer,	of timely health seeking behaviors	-Community dialogue days -Use of MTMSGs to sensitize caregivers on proper child practices -Sensitize the MTMSGs on family MUAC for screenings at home and early detection of malnutrition	-No. of CUs sensitized on family MUAC		focal person
8. Maternal workload	CHV, Chief, Pastor, *Mkasa* (Village elder)	-Advocating for male involvement so as to reduce the workload advocacy	-*Baraza, kokwo* and community dialogues that emphasize on male involvement in child welfare -Educating the caregivers on practicing and importance of child care	-No. of community dialogue days	-Community dialogues conducted	-Community strategy focal person
9. Irregular outreaches	Caregivers, CHVs	-Encourage partners to integrate all outreaches as well as coordinating and linking them to the health facilities.	-Develop a checklist on what should be done during outreaches and share with implementers	-No. of outreaches offering integrated services	-Outreach reports on sites offering integrated services. -Checklist on outreaches developed and shared among partners	-DPHN, CEPI, Nutritionist

6.0 Appendices

Annex 1: West Pokot SQUEAC Survey Team

Name	Gender	Position	Organization
1. Jacob Cherr	M	Sub county nutrition officer	MOH
2. Mary Okello	F	Monitoring & Evaluation officer	ACF
3. Elsen Cheruto	F	Nutrition officer	ACF
4. Jedidah Ngui	F	Nutrition officer Volunteer	MOH
5. Shaleen Njuki	F	Nutrition officer Volunteer	MOH
6. Salome Lorema	F	Nutrition officer Volunteer	MOH
7. Joash Altoria	M	Nutrition officer Volunteer	MOH
8. Hilda Kalum	F	Nutrition officer Volunteer	MOH
9. Jane Molo	F	Nutrition officer Volunteer	MOH
10. Kurgat	M	Nutrition officer Volunteer	MOH
11. Regina Murio	F	Nutrition officer Volunteer	MOH
12. Batei	M	Nutrition officer Volunteer	MOH
13. Ian Muriiri	M	Nutrition officer Volunteer	MOH
14. Mariamu Hazel	F	Nutrition officer Volunteer	MOH
15. Sharon Jepng'etich	F	Nutrition officer Volunteer	MOH
16. Jacqueline Macharia	F	SQUEAC Technical Support	MOH

Annex 2: A Snap shot of SFP register for Tamkal Health Facility

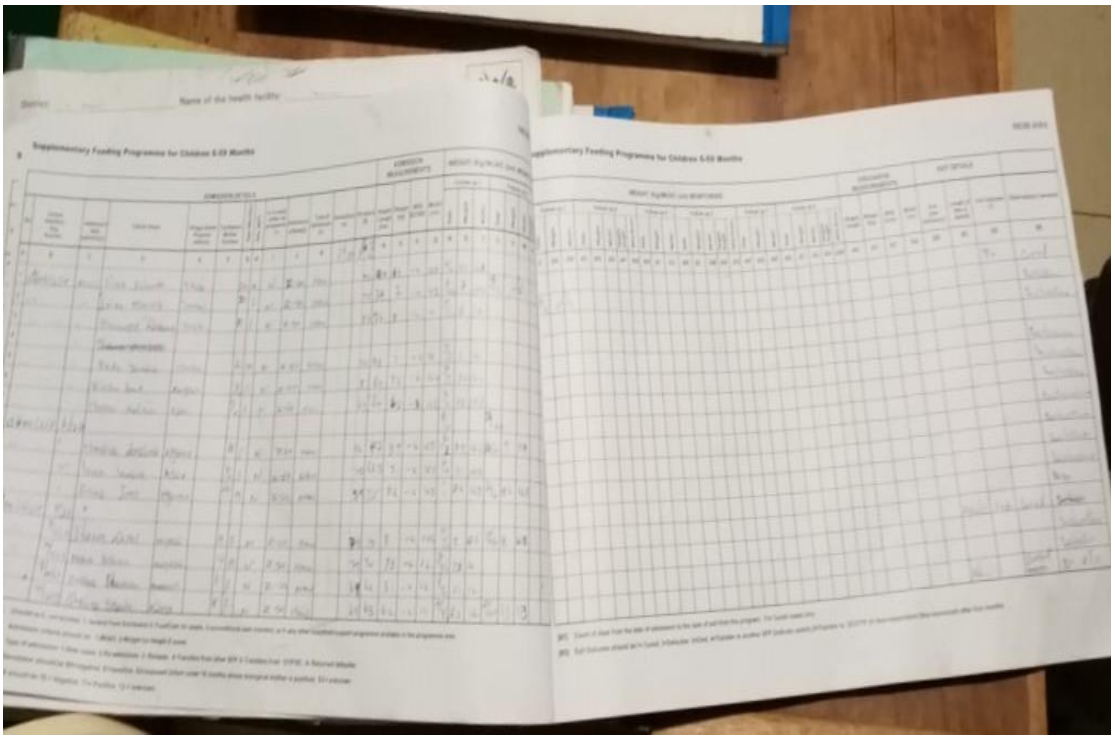


Figure 10: A snap shot of SFP register from Tamkal Health Facility

Annex 3: Pokot Central SQUEAC Work plan

POKOT CENTRAL SQUEAC WORKPLAN	
TASK	**Date**
Preliminary activities Quantitative data collection to be done before classroom training	12th-17th Nov 2019
Classroom training Training on SQUEAC Methodology and Community Assessment – quantitative and qualitative tools Local terminology and seasonal calendar (done in the field)	19th-20th Nov 2019
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 Preparation for stage 2	21st-29th Nov 2019
Total no. days	17

Annex 4: Referral Slip

REFERRAL SLIP

Date: _____

Child name: _____Caretaker name: _____

Village Name: _____ Type of Program referred to: _____

Sex: _____ Age: _____ MUAC: _____

Weight: _____Kg Height: _____cm WHZ: _____ Oedema(Y / N)

During our coverage survey in _____, our team has screened and identified this child to be malnourished.

In advance, we would like to thank you for giving this child necessary attention.

Comments: _____

Name of Team leader:

_____

Annex 5: Semi Structured Interview (SSI) guide Community-Other community people

(Please specify)

Name of Village……Health facility link……..Number interviewed:……. Method used……

Other COMMUNITY – PEOPLE (Please Specify)

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

- What are the common health problems that children experience here?
- Which are the most frequent? Rank (most frequent to least frequent).
- Are any more frequent at certain times of the year? When? Why?
- Which are the most serious? Rank. Why?

If malnutrition mentioned ask:

- What symptoms do these children have?
- What terms do you commonly use to describe this condition?
- Which children get this condition? Why?

HEALTH SEEKING BEHAVIOUR

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

If clinic/hospital mentioned:

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

If malnutrition not already mentioned ask/show pictures:

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

AWARENESS OF IMAM SERVICE

- Do you know of a place where this condition can be treated?
- How did you hear about it?
    - Who told you? When? What do you know about it?

- What are children given for this condition?

If people think the RUTF is a food ask:

  - What sort of food is it?
  - What do you call it?
  - Who can eat it?
  - What foods do you give your children to make them health/strong?

- Do you know children receiving this treatment?

PERCEPTIONS OF IMAM

- What do **you** think about this service?
- What are people saying about this service?

If people say it is good ask: What is good about it?

- Have you noticed a change in the children who are being treated?
- What improvements would you like to see to the service?

If people say it isn't good ask:

a. What is wrong with it?

- What do people not like about the service?
- How can we change it? What suggestions do you have?

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

- 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/she do it?
  d. How are children referred to the health center?

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

COVERAGE QUESTION

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

BARRIERS

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

Annex 6: Semi structured interview (SSI) guide for KEY COMMUNITY FIGURES

Name of Village…… Health facility link ……..Number interviewed:……. Method used……

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 behavior

KNOWLEDGE AND UNDERSTANDING OF IMAM

- Are you aware of any nutrition service at your local clinic?
- Who told you about it?
- When did you hear about it?
- 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

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

PERCEPTIONS OF IMAM

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

BARRIERS/COVERAGE QUESTION

- Do you know any children currently receiving treatment in the village?
    a. What can you tell me about them?
- 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?
- Do you know any children who have defaulted/stopped coming?
    a. Why is that? How can we encourage them to return for treatment?

STIGMA

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

COMMUNICATIONS

- 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 organization of activities = passive or active)

- Have you had any feedback from the volunteer/clinic staff/MoH officials about the service?
- Do you know what the results are (number of children cured)?

IMPROVEMENTS

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

Annex 7: Semi Structured Interview guide-TRADITIONAL HEALERS

Name of Village…… Health facility link ……..Number interviewed:……. Method used……

TRADITIONAL HEALER / OTHER HEALER

TREATMENT AND PERCEPTION OF MALNUTRITION

Start the discussion by asking:

- What types of illnesses do you treat? Most common? How many patients do you see a week?
- How do you treat this illness (ask for the each illness mentioned by the healer)? What do you do if the treatment is not effective?

If not mentioned show picture of malnourished children and ask:

- 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?
- 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

- Are you aware of any nutrition service at your local clinic?
- Who told you about it?
- When did you hear about it?
- 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/SFP day?
    e. Identification of children?

Etc.

Annex 8: Semi Structured Interview guide-CARERS OF BENEFICIARIES

Name of Village…… Health facility link ……..Number interviewed:…….. Method used……

CARERS OF BENEFICIARIES

(Individual case history)

HISTORY OF THE ILLNESS

- 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

- What did you do when your child became ill?
- Did anyone tell you to go to the health center (information source)?
- How long was it before you went to the health center?

INFORMATION SOURCE FOR THE OTP/SFP

- 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?
- What did you hear about it?
- What made you come?

AWARENESS OF/CONTACT WITH CHV (CASE FINDER)

- 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

- What did the clinic staff tell you about your child's condition?
- 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/RUSF etc.?)
- What does the staff call the treatment? What do you call the treatment?

STANDARD OF SERVICE

- How long do you usually wait before the nurse sees you?
- How much time do you spend with the nurse?
    a. How does the staff treat you?
    b. Have you ever been scolded? Why?
- 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

- 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

- How easy is it for you to come every week?
  a. What makes it difficult / stops you from coming sometimes?
- 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

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

Annex 9: Semi structured interview guide-GROUP DISCUSSION WITH CARERS

Name of Village…… Health facility link ……..Number interviewed:……. Method used……

Group discussion with carers

INFORMATION SOURCE FOR THE OTP

- 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?
- What did you hear about it?
- What made you come?

AWARENESS OF/CONTACT WITH CHV (CASE FINDER)

- 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

- How long has your child been receiving treatment?
- Difference in child's condition?
- Have you had any difficulties in following the treatment/attending every week? (Probe for: distance, waiting time, welcome, etc.)
- Have you missed a week? Why?
- 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: What do you think of the service?

    c. What are the strengths/weaknesses?
    d. What could be improved?

DISTANCE: How far is it from your home to the clinic?

    e. How do you get here? Walk/transport?
    f. How long does it take?
    g. Determine the farthest distance travelled within the group

- Do you have any other reason to come to this clinic/this place?

COVERAGE QUESTION/DEFAULTING

- 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?
- 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? Why/why not?

PERCEPTION OF IMAM

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

STIGMA

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

If stigma exists:

- How does the stigma affect you personally? In what way?

FEEDBACK: Have you any messages you want us to give to the people running the service?

Annex 10: Semi Structured Interview guide-COMMUNITY HEALTH VOLUNTEERS

Name of Village…… Health facility link ……..Number interviewed:…….. Method used……

COMMUNITY HEALTH VOLUNTEERS (CHV)

ROLE

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

EXPLANATION GIVEN TO MOTHERS

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

REFERRAL AND FOLLOW UP

- 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?
- Are you aware of any children who have stopped coming?
    a. Why is that? How can we encourage them to return?
- Are you ever asked to visit a case that is not improving / has been absent? Tell me about the last one you visited.

REJECTION

- 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?
- Are you aware of any other children who went spontaneously to the health center and were turned away and not given treatment? Probe: a-d as above.

COVERAGE QUESTION

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

COMMUNICATIONS

- When was your last contact with clinic staff?

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

OPINION OF THE OTP/SFP

- What is your opinion of the OTP/SFP? Why?
- What is the opinion of the community?

MOTIVATION

- Appreciation of your work by the community?
- Appreciation of your work by programme staff?
- Do you enjoy your role? Why / why not?
- Challenges / difficulties?

IMPROVEMENTS

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

Annex 11: Semi-Structured Interview guide-IMAM PROGRAM STAFF

Health facility……

IMAM PROGRAM STAFF(Nurses/Nutritionists)

IMAM INVOLVEMENT AND CHALLENGES

- How long have you been working on IMAM?
    a. How many staff are involved/trained on IMAM?
- When were you trained on IMAM?
    a. Have you had refresher training?
    b. Is there any additional training you feel you need?
- 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

- 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?
- What do you think are the causes of malnutrition here?

REFERRAL

- 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

- Do children who are referred by the volunteer come with a referral slip/paper?
    a. What do you do with the referral slips?
- 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?
- How do you refer patients to the stabilization center? 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

- 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?

- Have you had any wrong referrals from the volunteer?
    a. How many? What was the problem? Did you report back to the volunteer?

DEFAULTING

- How many children are absent for more than 1 week during the course of treatment?
    a. Why do you think this is?
- How many children default?
    a. Why do you think this is?
- Is there a system to follow up on defaulters? How does it work? How could we encourage children to return for treatment?
- What barriers prevent mothers from bringing their children to the OTP/SFP?

COVERAGE QUESTION

- Are you aware of any children with this condition who don't come to the Health Facility? Why is that?

COMMUNICATIONS

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

OPINION OF THE SERVICE

- Does the OTP/SFP give good results?
- Has the condition of the children improved?

WORK LOAD

- Does the OTP/SFP give you more work?
- What changes have you had to make to your routine activities?

IMPROVEMENTS

- Challenges? Problems? Improvements?
- What messages do you want us to pass to the people organizing IMAM?

Annex 12: Semi-Structured Interview Guide – NGO FIELD AGENTS

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?
- 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

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

FOLLOW UP / HOME VISITS

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

OPINION OF OTP

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

Annex 13: Seasonal Calendar (12 months): Village Elders

Name of Village…… Health facility link ……..Number interviewed:……. Method used……

Indicate the months when the seasons **occurred most**. Please Specify where applicable

Season/Month	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**
Climate (specify rainy/dry)												
Migration												
Kidding and lambing												
Floods/drought												
Insecurity (Specify incidents)												
Mass MUAC screening												
Childhood illnesses (specify illness e.g Diarrhea, URTI, Fever...)												
Agricultural activities (specify eg Planting or harvest)												
Workload for mothers (Specify the workload)												
Workload for fathers (Specify the workload)												
Other (Specify)												