



# Kajiado County Community Assessment Report

August 2023

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## ACCRONYMS AND ABBREVIATIONS

ACT	Artemisinin-based Combination Therapy
ANC	Antenatal care
C4D	Communication for Development
CA	Community Assessment
CBO	Community Based Organization
CHC	Community Health Committee
CHP	Community Health Promoter
CIDP	County integrated development plans
CLTS	Community-Led Total Sanitation
CNAP	County Nutrition Action Plan
CNTF	County Nutrition Technical Forum
CRH	County Referral Hospital
CSG	County Steering Group
CSI	Coping strategy index
CTP	Cash Transfer Program
CU	Community Unit
CWC	Child welfare clinic
CWC	Child-Welfare Clinic
DHIS	District Health Information System
DQA	Data Quality Audit
EBF	Exclusive Breast Feeding
ECDE	Early Childhood Development Education
ENA	Emergency nutrition assessment
FBO	Faith Based Organization
FCS	Food consumption score
FGD	Focused Group Discussion
FGDs	Focus Group Discussions
FSOM	Food security outcome monitoring
GAM	Global acute malnutrition
HAZ	Weight -for -Height Z-Scores
HAZ	Height-for-Age z-scores
HC	Health Center
HCP	Health Care Practitioner
HEDU	Health Education
HF	Health Facility
HH	Household
HiNi	High impact nutrition interventions
HPM	Health Program Manager
IEC	Information Education and Communication
IFAS	Iron folic Acid Supplementation
IGD	Informal Group Discussion
IMAM	Integrated Management of Acute Malnutrition
IMCI	Integrated Management of Childhood Illness
IPC AMN	Integrated Phase Classification for Acute Malnutrition
KAP	Knowledge, Attitudes and Practices
KDHS	Kenya Demographic Health Survey
KEMSA	Kenya Medical Supplies Agency
KEPI	Kenya Expanded Program for Immunization
KHIS	Kenya Health Information System
KII	Key Informant Interview





KNBS	Kenya National Bureau of Statistics
KNBS	Kenya National Bureau of Statistics
KRCS	Kenya Red Cross Society
MAM	Moderate Acute Malnutrition
MoALF	Ministry of Agriculture, Livestock and Fisheries
MoE	Ministry of Education
MoH	Ministry of Health
MoTC	Ministry of Trade and Commerce
MUAC	Mid Upper Arm Circumference
NDMA	National Drought Management Authority
NITWG	Nutrition Information Technical Working Group
NSO	Nutrition Support Officer
ODK	Open Data Kit
OJT	On job training
OPV	Oral Polio Vaccine
OTP	Out-patient Therapeutic Program
PPS	probability proportional to size
rCSI	Reducing Coping Strategy Index
RUSF	Ready-to-Use Supplementary Foods
RUTF	Ready-to-Use Therapeutic Foods
SAM	Severe Acute Malnutrition
SC	Stabilization Center
SCNTF	Sub County Nutrition Technical Forum
SFP	Supplementary Feeding Program
SMART	Standardized Monitoring Assessment of Relief and Transitions
SQUEAC	Semi-Quantitative Evaluation of Access and Coverage
SSI	Semi-Structured Interviews
TBA	Traditional Birth Attendant
THP	Traditional Healing Practitioner
TOT	Trainer of Trainees
TSFP	Therapeutic Supplementary Feeding Program
UNICEF	United nation children education fund
URTIs	Upper Respiratory Tract Infections
WaSH	Water, Sanitation and Hygiene
WAZ	Weight-for-Age z-scores
WFP	World Food Programme
WHO	World Health Organization
WHZ	Weight-for-Age z-scores

## INTRODUCTION

### Background Information

Kajiado County covers an approximate area of 21,871.1 (Sq. Km) with an estimated population of 1,117,840 people (KNBS, 2019) and an average household size of 3.5. the County is administratively divided into five sub counties namely: Kajiado Central, Kajiado





North, Kajiado South, Kajiado East and Kajiado West. According to the National Drought Management Authority (NDMA), Kajiado County has three main livelihood zones namely; pastoral all species (52%), agro-pastoral (31%) and mixed farming (12%) livelihood zones. The approximate proportion of pop per livelihood zone is Pastoralism (41.9%), unskilled labour /formal (36.9%) Agropastoralism (8.8%) mixed farming (9.2%), irrigated cropping (2.8%) and casual waged labour (0.4%).

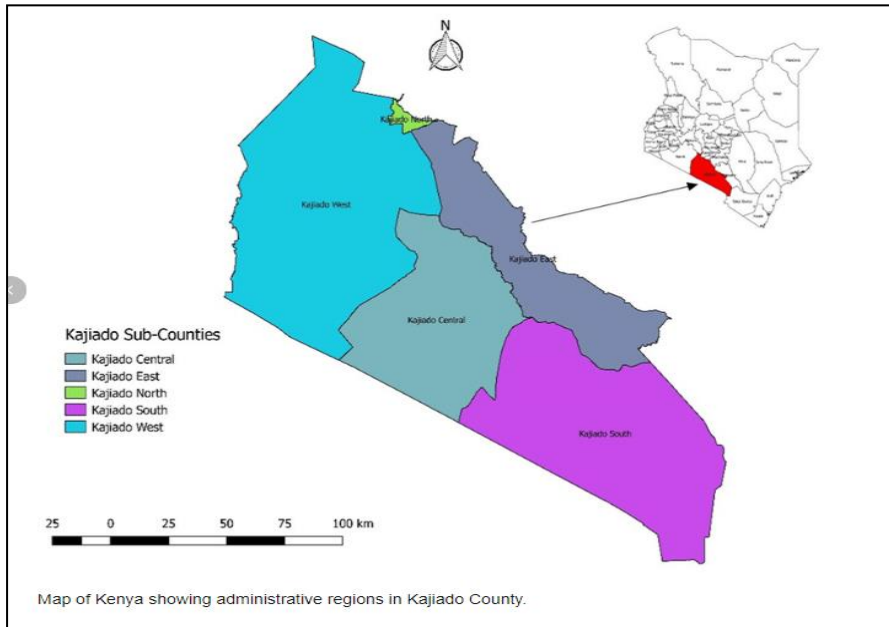


Figure 1: Map of Kajiado County- Livelihood zones

### Nutrition Status

The global acute malnutrition (GAM) prevalence by WHZ based on the County SMART survey 2023 was at 9.2% while severe acute malnutrition (SAM) prevalence was at 0.9%. Integrated phase classification for acute malnutrition classified the County as Stressed (IPC Phase 2). GAM and SAM by MUAC is 4.6% and 1.3% respectively (Integrated SMART survey of July 2023).

### Admission Trends

In 2022, the OTP admission cases were 4197, almost three folds compared to 1495 cases admitted in 2020 and 1595 cases admitted in 2021. In SFP, the admission cases in 2022 were four folds those admitted in 2020 and 2021. The admission cases were 5614,1283 and 1200 in 2022, 2021 and 2020 respectively. SAM program performance against caseloads and targets was 120% and 161%, while SFP program performance against caseloads and targets was 39% and 78% respectively as at December 2022

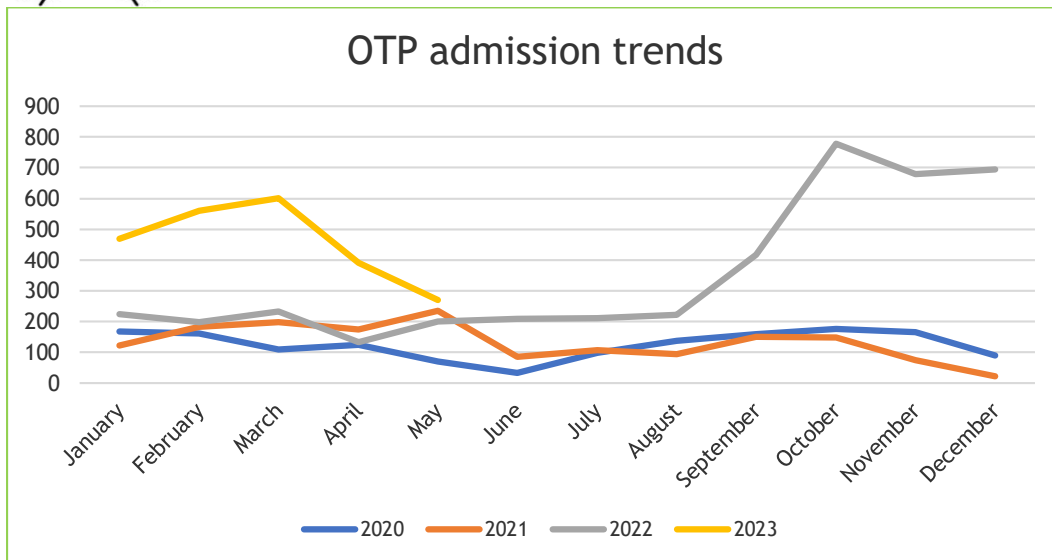


Figure 2: OTP Admission Trends (KHIS Data)

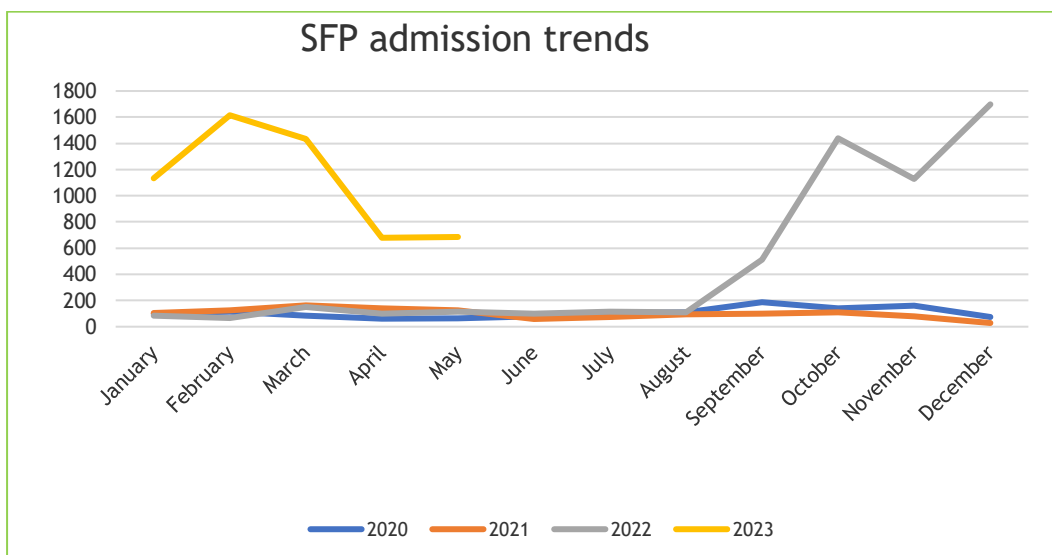


Figure 3: SFP Admission Trends (KHIS Data)

### IMAM Performance Indicators

The Cure rates for OTP and SFP programs in the County remained below the SPHERE minimum standards of  $\geq 75\%$ . Defaulter rates for OTP and SFP program in the County has been above the sphere minimum standards of  $< 15\%$ . Non - response rate for OTP and SFP program in the County has increased in the County especially in the 3<sup>rd</sup> and 4<sup>th</sup> Quarter of the year.

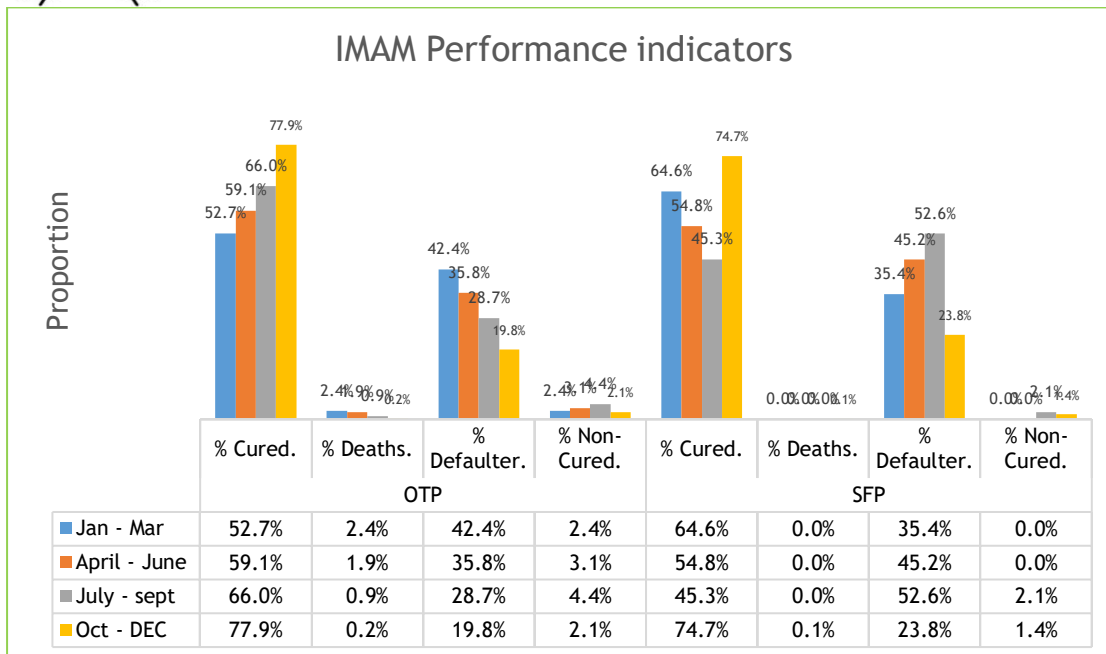


Figure 4: IMAM performance indicators in Kajiado County

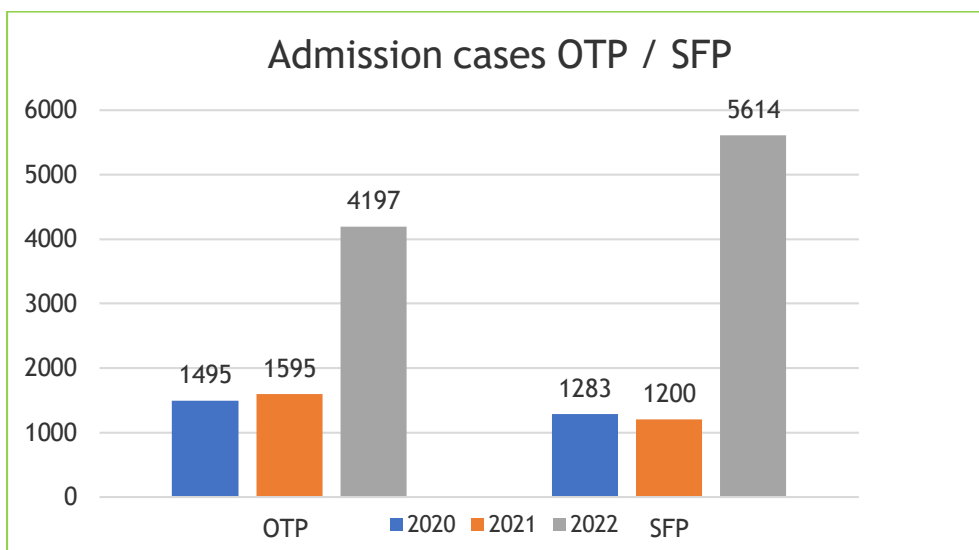


Figure 5: Total IMAM Admission cases (KHIS Data)

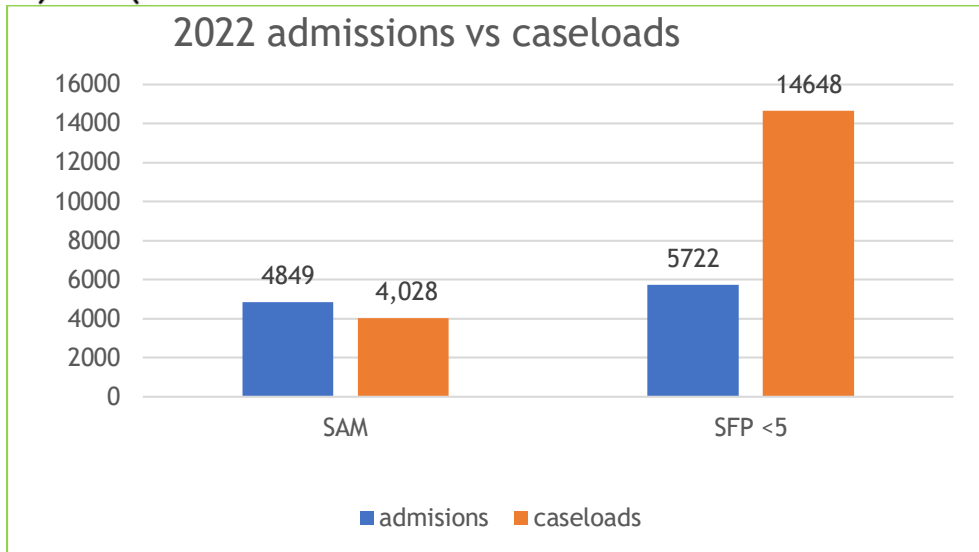


Figure 6: Admissions versus caseloads

### Justification for the Assessment

Kajiado county IMAM program coverage is unknown. No coverage assessment has ever been conducted. The emergency drought situation has resulted into heightened nutrition response activities including scaling up of IMAM activities. Currently the total IMAM outreach sites in the county are 130 all of which are imbedded in a Health facility. The total functional outreach sites in the county are 21 and a total of 119 non-functional outreach sites. A mass screening conducted in December 2022 and February 2023 indicated that majority of the children screened were not in the program. The county has not experienced a detailed review of IMAM program access and coverage, therefore, there is need to conduct coverage assessment. In addition, there was need to determine the program coverage to inform on program performance and decision making. Being a Semi-arid county, Kajiado is a drought prone area that experiences frequent, successive and prolonged drought. As such, the county requires continuous surveillance of nutrition situation. There is limited access and coverage of IMAM services in the county, thus the assessment will seek to establish the factors that influence and affect community decisions to use CMAM services. Compared to KDHS 2014 and 2022 GAM levels have increased from 5% to 7.6% in 2022. The CA would provide information about the bottlenecks to CMAM program and come up with appropriate action plan. Being the first Community Assessment, the survey will act as baseline.

### Community Assessment Objectives

- To explore community systems, structures and actors, including existing networks of community volunteers, which could potentially be used for community engagement
- To understand community knowledge, perceptions and behaviours regarding childhood acute malnutrition and other illnesses, as well as CMAM services
- To assess factors, which influence community decisions to access to and use CMAM services
- To assess the strengths and weaknesses of the current community engagement strategies, as well as opportunities and threats for future CMAM collaboration
- To develop an action plan and a comprehensive community engagement strategy to improve access and uptake of the CMAM services



## Community Assessment Approach

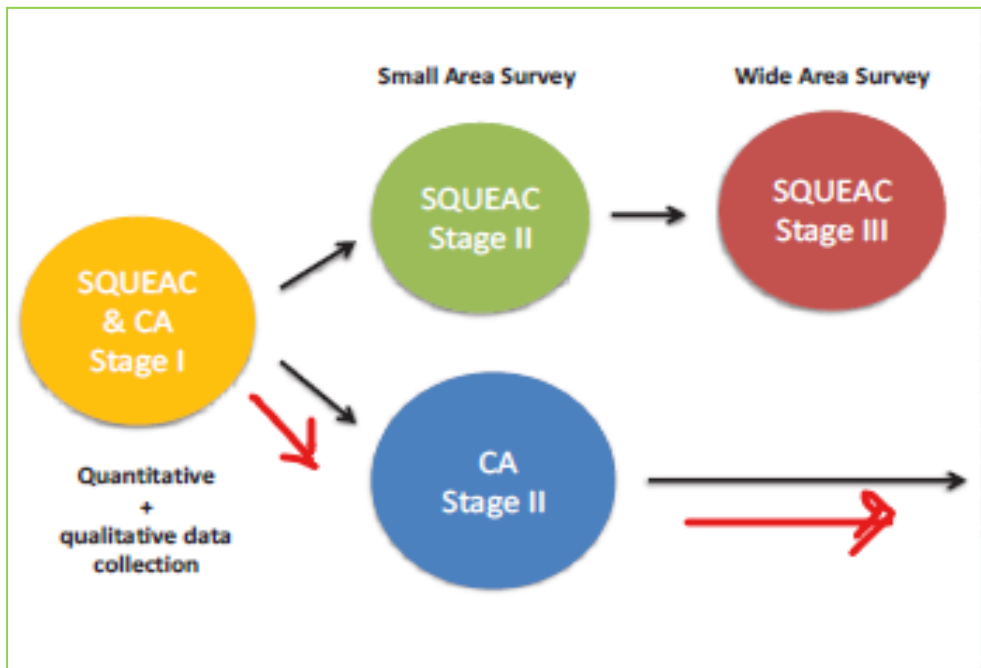


Figure 7: Illustration of difference between SQUEAC and CA forms of coverage methodologies

### Key Community Assessment Steps

Kajiado CA involved two main stages with a seven-step process namely:

#### **Community Assessment Stage 1**

**Step 1:** Training of enumerators and identification of stakeholders

**Step 2:** Quantitative data collection.

**Step 3:** Data synthesis, interpretation and analysis of quantitative data

#### **Community Assessment Stage 2**

**Step 4:** Qualitative data collection

**Step 5:** Qualitative data analysis, triangulation

**Step 6:** Development of barriers and boosters and weighting

**Step 7:** Data validation and action plan development

### Community Assessment Stage 1

#### **Step 1: Training of enumerators and identification of stakeholders**

- Enumerators with previous experience on assessment and surveys to be identified and recruited by the County Health Management Team (CHMT) with the leadership of the County Nutrition Coordinator
- **Assessment Team composition**
  - A team of two (2) enumerators and one (1) team leader was involved in data collection for each sub county.
  - Overall coordination at County Level:
    - CNC - Coordinate the Activity
    - CHRIO - Coordinate data entry and collection
    - Partners- Helps in the supervision of data collection and Survey Manager



- Two Supervisors for each Sub- County:
  - SCHRIO- Helps in the supervision of data collection
  - SCNO - Helps in the supervision of data collection

## Step 2: Qualitative and Quantitative data collection

**Table 1: Qualitative and Quantitative data collection**

Quantitative data to be collected	Quantitative data to be collected
<p>The following data will be collected in all IMAM Health facilities (separately for OTP and SFP) by month</p> <ul style="list-style-type: none"> <li>• No. of weeks in a month with 100% stock availability (RUTF or RUSF)</li> <li>• No. of weeks in a month with 100% HR availability</li> <li>• No. of children screened in the community in the catchment area of the facility</li> <li>• No. of new enrolments to IMAM program</li> <li>• No. of cases discharged as defaulters from the program</li> <li>• No. of cases discharged as non-responders from the program</li> <li>• No. of cases discharged as cured from the program</li> <li>• The average length of stay for children discharged as cured</li> <li>• MUAC at admission for all children aged 6-59 months (during 12 months before data collection)</li> <li>• WHZ score at admission for all children aged 6-59 months (during 12 months before data collection)</li> </ul>	<ul style="list-style-type: none"> <li>• Exhaustive data will be collected and triangulated by source and method from the Sampled sites</li> <li>• Boosters and barriers to program coverage will be established through the BBQ (Boosters, Barriers, and Questions) tool.</li> <li>• Several themes will be explored including: -           <ul style="list-style-type: none"> <li>• Understanding of malnutrition and knowledge of the signs of malnutrition</li> <li>• Pathways to health care and Knowledge on the existence of Treatment</li> <li>• Appreciation of the service and quality of the care</li> <li>• Community mobilization</li> <li>• Barriers and boosters to access and uptake.</li> <li>• Communication channels for the community</li> </ul> </li> </ul>

**Table 2: CA Data collection Methods and Tools**

Qualitative (Both SAM & MAM)	Quantitative (Both SAM & MAM)
Carers of malnourished children (SAM & MAM) - SSI	MUAC at admission
CBO/FBO - SSI	Last MUAC before cure
CHVs (facility & community - based) - KII	Last MUAC before default
Traditional Healers - KII	Admissions and identified Malnourished
TBAs/Mid-wives - KII	Last Malnourished score before cure
Carers of Do Not Attend (DNA) Cases - KII	Last malnourished score before default
Carers of Defaulting cases (SAM & MAM) KII	Length of stay before default
H/Workers - KII	Length of stay before cure
Health facility - observations	Home villages of admitted cases and defaulting cases



Women - FGD	CMAM site origin for children in SC
Men - FGD	Referral source
NGO representative - KII	Outreach worker activity per village
Community leaders - KII	Village summary sheet
Chemist/Shop Attendant	Village info per catchment area
IMAM Program Managers (Nutritionists, Nurses, Cos)	

### Sampling for Quantitative Data Collection

- The objective of the Stage will be to identify areas of high and low coverage
- All IMAM offering H/Fs were targeted assessment

**Table 3: Sampling for Quantitative data collection**

Level	Kajiado Central	Kajiado South	Kajiado East	Kajiado West	Kajiado North	Total	Sampled	Sampling method
Level 5	1-GoK	0-	0	0	0	1	All Sampled and targeted for Quantitative data analysis	Census
Level 4	0-GoK	2-GoK	2-GoK	0	2	6		Census
Level 3	3-GoK	9-GK 2-Private	2-GoK	2	3	18		Census
Level 2	26-GoK 2-FBO	18-GOK 2-FBO	22-GoK 8-Private	40-GoK	3 - GoK 4 - Private	120		Census
<b>Total</b>	<b>34</b>	<b>34</b>	<b>32</b>	<b>42</b>	<b>12</b>	<b>154</b>		

### Sampling for Quantitative Data Collection

- This would be guided by the findings of the quantitative data review.
- The objective of the Stage was to identify reasons for high and low coverage

**Table 4: Sampling for Qualitative data collection**

Level	Kajiado Central	Kajiado South	Kajiado East	Kajiado West	Kajiado North	Total	Sampled	Sampling method
Level 5	1-GoK	0-	0	0	0	1	1	Census
Level 4	0-GoK	2-GoK	2-GoK	0	2	6	6	Census
Level 3	3-GoK	9-GK 2-Private	2-GoK	2	3	18	10	Census
Level 2	26-GoK 2-FBO	18-GOK 2-FBO	22-GoK 8-Private	40-GoK	3 - GoK 4 - Private	120	20	Purposive Randomization
<b>Total</b>	<b>34</b>	<b>34</b>	<b>32</b>	<b>42</b>	<b>12</b>	<b>154</b>	<b>37</b>	

## Community Assessment Stage 2





#### Step 4: Qualitative data collection

#### Step 5: Qualitative data analysis, triangulation

#### Step 6: Development of barriers and boosters and weighting

#### Quality Assurance

The following measures were put in place

- Ensure in depth and quality training is done to participants.
- Custom design interview guides to fit Kajiado context hence ensure richness of information being sought.
- Ensure proper sampling is done.
- Daily Quality Checks daily to be conducted for both qualitative and quantitative data.
- Ensure that consent is sought at the Household level and at the community level through all the stages.

## COMMUNITY ASSESSMENT FINDINGS

### QUANTITATIVE DATA ANALYSIS

#### Overview of Quantitative Findings

##### Data Collection method:

- Data obtained from health facilities offering IMAM services
- Quantitative data obtained from In-patient, Outpatient Therapeutic Program and Supplementary Feeding Program beneficiaries' registers, monthly nutrition program reports, stock bins, stock cards and ration cards from all from the entire IMAM implementing health facilities.

##### Major gaps identified:

- Incomplete details of the admission criteria, missing details of the discharge criteria, lack of referral slips, lack of ration cards.
- There were missing return (TCA) dates in some registers
- Cases overstaying in program; some defaulters overstayed in the registers without being exited
- RUTF/RUSF rations issued not indicated in some of the clients' records.
- Mix up of the admission and discharge criteria observed
- No beneficiary ration cards and upon enquiry, the county Health Department had not factored in to procure more. Documentation was being done in outpatient treatment booklet or MCH booklets.
- Monthly reports from some facilities did not tally with the source documents (beneficiary registers).
- In most health facilities there were no CHV activity records; it seemed that there were few cases of referral by CHVs as evidenced by filed MOH 100 referral slips.



**Table 5: A Summary of Observations on data gaps per Health facility**

<b>KAJIADO NORTH</b>	<b><u>Kajiado West</u></b>
<b>MATASIA HC</b>	<b>OLDONYO LASHO</b>
<ul style="list-style-type: none"> <li>- Some defaulters discharged as cured</li> <li>- Children not responding to treatment also indicated as cured</li> <li>- Colour coding</li> </ul>	<ul style="list-style-type: none"> <li>- All the names were recorded under one general village.</li> <li>- There are no OTP cases</li> <li>- There was high entry number in December due to outreaches and no follow up</li> </ul>
<b>NGONG SCH</b>	<b>OLDONYO NYOKIE</b>
<ul style="list-style-type: none"> <li>- Invalid admission criteria</li> <li>- Wrong discharge criteria</li> <li>- No report was found for commodities from Aug to Dec</li> </ul>	<ul style="list-style-type: none"> <li>- Some villages have not been recorded</li> <li>- The dates for cured cases have not been indicated</li> <li>- LOS OTP and SFP have not been indicated</li> </ul>
<b>ZAMZAM</b>	<b>ILKIRAMATIAN DISPENSARY</b>
<ul style="list-style-type: none"> <li>- Failure to indicate clients as defaulters after 3 consecutive visits</li> <li>- Wrong admission criteria</li> </ul>	<ul style="list-style-type: none"> <li>- Wrong admission criteria used</li> <li>- The exit dates of the defaulters were not indicated in both OTP and SFP</li> <li>- DARAJA village is a catchment area for both Irkiramatian dispensary and Entasopia health Centre</li> </ul>
<b>OLOOLUA</b>	<b>OLDORKO DISPENSARY</b>
<ul style="list-style-type: none"> <li>- Not indicating clients as defaulters</li> <li>- No exit dates instead indicated as to be cured on</li> </ul>	<ul style="list-style-type: none"> <li>- LOS not calculated</li> <li>- There is no admission by WHZ</li> <li>- EWUASO KEDONG HEALTH CENTRE</li> <li>- High entries in SFP for Oct. 2022 with no follow up</li> </ul>
<b>BEACON OF HOPE</b>	<b>Kajiado Central</b>
<ul style="list-style-type: none"> <li>- No exit dates</li> <li>- WAMA</li> <li>- No data from Aug to Nov</li> </ul>	<b>ILMARBA DISPENSARY</b>
<b>OLTEPESI</b>	<ul style="list-style-type: none"> <li>- Wrong admission criteria from February</li> <li>- No follow up was done [August/February]</li> <li>- All patients admitted by MUAC</li> </ul>
<ul style="list-style-type: none"> <li>- No exit WHZ</li> <li>- No admission criteria for some children</li> </ul>	<b>OLELESHA DISPENSARY</b>
<b>ESONORUA</b>	<ul style="list-style-type: none"> <li>- All defaulters admitted during mass screening</li> <li>- Nurse have been on maternity leave since February</li> <li>- No active case in the program</li> <li>- Supplements issued by CHA not documented</li> <li>- Stock cards not updated since march</li> </ul>
<ul style="list-style-type: none"> <li>- OTP and SFP mixed in one book</li> <li>- RUSF stolen</li> <li>- Wrong discharge criteria</li> </ul>	<b>NENTONAI DISPENSARY</b>
<b>ENKOEOREI</b>	<ul style="list-style-type: none"> <li>- Low caseloads</li> <li>- Wrong admission criteria</li> </ul>
<ul style="list-style-type: none"> <li>- Admission criteria is WHZ but manages with MUAC</li> <li>- No discharge parameters and dates</li> </ul>	<b>MAILIWA DISPENSARY</b>
<b>ST MARY</b>	<ul style="list-style-type: none"> <li>- Wrong OTP admission criteria</li> <li>- Those admitted by MUAC are blank</li> <li>- Other MUAC measurements are <math>\geq 11.5</math></li> <li>- No WHZ admissions</li> <li>- No stock cards available</li> </ul>
<ul style="list-style-type: none"> <li>- Most clients not declared as defaulters, cured, non-response</li> <li>- No exit criteria for some clients</li> <li>- No exit dates</li> <li>- Missing exiting parameters</li> </ul>	<b>EMURUA DIKIR</b>
<b>AJAM</b>	<ul style="list-style-type: none"> <li>- SFP/ OTP information are in the service book hence no follow up</li> <li>- No admission criteria noted in the report books</li> <li>- Wrong admission criteria used</li> </ul>
<ul style="list-style-type: none"> <li>- No data on cured, defaulters and non-response</li> <li>- No admission dates</li> </ul>	<b>CMF KUMPA</b>
<b>TEAM 2 OBSERVATIONS.</b>	<ul style="list-style-type: none"> <li>- No admission criteria for several clients</li> <li>- All exits on may</li> <li>- OTP admissions on SFP book</li> <li>- High number of defaulters</li> <li>- Wrong cure rates</li> <li>- Length of stay lies over the estimated range</li> <li>- Follow up not appropriately done</li> </ul>
<b>KMS - KAJIADO.</b>	<b>Imbirikani sub county hospital</b>
<ul style="list-style-type: none"> <li>- Dates missing in MOH 734.</li> <li>- Wrong admission criteria in OTP.</li> </ul>	
<b>AIC DISPENSARY</b>	
<ul style="list-style-type: none"> <li>- No discharge measurements.</li> </ul>	
<b>SAJILONI DISPENSARY.</b>	
<ul style="list-style-type: none"> <li>- PLW in OTP Register.</li> <li>- Outcome indicators apart from cured not documented.</li> <li>- No IMAM services/ report 734 for Feb 23 - May 23.</li> </ul>	
<b>ENKORIKA HEALTH CENTRE.</b>	
<ul style="list-style-type: none"> <li>- Registers well updated.</li> <li>- Children overstaying in the program.</li> <li>- Proof of referral forms.</li> </ul>	
<b>OLOYIANKALANI DISPENSARY.</b>	
<ul style="list-style-type: none"> <li>- IMAM registers well updated.</li> </ul>	



<p><b>MILE 46 HEALTH CENTRE.</b></p> <ul style="list-style-type: none"> <li>- Registers well updated.</li> </ul> <p><b>OLENARUA DISPENSARY.</b></p> <ul style="list-style-type: none"> <li>- No OTP REGISTER.</li> <li>- Using RUTF for SFP clients.</li> </ul> <p><b>EMARORO DISPENSARY.</b></p> <ul style="list-style-type: none"> <li>- Registers not updated.</li> </ul> <p><b>NGATU DISPENSARY.</b></p> <ul style="list-style-type: none"> <li>- NO defaulter list.</li> </ul> <p><b>MASHUURU SUB COUNTY.</b></p> <ul style="list-style-type: none"> <li>- Registers well updated.</li> </ul> <p><b>FATIMA LENKISM H/C.</b></p> <ul style="list-style-type: none"> <li>- Registers not well updated.</li> </ul> <p><b>ILOIRERO DISPENSARY.</b></p> <ul style="list-style-type: none"> <li>- Registers not updated.</li> </ul> <p><b>Iltal Dispensary</b></p> <ul style="list-style-type: none"> <li>- Use of old registers</li> <li>- Villages of beneficiaries not documented</li> <li>- Both caregiver and child documented in the registers</li> <li>- No follow up of clients, no discharges</li> <li>- No SFP/OTP commodities</li> </ul> <p><b>Merueshi Dispensary</b></p> <ul style="list-style-type: none"> <li>- Bin cards filled from April 2023</li> <li>- Defaulters not discharged</li> <li>- Admission criteria only based on MUAC</li> <li>- Number of days in the programme not noted</li> </ul> <p><b>Kimana H/C</b></p> <ul style="list-style-type: none"> <li>- Exit dates missing</li> <li>- Use of both MUAC and WHZ as admission criteria</li> <li>- No discharge measurements for OTP cured patient</li> <li>- Wrong discharge criteria</li> <li>- Wrong admission criteria</li> <li>- Defaulters discharged as cured</li> </ul> <p><b>Langata Enkima Dispensary</b></p> <ul style="list-style-type: none"> <li>- Wrong discharge criteria</li> <li>- Length of stay not documented</li> <li>- No record for 2022</li> </ul> <p><b>Illasit Dispensary</b></p> <ul style="list-style-type: none"> <li>- Admission only based on MUAC</li> <li>- Wrong discharge criteria</li> <li>- Defaulters not discharged</li> <li>- High default rate</li> </ul> <p><b>Olgumi Dispensary</b></p> <ul style="list-style-type: none"> <li>- Admissions since April 2023 only</li> <li>- Only one village documented</li> <li>- Wrong admission and discharge criteria</li> <li>- No follow up of clients</li> <li>- Theft of commodities</li> <li>- Bin cards unavailable</li> </ul> <p><b>Kisharu Dispensary</b></p> <ul style="list-style-type: none"> <li>- Use of one register for both OTP and SFP</li> <li>- No weighing scale hence only using MUAC</li> <li>- Defaulters not discharged</li> </ul> <p><b>Njukini Dispensary</b></p> <ul style="list-style-type: none"> <li>- Wrong admission and discharge criteria</li> <li>- Bin cards not updated</li> </ul>	<ul style="list-style-type: none"> <li>- Wrong admission criteria e.g. (MUAC of &lt;13.0cm)</li> <li>- Missing discharge measurements and exit outcomes</li> <li>- Some clients are missing some anthropometric measurements on follow up visits</li> <li>- Two admission criteria used (z-score and MUAC)</li> <li>- Some clients cure immediately on admission</li> <li>- Early discharge in OTP (MUAC of 10.7cm transferred to SFP)</li> <li>- Incomplete documentation</li> <li>- Registers do not communicate with reports</li> </ul> <p><b>Oltiasika dispensary</b></p> <ul style="list-style-type: none"> <li>- Exit outcome is not indicated both OTP and SFP</li> <li>- Wrong admission criteria</li> <li>- Discharge measurements not indicated</li> <li>- RUSF documentation started 31st October 2022, RUTF 23rd September and CSB 26th September 2022</li> <li>- Incomplete data (MOH 704)</li> </ul> <p><b>Olorika Dispensary</b></p> <ul style="list-style-type: none"> <li>- No use of codes</li> <li>- Client who didn't miss three visits but indicated as defaulter</li> <li>- Use of two admission criteria</li> <li>- Bin cards are not well updated</li> <li>- No muac, weight and z-score in most clients</li> <li>- Reported data but not in the register (CHANNIS)</li> </ul> <p><b>Isinet health center</b></p> <ul style="list-style-type: none"> <li>- Defaulted at the first week and discharged as cured</li> <li>- Alos is not indicated</li> <li>- No non-respondence</li> <li>- Wrong admission criteria</li> </ul> <p><b>Murtot health center</b></p> <ul style="list-style-type: none"> <li>- No data from dec 2021- August 2022</li> <li>- From November 2022 - Feb 2023</li> <li>- No use of codes</li> <li>- Wrong admission criteria used - a client with MUAC of 12.3 admitted in OTP</li> <li>- Premature discharge (clients are discharged on their first follow up as cured)</li> <li>- High number of defaulters due to long distance</li> <li>- Incomplete documentation</li> <li>- No discharge measurements and some clients are missing follow up measurements</li> <li>- Using of two admission criteria</li> <li>- Some clients' admission dates not indicated</li> </ul> <p><b>Loitoktok Sub-County hospital</b></p> <ul style="list-style-type: none"> <li>- Rising of two Admissions criteria</li> <li>- Early discharge (OTP MUAC of exactly 11.5cm)</li> <li>- No referral mechanism</li> <li>- Amoxicillin and ACT is not administered in STP.</li> <li>- Discharge of impatient clients with z-csore of &lt;-4</li> <li>- April 2023 - Incomplete data</li> <li>- June death/underlying condition</li> </ul> <p><b>KIKELELWA DISPENSARY</b></p> <ul style="list-style-type: none"> <li>- Organize registers</li> <li>- Used of two admission criteria</li> <li>- No use of codes</li> <li>- High number of defaulters</li> </ul>
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- Defaulters not discharged
- Premature discharge of cured patients
- Oloirien Dispensary**
- Defaulters not discharged
- Wrong discharge and cured criteria
- Non respondents discharged as cured
- OLMERRUI DISPENSARY**
- OTP registers starts in March 2023
- No patients from SFP from August 2022 to April 2023
- SFP starts in October 2023
- Not indicated discharge dates and length of stays
- March 2023-1 RIP due to hydrocephalus
- NOTE: They don't have MOH 734,
- ENGIGIRGIR DISPENSARY**
- No data from August 2022 to December
- Registers not well captured & Anthropometric measurements
- Exit outcomes for OTP not indicated, length of stays, exit outcomes
- 100% defaulter rates due to loss of follow-ups
- Poor documentation
- Poor handling of Nutrition programs
- NOTE: not indicated, while criteria's not in the books
- Don't have bincards for OTP yet they report on MOH734
- OLPOLASAT DISPENSARY**
- Poor documentations of exits
- Wrong criteria of Admissions and discharges.
- OLTURUTO DISPENSARY**
- No admissions from august 2023-June 2023
- Long periods of long stays
- KITENGELA MEDICAL SERVICES.**
- Poor indication of exit outcomes
- Not indicating defaulters, cured at end of discharge
- Two types of admission criteria
- ILKULENYETI DISPENSARY**
- Poor indications of MUAC
- High numbers of defaulters - due to the long distance
- Two types of admission criteria
- Wrong WHZ Measurements
- ISINYA H/C**
- Poor documentations and criteria for some patients
- Too many long stays
- Some without the exit outcomes and length of stays
- Criteria indicated as two instead of one
- ERETETI DISPENSARY**
- Documentation of type of admissions are two
- Lengths of stays not indicated and exit outcomes
- 1 RIP due to other medical condition early February 2023.
- OLOIBOR AJIJK**
- Well documentation, less patients
- Admission criteria has two
- OSARAI DISPENSARY**
- Well documentation but poor admission criteria's in MUAC
- Exit outcomes and length of stays not indicated

- Wrong admission criteria
- NKAMA DISPENSERY**
- Bin cards not updated
- Poor documentation of registers
- High numbers of defaulters
- No use of codes
- Clients are admitted but no follow ups
- Discharge measurements
- IMPIRON DISPENSARY**
- Register well completed
- Close working relationship with CHVs
- No defaulters
- Use of codes in the registers
- Registers tallying with Reports
- Bin cards not well updated
- NAMELoK HEALTH Center**
- No use of codes
- Reports in the registers not tally with end month reports
- High number of defaulters
- No follow up
- Clients discharge in the second visit
- Wrong admission criteria
- Amboseli Dispensary**
- Wrong admission criteria
- No exit measurements
- No use of codes
- Clients discharge at follow up one
- Use of only one admission criteria (MUAC)
- Register reports not tallying with end month reports
- No follow up
- Olchorro dispensary**
- Wrong admission criteria
- Use of one criterion for admission (MUAC)
- No discharge measurements
- Poor documentation (no use of codes)
- Some clients discharge in second visit
- High number of defaulters
- Enkongu Narok Dispensary**
- Reports tallying with registers
- No exit criteria
- Use of only one admission criteria (MUAC)
- No use of codes
- Clients overstaying in the program after cured.
- Lemongo dispensary**
- No defaulters
- Wrong admission criteria
- Missing data
- No discharge measurements
- Discharge of clients as cured with MUAC <12cm
- No active case finding (screening of all U5 not done)
- No cu linked to facility
- FR ADRIANO**
- High numbers of defaulters
- Registers not well documented
- Poor admission and discharge criteria's
- Long stays



<p><b>KILOH DISPENSARY</b></p> <ul style="list-style-type: none"> <li>- Wrong criteria admission and mau</li> <li>- Discharge criteria not indicated plus exit outcomes</li> </ul> <p><b>KIMA DISPENSARY</b></p> <ul style="list-style-type: none"> <li>- Poor documentations</li> <li>- Poor admission and discharge criteria</li> <li>- Exit outcomes and length of stay not indicated</li> </ul> <p><b>MASIMBA H/C</b></p> <ul style="list-style-type: none"> <li>- Discharge criteria not indicated</li> <li>- Long length stays</li> <li>- Check on admission criteria</li> </ul>	<ul style="list-style-type: none"> <li>- No exit outcomes</li> </ul> <p><b>LEMPEI DISPENSARY</b></p> <ul style="list-style-type: none"> <li>- Well documentation</li> <li>- Two admission criteria</li> <li>- No exit outcomes</li> </ul> <p><b>SAMULI DISPENSARY</b></p> <ul style="list-style-type: none"> <li>- NO OTP clients</li> <li>- Less defaulter</li> <li>- No discharges yet</li> <li>- Well documentation</li> </ul>
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### Return distance to the IMAM Service Delivery Point (SDP)

Distance to the IMAM sites remains a challenge for caregivers in Kajiado County, with the rural sites being the most affected. Average distance remains 7.2km in Central, 11km in East and 4.4km in Kajiado North.

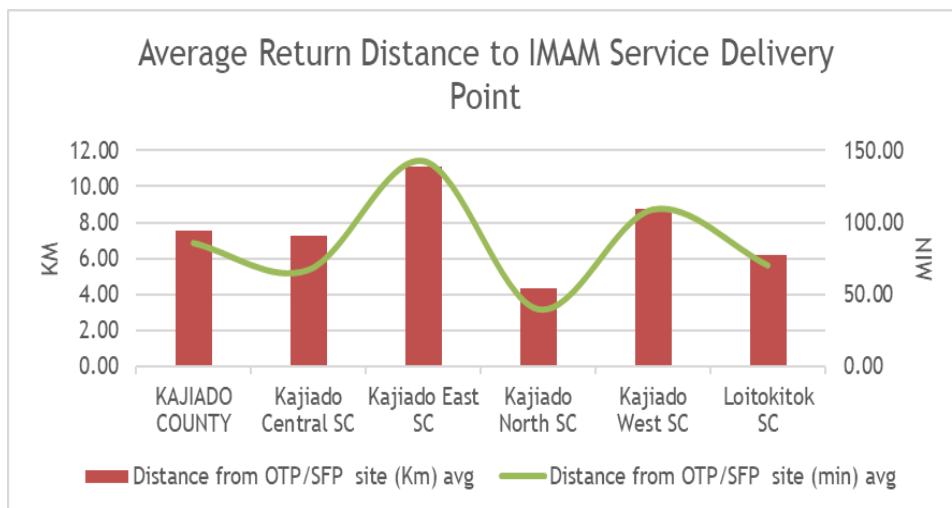


Figure 8: Average Return Distance to IMAM Service Delivery Point

## In-Patient Program

### In-Patient Admissions

Kajiado County has fifteen sites for management of SAM with complications. Most of the in-patient cases are direct admissions into program. Few cases referred from OTP indicating that no deterioration in the program. Stabilization Centers reporting referral from OTP are *Magadi*, *Namanga* and *Loitokitok*. More In-patient admissions observed in Kajiado County Referral Hospital.

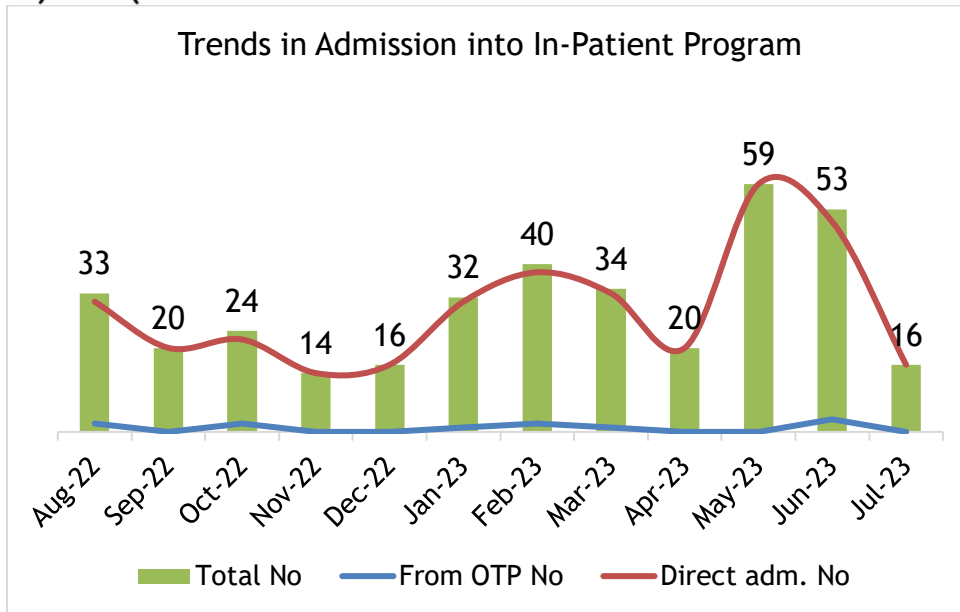


Figure 9: Trends in In-patient Admissions

### In-Patient Exit Outcome

Most of the in-patient cases in Kajiado County are being discharged to OTP. Most of the defaulters refused treatment because caregivers had left other children at home with no adequate care or the family was migrating. In-patient defaulting was common among the nomadic pastoralists. The reported deaths were attributed to late treatment seeking when the condition is already critical.

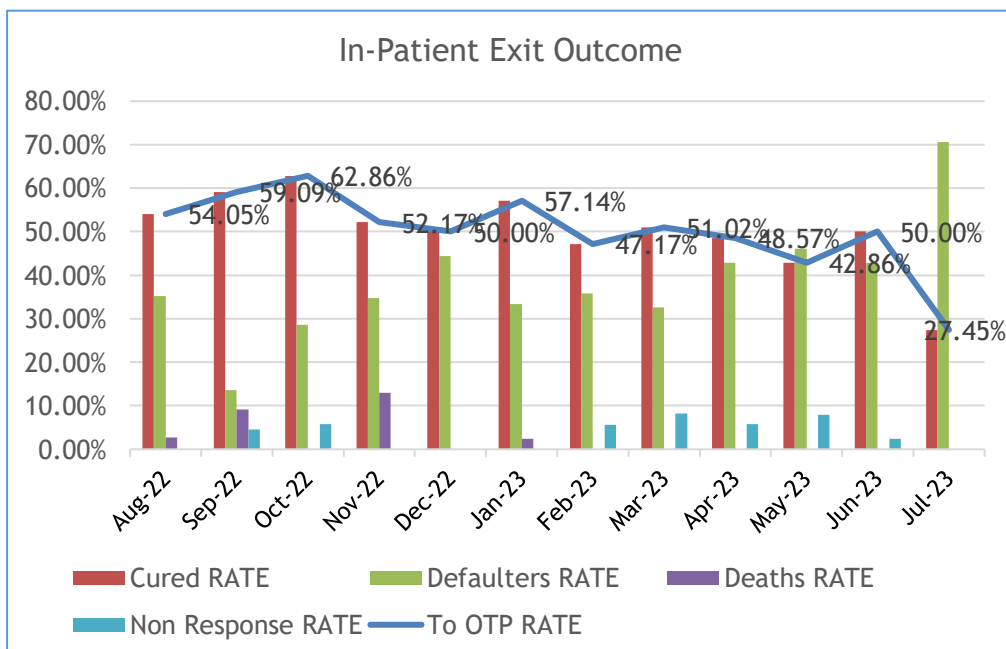


Figure 10: Trends in In-patient program exit outcomes

### Length of Stay in In-patient program

The average LoS in the in-patient program before discharge to OTP and cured is 8 days with Median Values at 42.5 and 41.5 respectively.

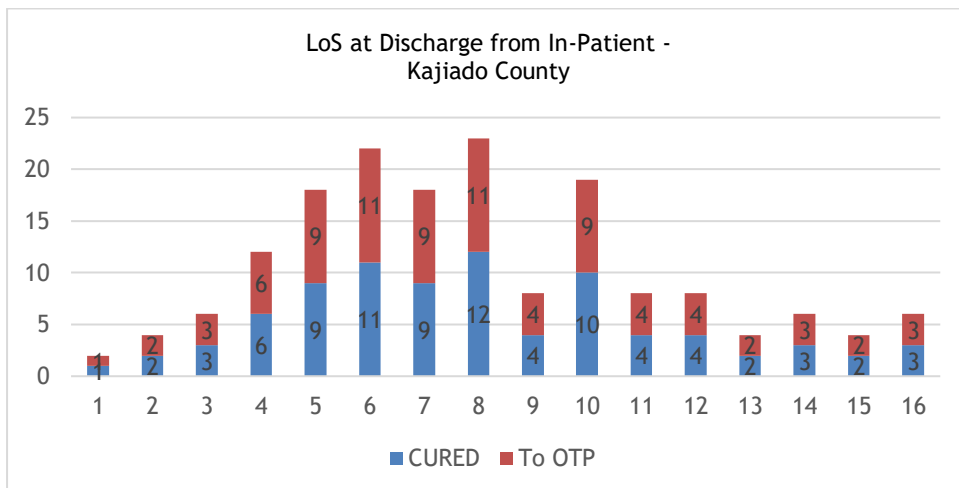


Figure 11: LoS in In-patient program before discharge cured and refer to OTP

## OUTPATIENT THERAPEUTIC PROGRAM (OTP)

### Referral Mode

Referrals into OTP majorly done by Health care workers when children come for Out-patient department services. Some more cases of self-referral observed in the sub counties, attributed to pockets of CUs implementing the Family MUAC approach. Kajiado County utilizes all the three admission criteria into IMAM program as outlined in the IMAM guideline for Kenya. The predominant admission criteria into OTP in the county is WHZ score (over 80% of the total admissions assessed).

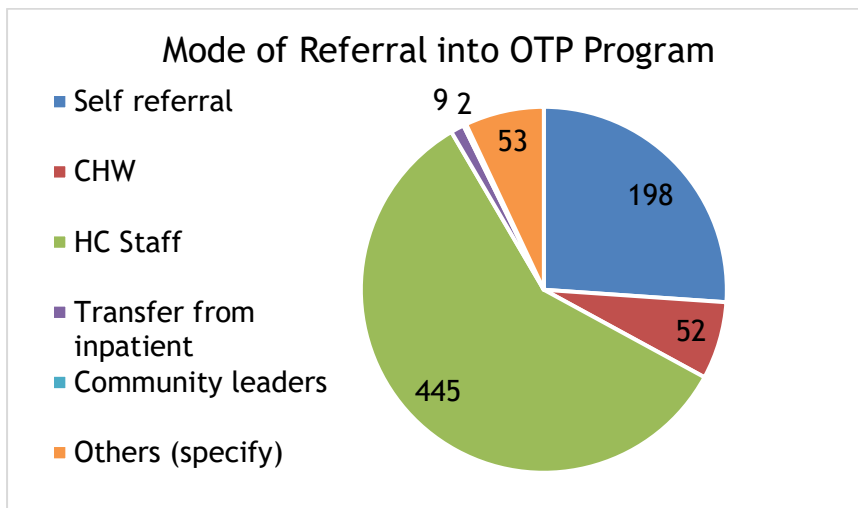


Figure 12: Referral Mode into OTP Program

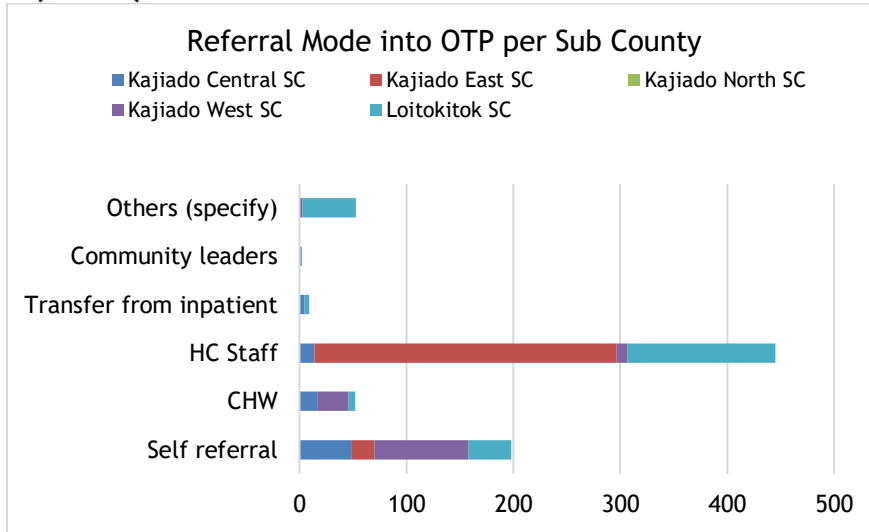
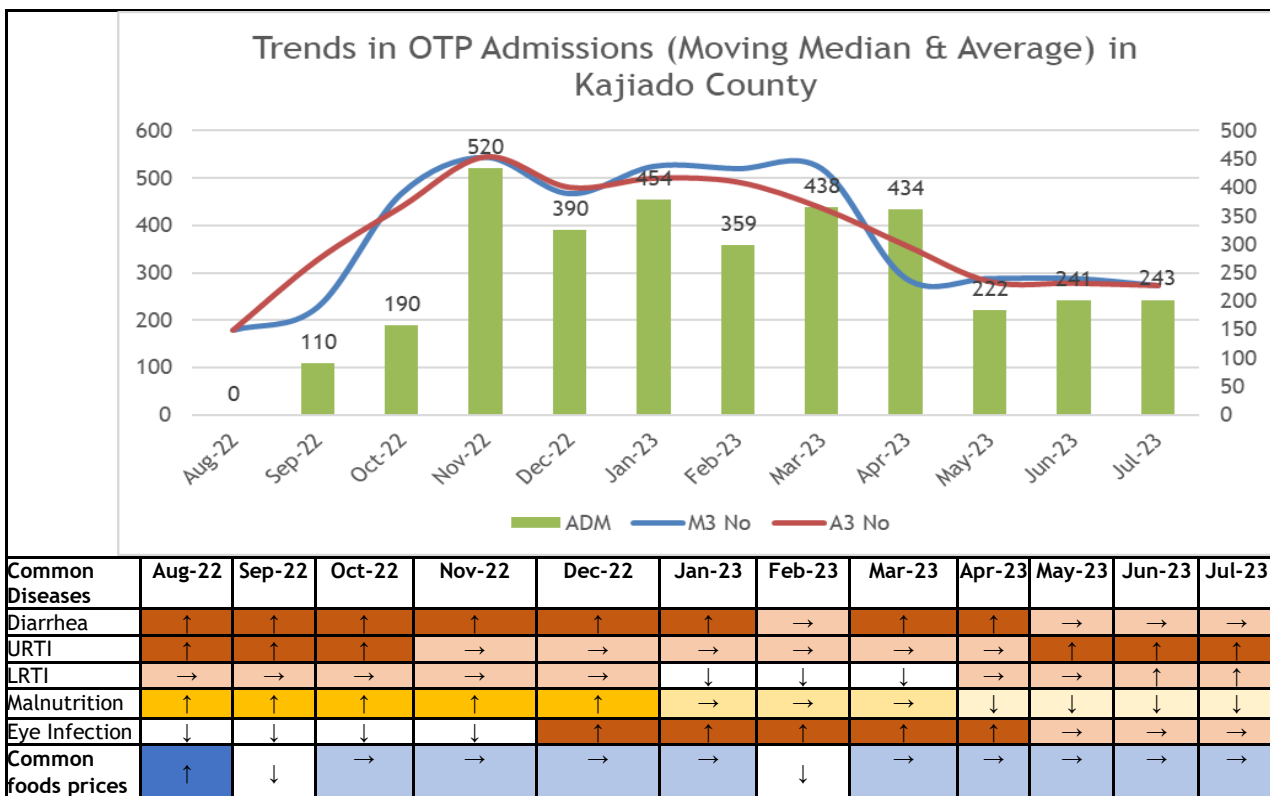


Figure 13: Referral Mode into OTP Program per Sub County

## OTP Admissions

### Trends in OTP Admissions

Generally, new cases were observed to increase in 2022 compared to the previous years, attributed to the prolonged drought season, with a downward case being in May, June and July 2023. During the analysis period (May 2022 to April 2023), increasing admissions over time were observed, on the increasing trend from September 2022 to April 2023. This was majorly attributed to heightened case finding through mass screening, family MUAC and outreach activities, which are part of the scaled-up drought response activities.







Planting & weeding	↓	↓	↑	↑	↑	↓	↓	↓	↑	↑	↓	↓
Harvesting	↑	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓
In-Migration	↓	↑	↑	↓	↓	↓	↑	↑	↑	↑	↑	↑
Out-Migration	↑	↑	↑	↑	→	→	→	→	→	→	→	↓
Drought / famine	↑	↑	↑	↑	→	→	↑	↑	↓	↓	↓	↓

Figure 14: Moving Median & Average for OTP Admission Trends in Kajiado County

### Admissions against Under-five population in Kajiado

This was assessed for all the admission criteria to estimate the proportion of total admission among all the under-five populations. Kajiado West had more OTP admissions (22.5%) than the rest of the Sub counties. The analysis also looked at admission per health facility in each sub county.

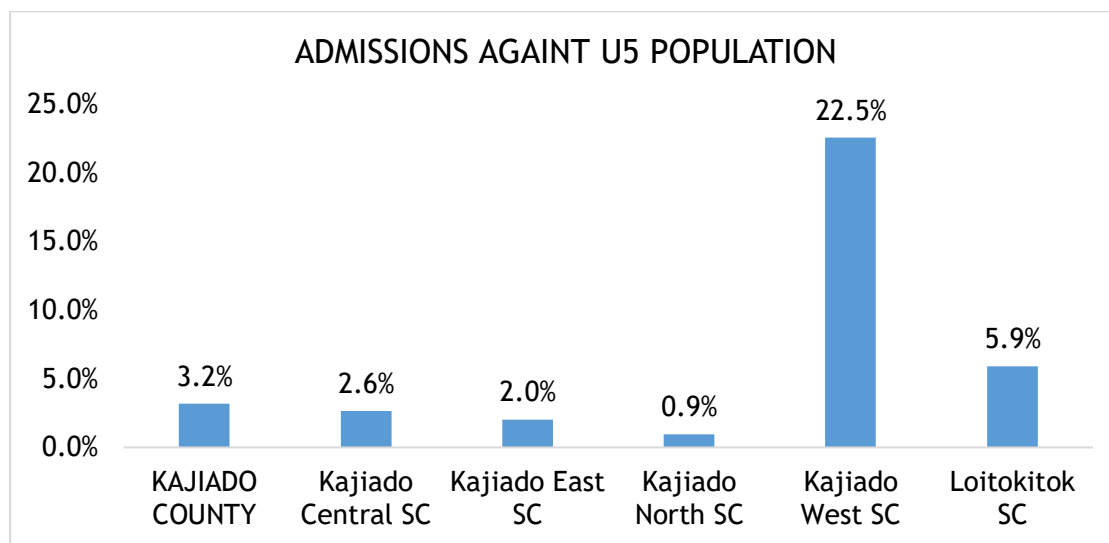


Figure 15: Proportion of children admitted into OTP out of the U5 population per Sub County

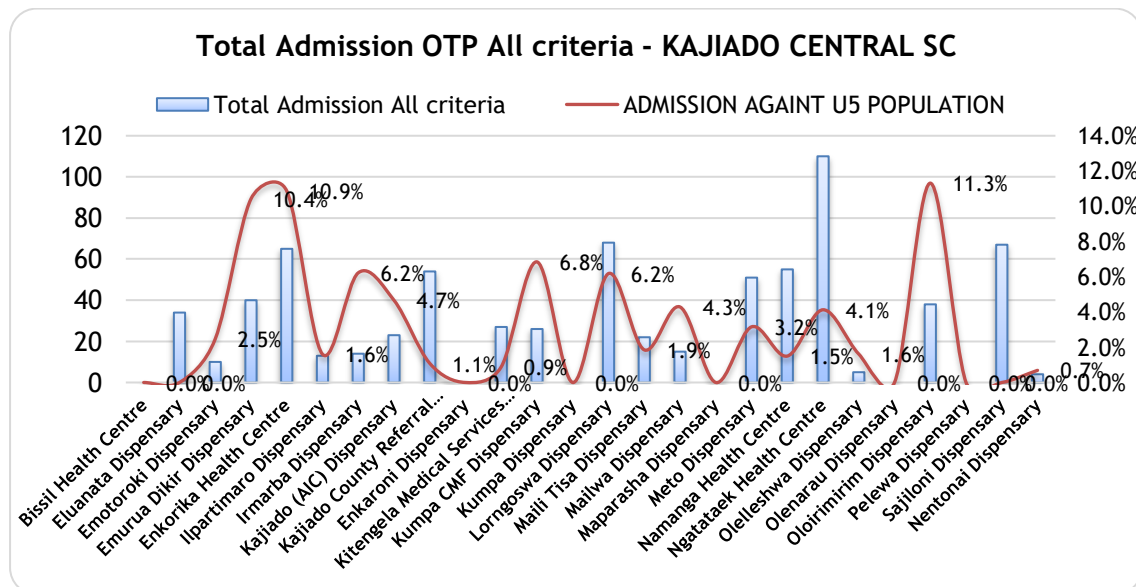


Figure 16: Proportion of children admitted into OTP out of the U5 population per H/Facility in Central

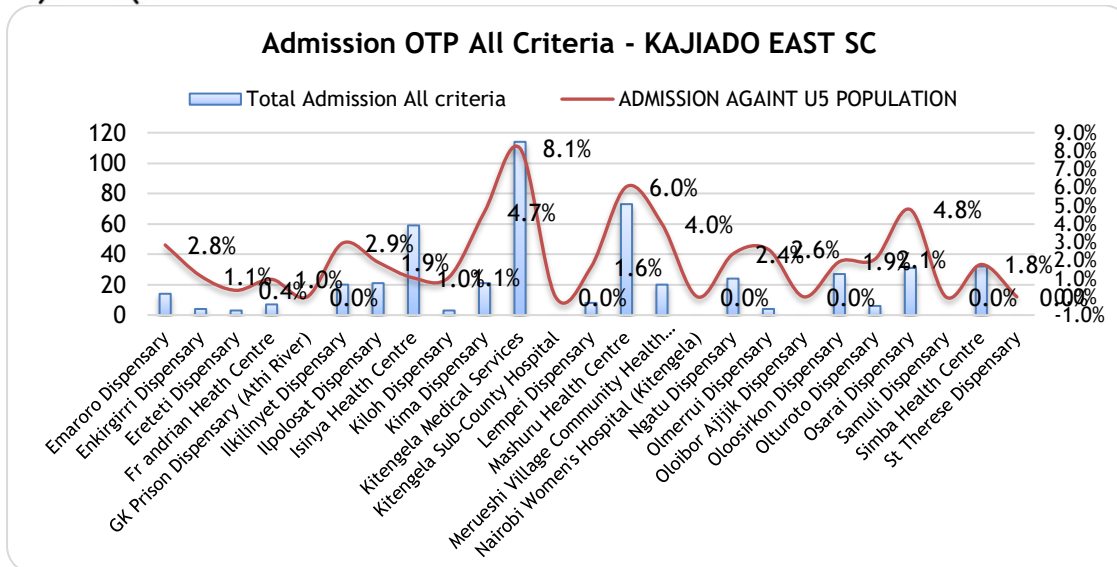


Figure 17: Proportion of children admitted into OTP out of the U5 population per H/Facility in East

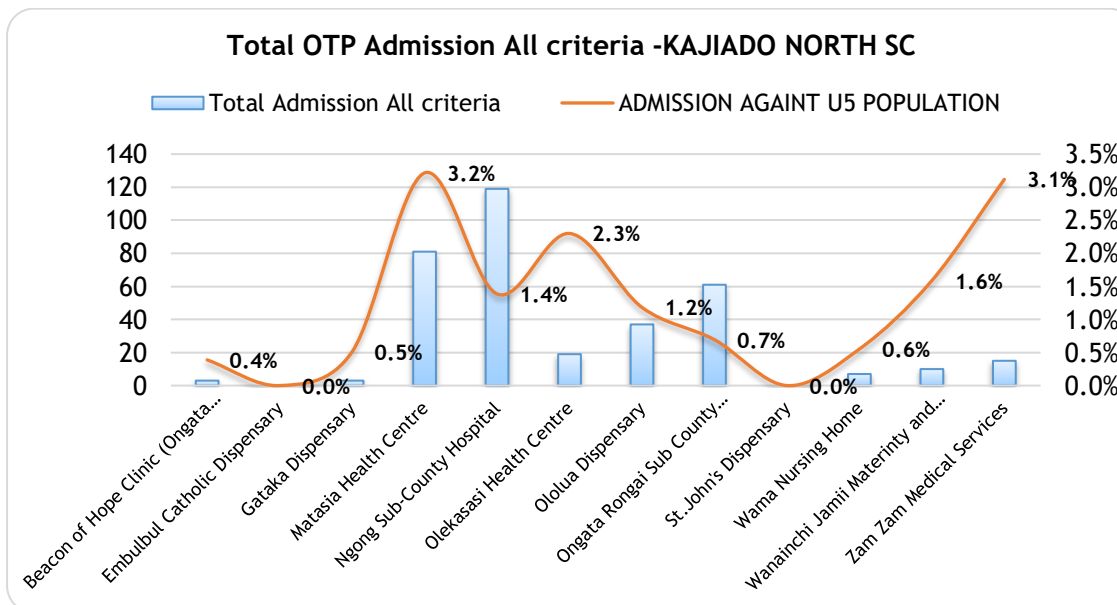


Figure 18: Proportion of children admitted into OTP out of the U5 population per H/Facility in North

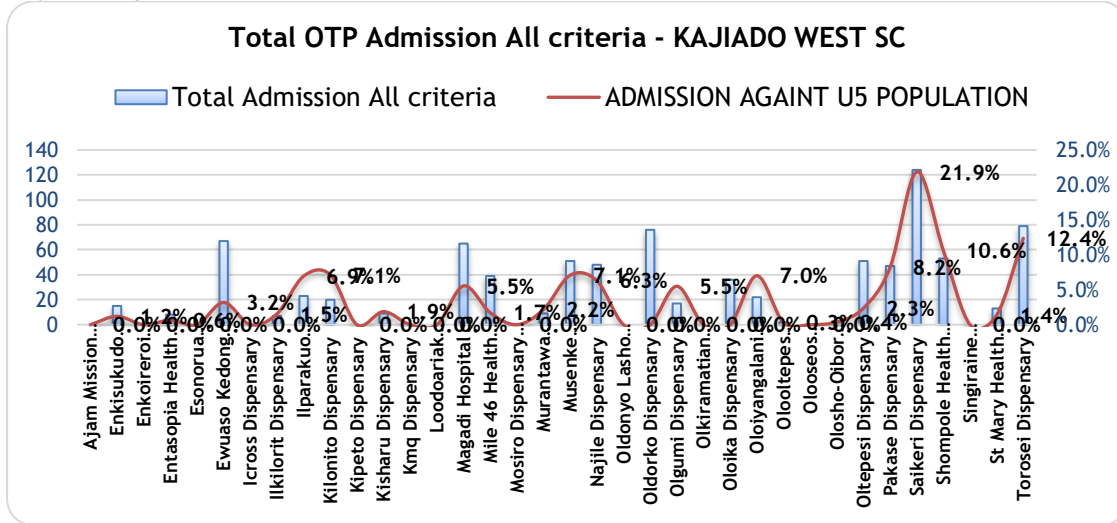


Figure 19: Proportion of children admitted into OTP out of the U5 population per H/Facility in West

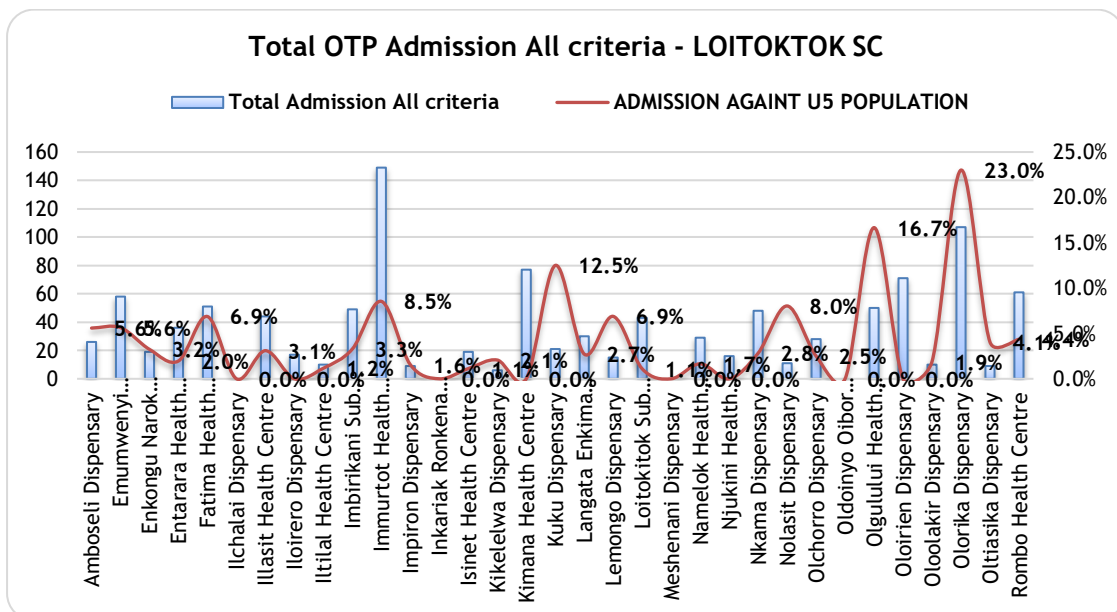


Figure 20: Proportion of children admitted into OTP out of the U5 population per H/Facility in Loitokitok

### Admissions by WHZ score

The median WHZ score at Admission is  $< -3$  SD to  $= -3$  SD with the median value being 1043.5. Late admissions into OTP program were observed majorly in Kajiado Central, West, and Loitokitok.

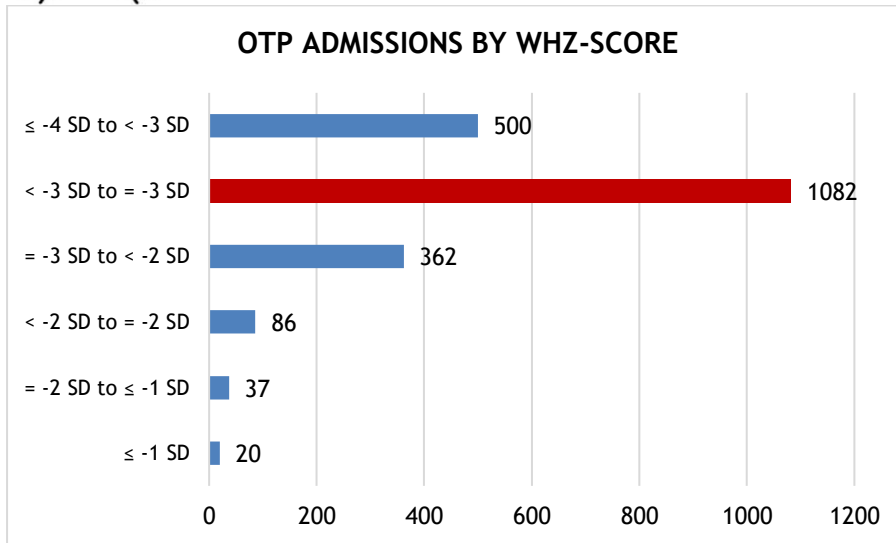


Figure 21: Median Z score at Admission into OTP

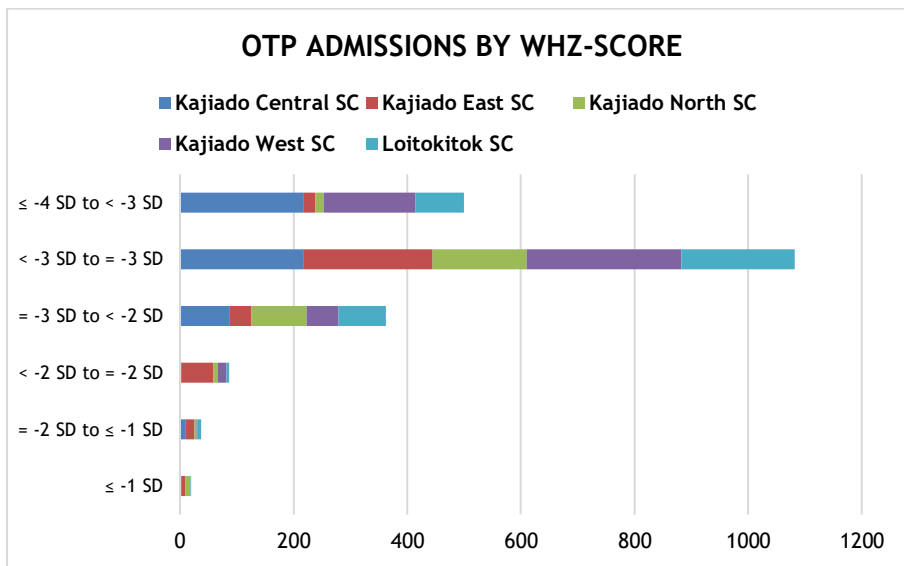


Figure 22: WHZ score at Admission per Sub County in Kajiado County

### MUAC at Admission into OTP

The MUAC at Admission into OTP in Kajiado County is 11.2cm (median value being 742.5) indicating early admission. Some very late admission cases (<10.0cm) were observed majorly in Loitokitok, Kajiado North and Kajiado West.

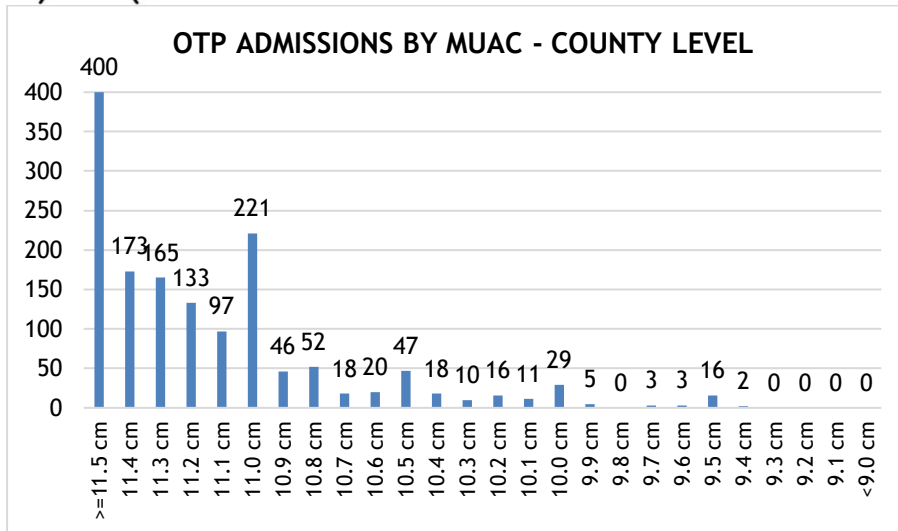


Figure 23: Median MUAC at Admission into OTP

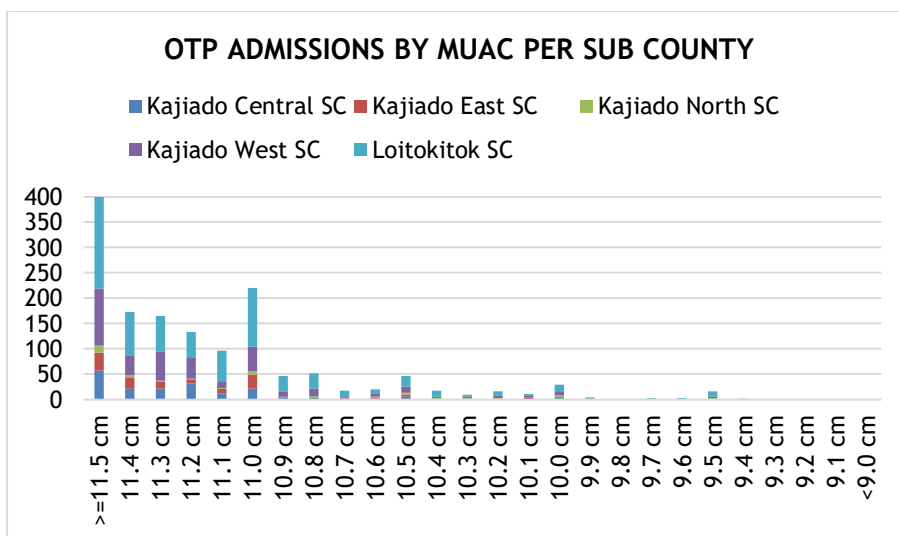


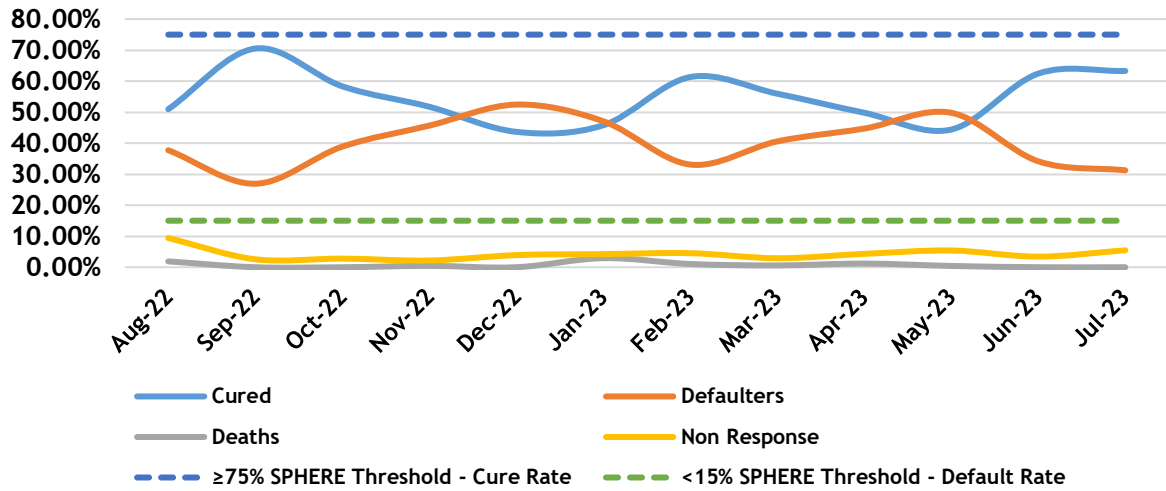
Figure 24: MUAC at Admission into OTP per Sub County

## OTP performance Indicators

Overly, Kajiado County has poor exit outcomes throughout the assessment period with cured rates of <75% and defaulter rates of >15% SPHERE thresholds. All the sub counties affected by the high defaulter rates. High default rates were attributed to migration and maternal workload, with little follow up of health services by caregivers and inadequate case finding by CHVs.



### Trends in OTP Exit Outcomes in Kajiado County



Common Diseases	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Diarrhea	↑	↑	↑	↑	↑	↑	→	↑	↑	→	→	→
URTI	↑	↑	↑	→	→	→	→	→	→	↑	↑	↑
LRTI	→	→	→	→	→	↓	↓	↓	→	→	↑	↑
Malnutrition	↑	↑	↑	↑	↑	→	→	→	↓	↓	↓	↓
Eye Infection	↓	↓	↓	↓	↑	↑	↑	↑	↑	→	→	→
Common foods prices	↑	↓	→	→	→	→	↓	→	→	→	→	→
Planting & weeding	↓	↓	↑	↑	↑	↓	↓	↓	↑	↑	↓	↓
Harvesting	↑	↓	→	→	→	→	↓	→	→	→	→	→
In-Migration	↓	↑	↑	↓	↓	↓	↑	↑	↑	↑	↑	↑
Out-Migration	↑	↑	↑	↑	→	→	→	→	→	→	→	↓
Drought / famine	↑	↑	↑	↑	→	→	↑	↑	↓	↓	↓	↓

Figure 25: Trends in OTP Outcomes in Kajiado County

### Exit Outcomes per Sub County and Health facilities

From the analysis of the source documents, poor exit outcomes across the sub counties characterized by very low cure rates (<75%) and high defaulter rates (>15%), indicating poor OTP coverage.

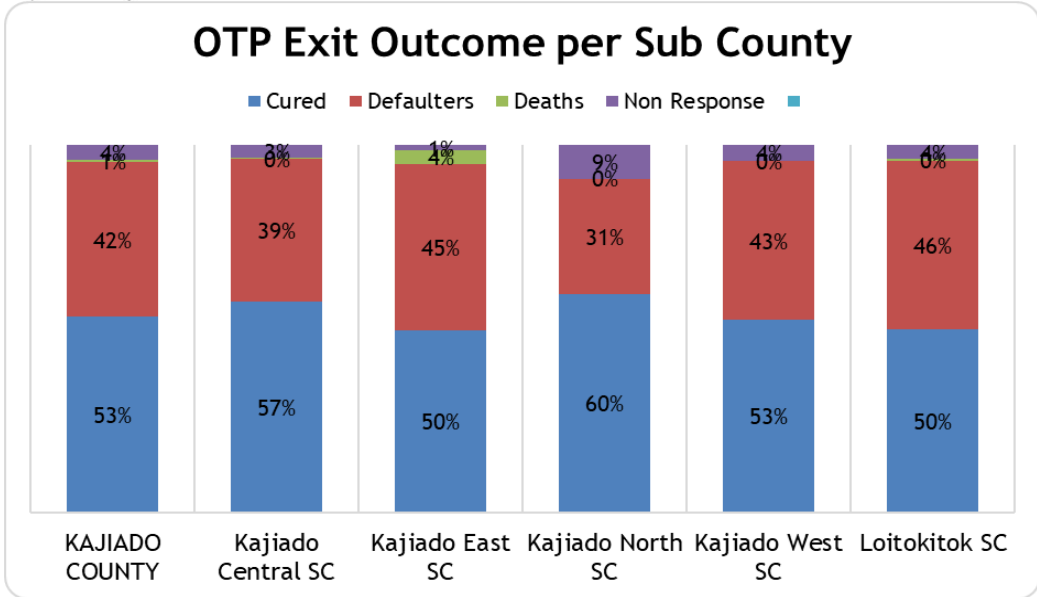


Figure 26: OTP Exit Outcomes per Sub County in Kajiado County

In Kajiado Central, poor exit outcomes were observed across the H/Facilities. Most affected H/Fs are Emurua Dikir, Kajiado CRH, KMS (Kajiado), Kumpa CMF, Mailwa, Ngatataek, Oleleshwa, Nentonai.

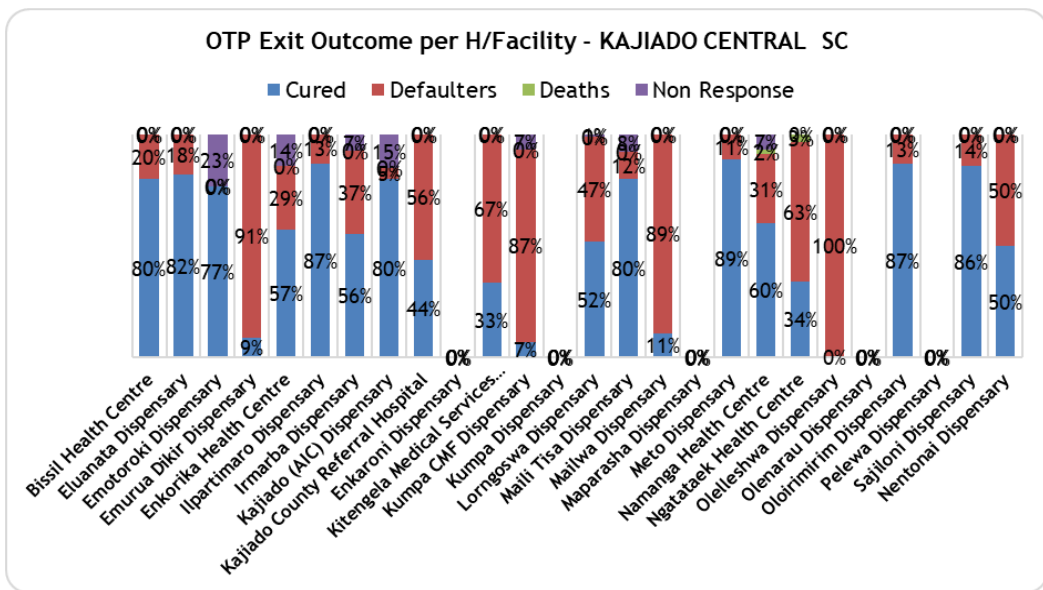


Figure 27: OTP EXIT Outcome per Health Facility - KAJIADO CENTRAL SC

In Kajiado East, poor exit outcomes were observed across the health facilities. Most affected health facilities are Emaroro, Enkingirri, Ilkilinyet, Isinya, Kiloh, Kima, Lempei, Merueshi Village CHC, Olturoto, Osarai and Simba.

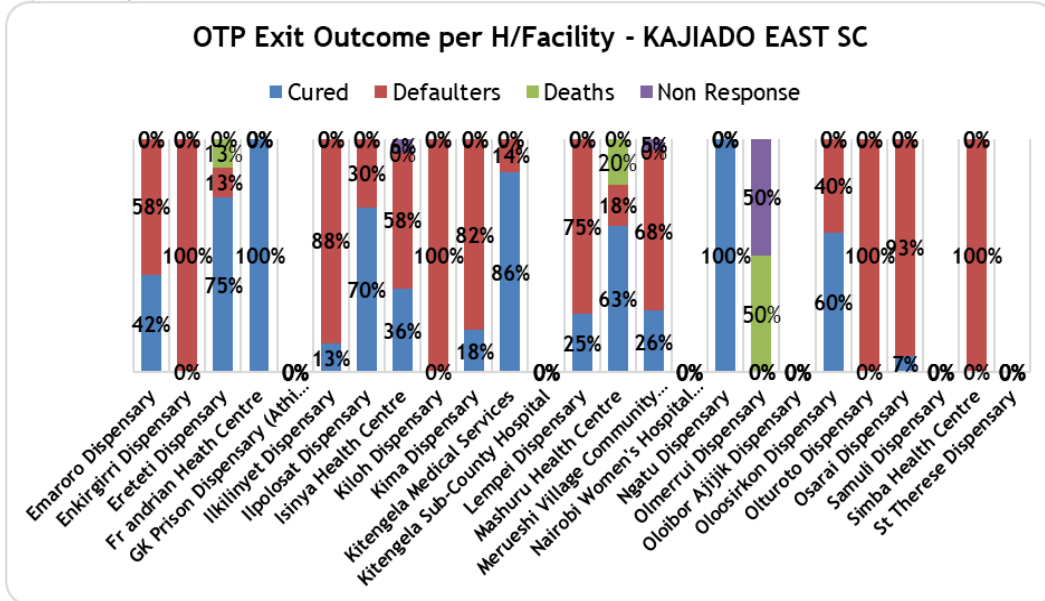


Figure 28: OTP Exit Outcome per H/Facility - KAJIADO EAST SC

In Kajiado North, poor exit outcomes were observed across the H/Facilities. Most affected health facilities are Matasia, Ololua, Rongai, Wama Nursing Home.

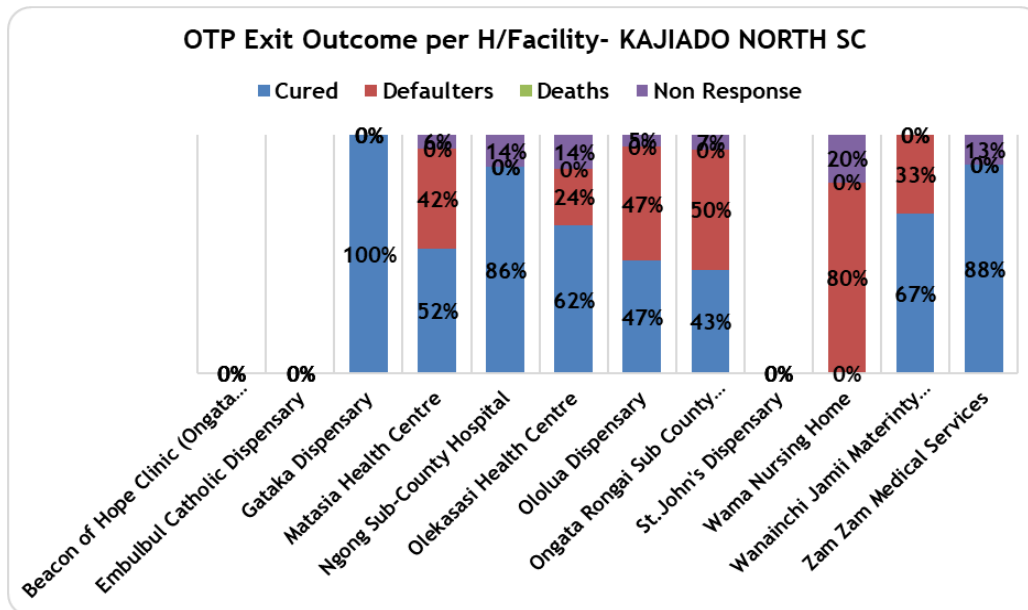


Figure 29: OTP Exit Outcome per H/Facility - KAJIADO NORTH SC

In Kajiado Wes, poor exit outcomes were also observed across the health facilities. The most affected health facilities are Esonorua, Ewaso Kedong', Magadi, Mile 46, Murantawa, Olgumi, Olkiramatian, Olosho-Oibor, Oltepesi, Saikeri, St. Marys Health Center.



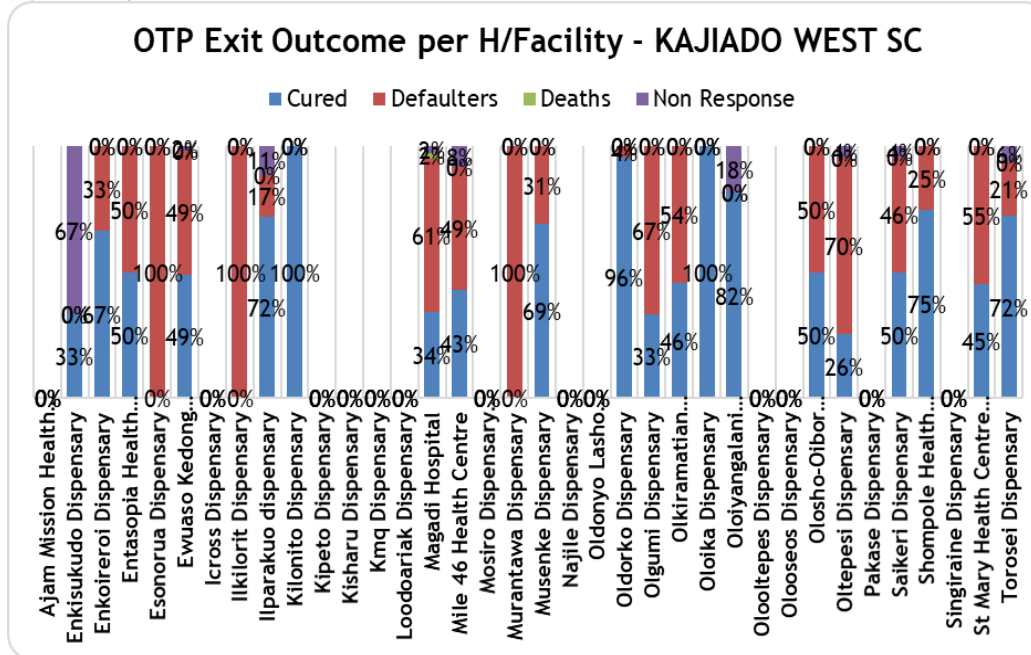


Figure 30: OTP Exit Outcome per H/Facility - KAJIADO WEST SC

In Loitokitok, poor exit outcomes were also observed across the H/Facilities with the most affected health facilities being Emumwenyi, Entarara, Illasit, Imbirikani, Immurtot, Kuku, Langa'ta Enkima, Namelok, Olchorro, Olgulului, Oloolakir, Olorika, Oltiasika and Rombo Health Center.

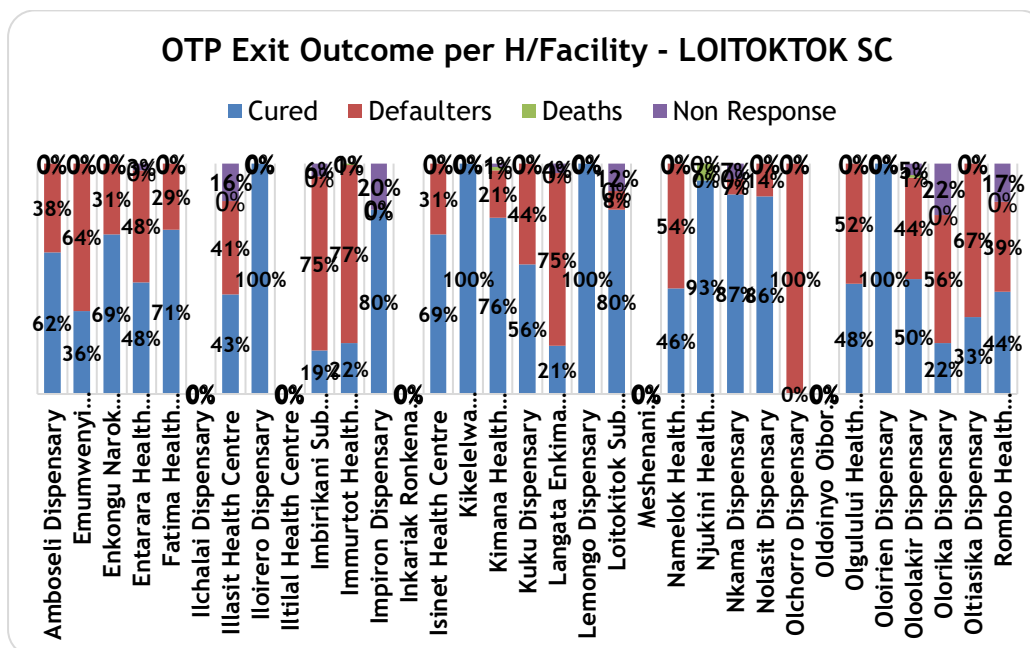


Figure 31: OTP Exit Outcome per H/Facility - KAJIADO SOUTH (LOITOKTOK) SC

### OTP Exit Outcome - Cure Rate

The proportion of cases being discharged as cured against admissions was generally low across the sub counties, with the highest being Kajiado Central. The county level proportion is 37% indicating poor outcome of OTP program in Kajiado.

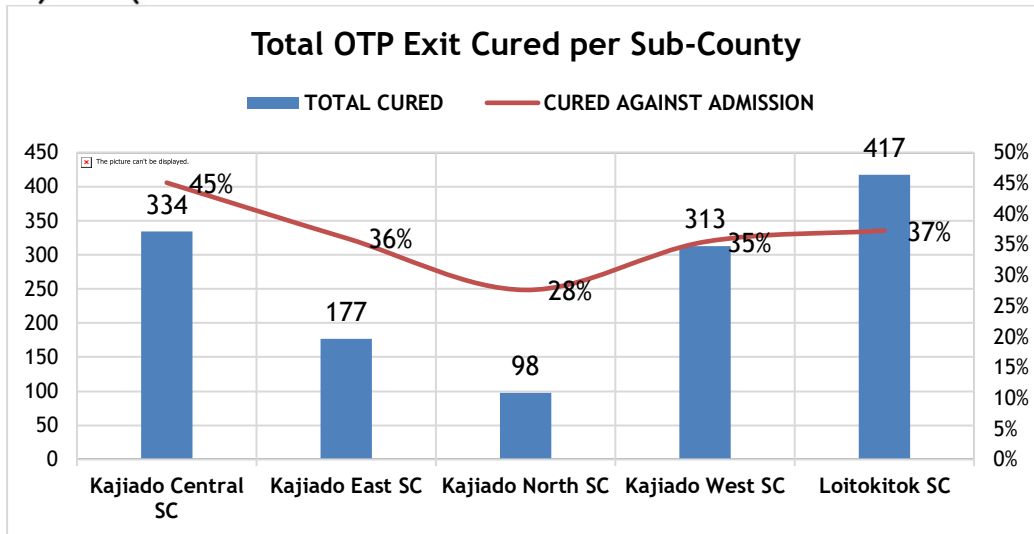


Figure 32: Proportion of OTP Exits cured against admissions per Sub County

More than half of the H/Facilities in the Sub County had a low proportion (<75%) of cases being discharged as cured against admissions. The best performing ones were Emotoroki, Irmarba, Kajiado AIC, Kajiado CRH, Lrongoswa, Meto and Nentonai

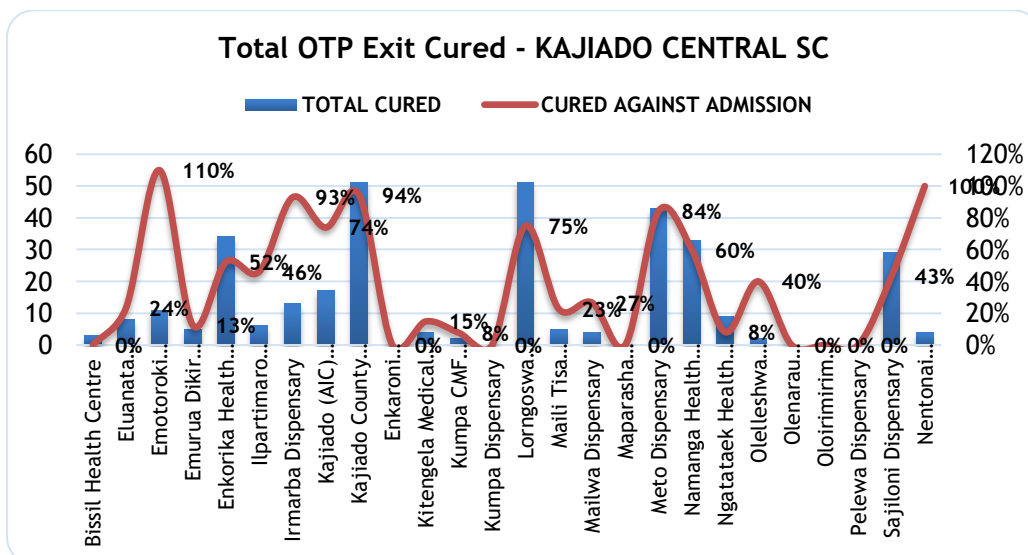


Figure 33: Proportion of OTP Exits cured against admissions in Central Sub County

Almost all the health facilities in Kajiado East Sub County had a low proportion (<75%) of cases being discharged as cured against admissions, except Isinya Health Centre.

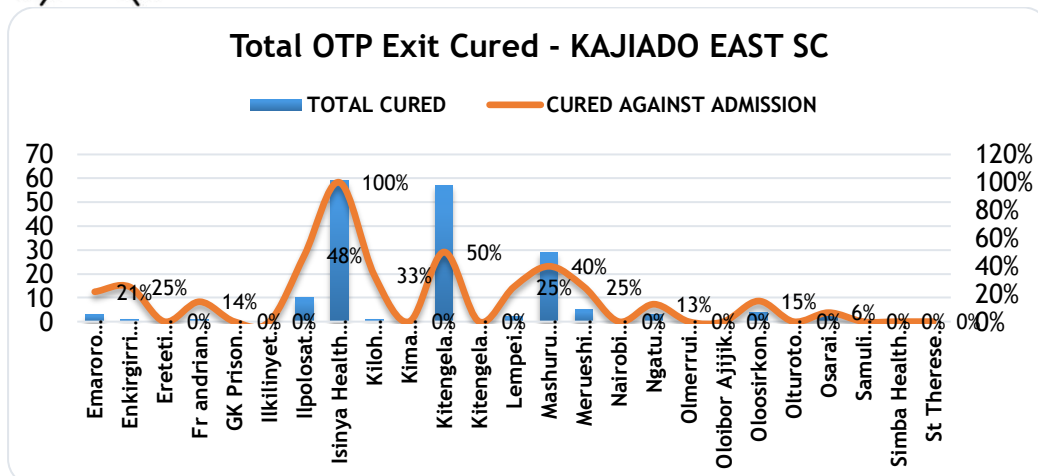


Figure 34: Proportion of OTP Exits cured against admissions in East Sub County

Almost all the health facilities in Kajiado North Sub County had a low proportion (<75%) of cases being discharged as cured against admissions, except ZamZam Medical Services.

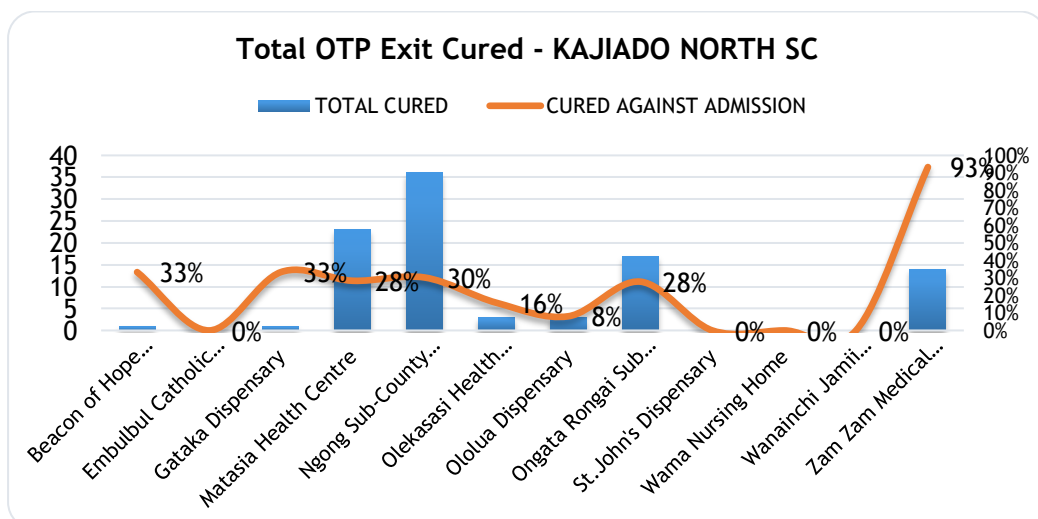


Figure 35: Proportion of OTP Exits cured against admissions in North Sub County

Almost all the health facilities in Kajiado West Sub County had a low proportion (<75%) of cases being discharged as cured against admissions, except Torosei.

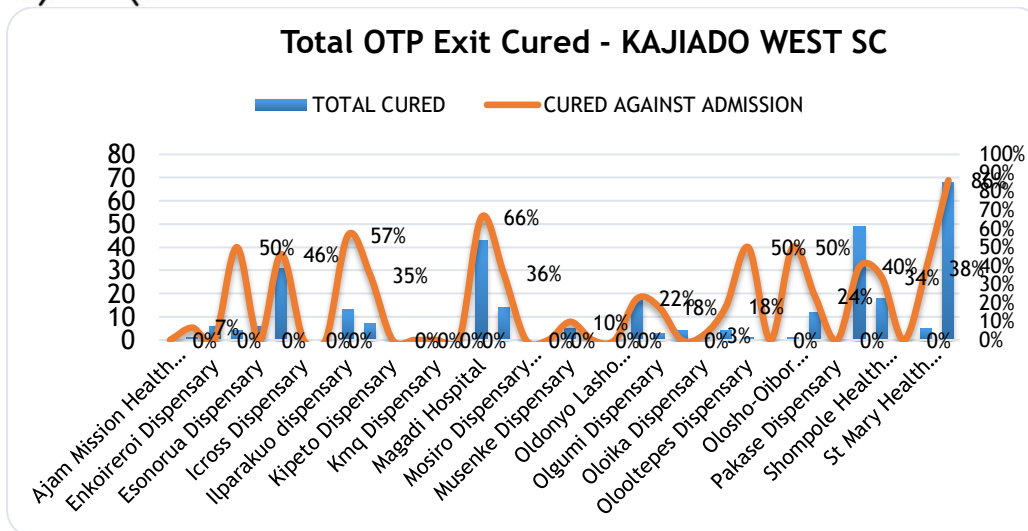


Figure 36: Proportion of OTP Exits cured against admissions in West Sub County

Almost all the H/Facilities in Loitoktok Sub County had a low proportion (<75%) of cases being discharged as cured against admissions, except Oloiren & Oololakir.

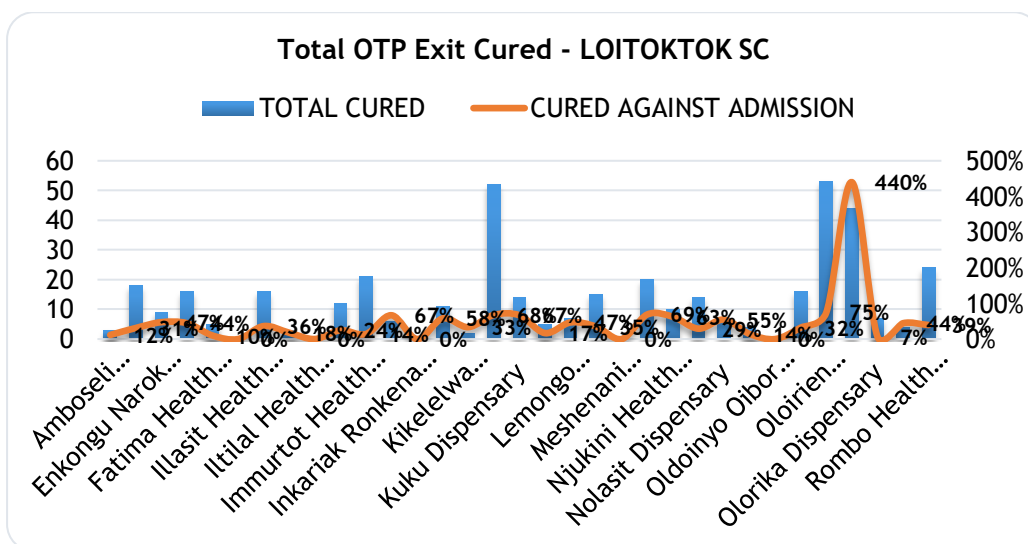


Figure 37: Proportion of OTP Exits cured against admissions in Loitoktok Sub County

#### WHZ score at Discharge Cured from OTP

The median value for exit cured from OTP for WHZ score admissions is <-2SD to = -2SD (median value being 439.5) indicating that cases were being discharged when already cured. Early discharge from program when cases are still severely malnourished attributed to a mix up of the discharge criteria and inadequate capacity on discharge criteria.

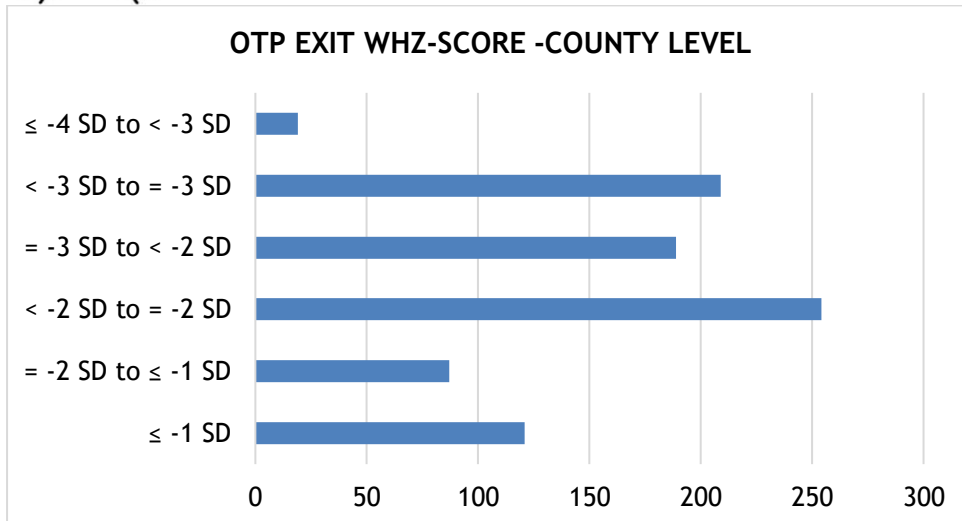


Figure 38: Median WHZ score at Discharge Cured from OTP

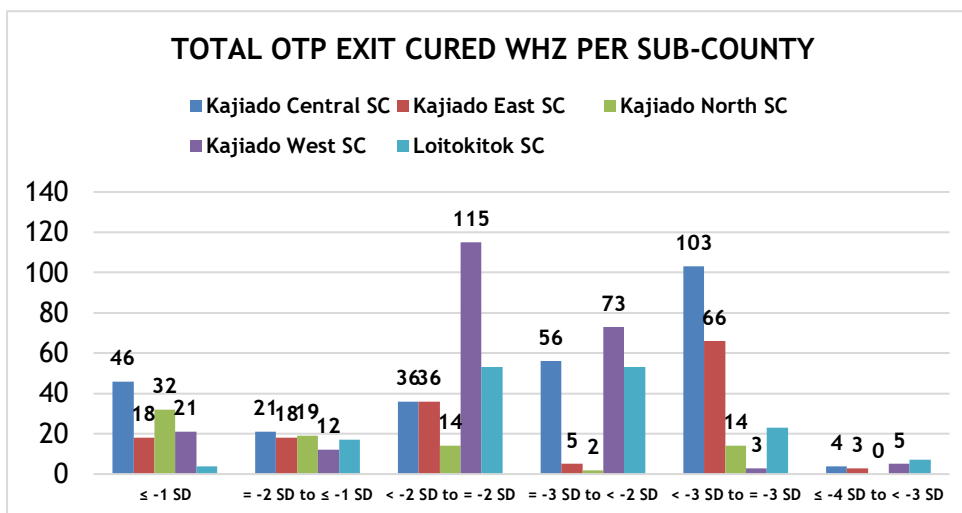


Figure 39: WHZ score at Discharge Cured from OTP per Sub County

### MUAC at discharge cured from OTP

Kajiado County observed the appropriate discharge criteria by MUAC for all the MUAC admissions, with the median value for MUAC at discharge cured from OTP being 11.7cm (median value being 686).

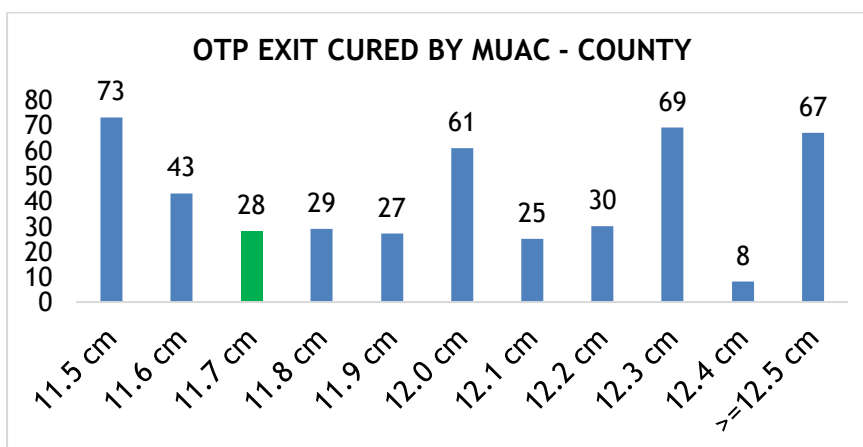


Figure 40: Median MUAC at discharge cured from OTP

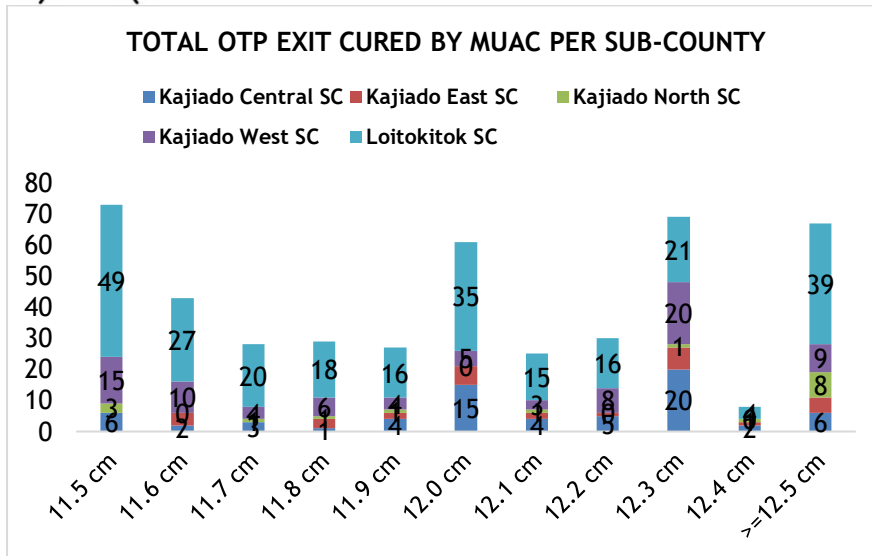


Figure 41: MUAC at discharge cured from OTP per Sub County

### Length of Stay at Discharge Cured from OTP

The median value for LoS at discharge cured from OTP is 5 weeks (median value being 634), lower than the recommended 8 weeks as per the IMAM Guideline. Very early discharges observed across the sub counties as indicated by LoS of <4 weeks, which are likely to contribute to relapses. On the other hand, very late (>10 weeks) discharge as cured was also observed, across the sub counties with some beneficiaries staying in the program as long as 15 weeks. This is a poor program performance, which can create a negative picture about, due to fatigue of the caregivers for overstaying in the program.

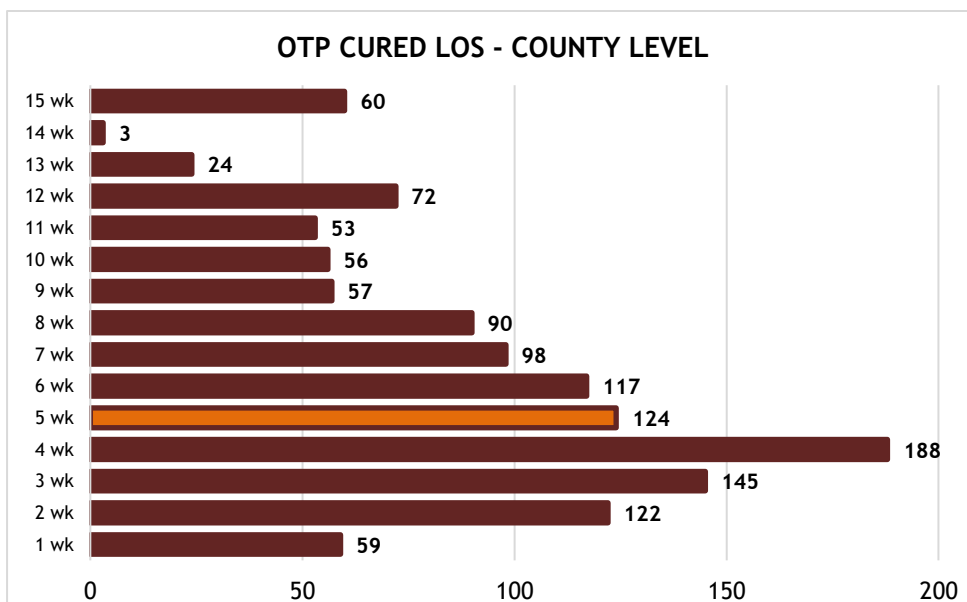


Figure 42: Median LoS at discharge Cured from OTP

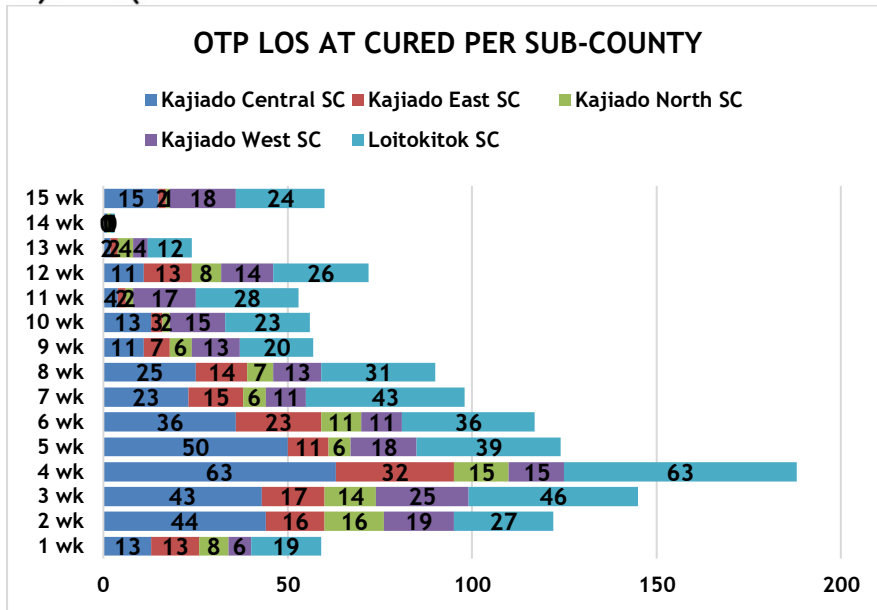


Figure 43: LoS at discharge Cured from OTP per Sub County

### OTP Exit Outcome - Defaulting

Defaulters are children who were enrolled into the programme, but have missed three consecutive visits. High defaulting rates are an indication of poor program coverage. IMAM program indicators should show a consistently low rate of defaulters. Program defaulter rates might vary over time, this might be due to deterioration in the security situation, leading to reduced access and availability of services, impacts of climatic conditions e.g., droughts, floods etc. that affect how populations can access services or patterns of labour demand. Defaulting in Kajiado County is very high affecting OTP performance negatively, with defaulter rates surpassing the SPHERE threshold of below 15%, across all the sub counties. High proportion of defaulters observed against the total admissions, affecting all the Sub Counties. The highest number of defaulters is reported in Kajiado North and Loitokitok which translates to 49% and Loitokitok 39% of the admissions, respectively.

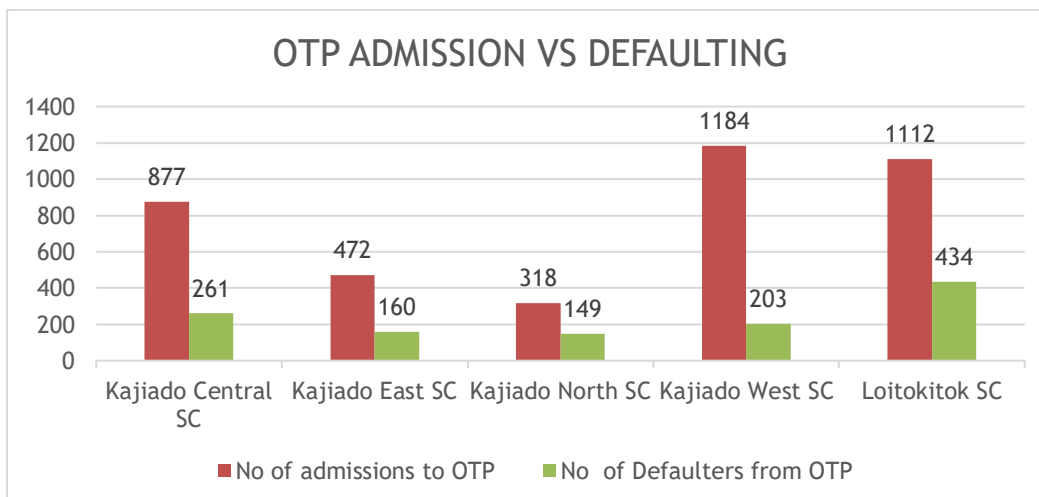


Figure 44: Number of cases admitted versus those defaulting from OTP

Table 6: Proportion Defaulting out of those admitted in OTP

Sub County	%Defaulting from OTP out of those admitted
Central	30%
East	34%



North	47%
West	17%
Loitokitok	39%

### WHZ and MUAC at Defaulting from OTP

The median value for WHZ score at the time of defaulting is  $< -3SD$  to  $= -3SD$  (median value being 320.5) indicating that more than 50% of the cases were defaulting while still SAM. Early defaulting is observed across all the sub counties in Kajiado.

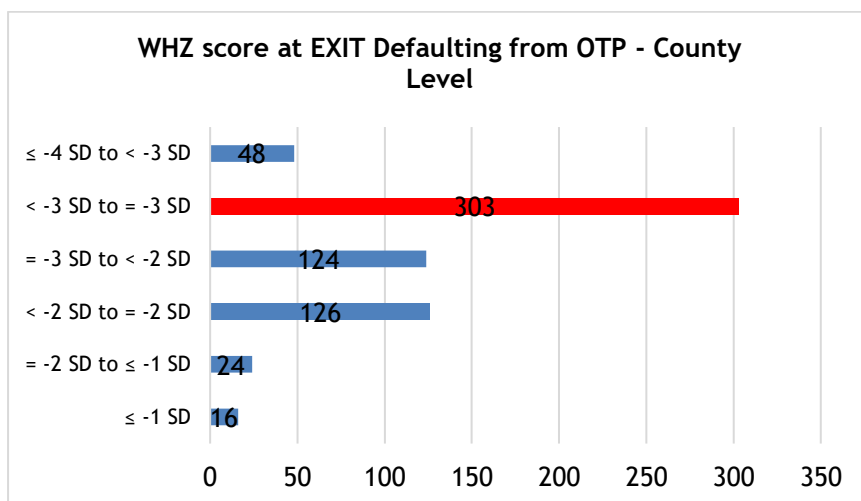


Figure 45: Median WHZ score at defaulting from OTP

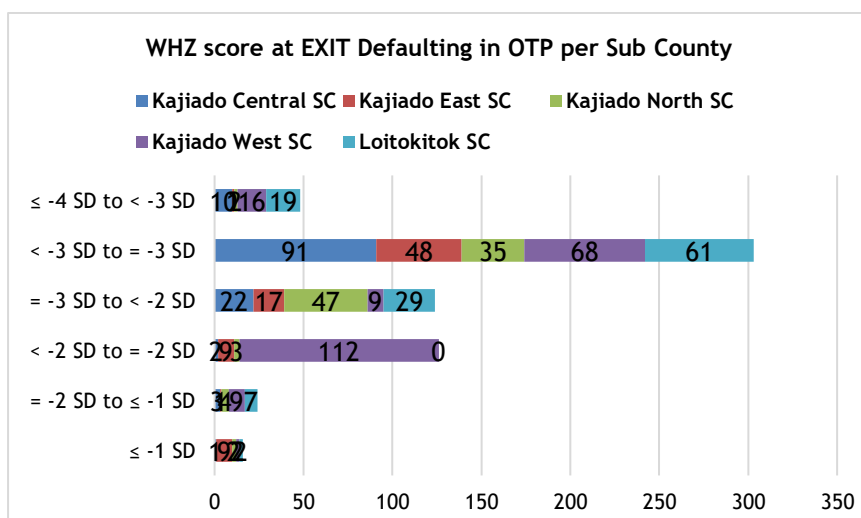


Figure 46: WHZ score at defaulting from OTP per Sub County

The median value for MUAC at defaulting from OTP is 11.3cm median value being 188; this shows that more than 50% cases defaulted while still SAM by MUAC.



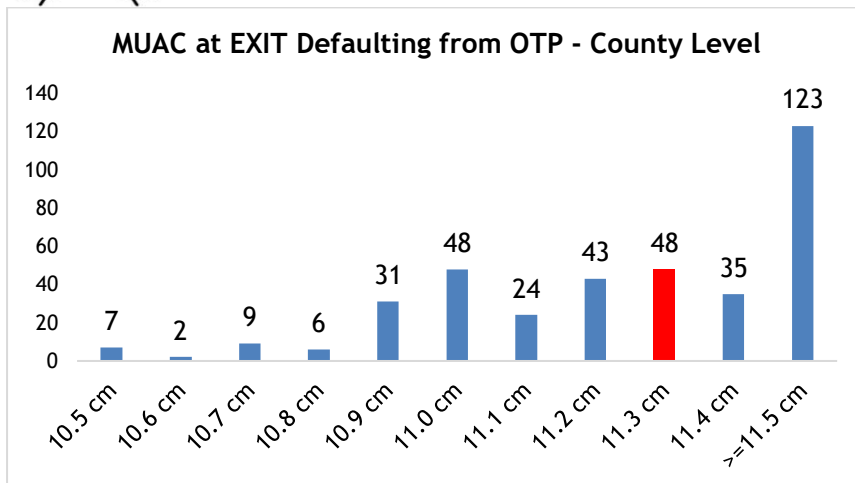


Figure 47: Median MUAC at defaulting from OTP in Kajiado

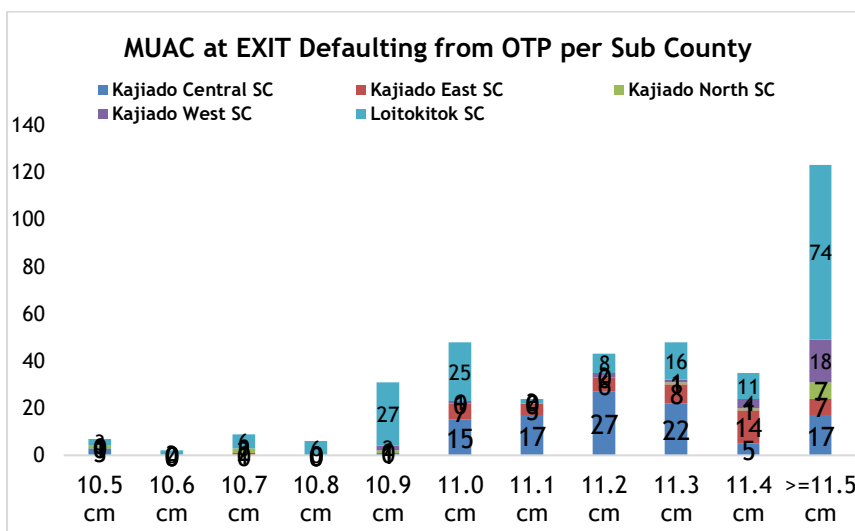


Figure 48: MUAC at defaulting from OTP per Sub County

The median LoS at discharge cured from OTP is 5 weeks (median value being 634); Very early discharges observed across the sub counties as indicated by LoS of <4 weeks, which could contribute to relapses

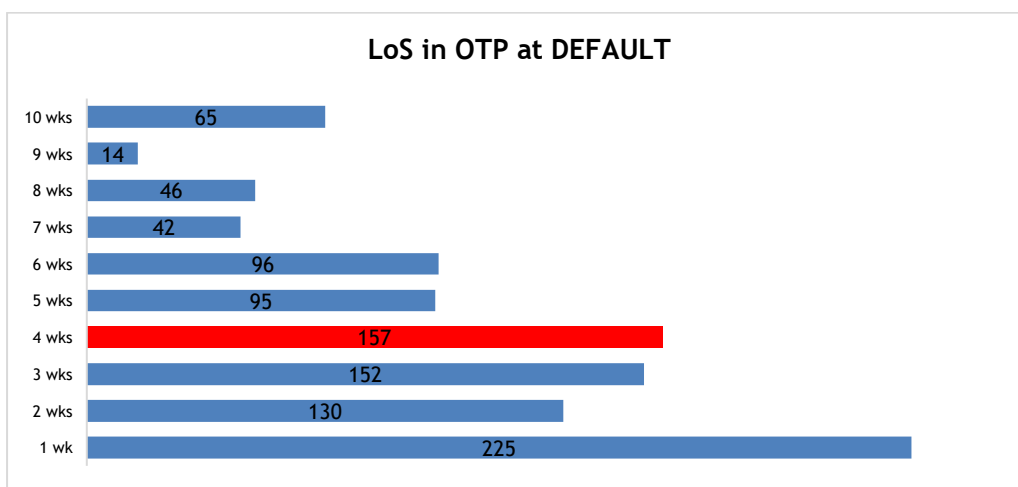


Figure 49: Median LoS at Default from OTP

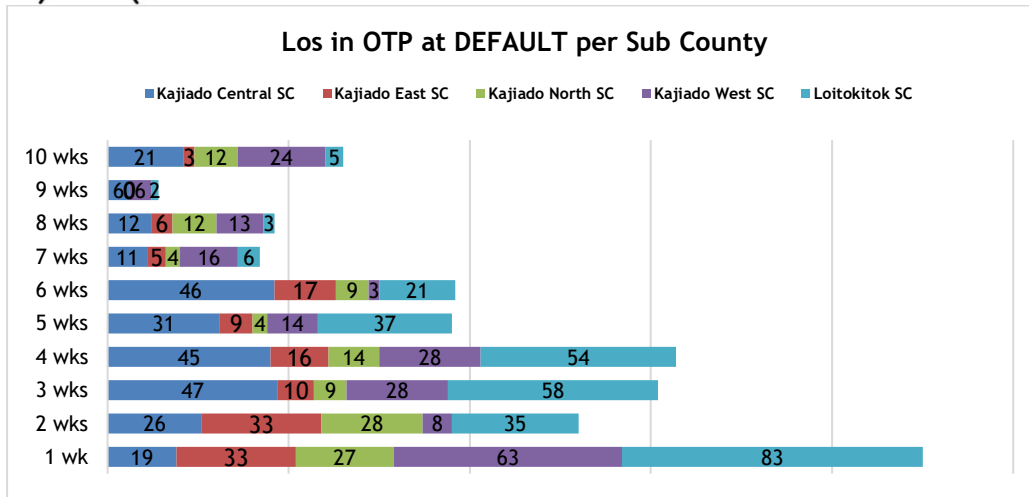


Figure 50: LoS at Default from OTP per Sub County

### Proportion of OTP Defaulting cases versus Admissions

When OTP admissions were further analyzed, it was observed that a high threshold of the admitted cases defaulted before discharge, with defaulter rates surpassing the SPHERE threshold of below 15% at the county level and across all the sub counties, with CENTRAL and NORTH performing poorly. This is an indication of poor client retention mechanisms in the health facilities.

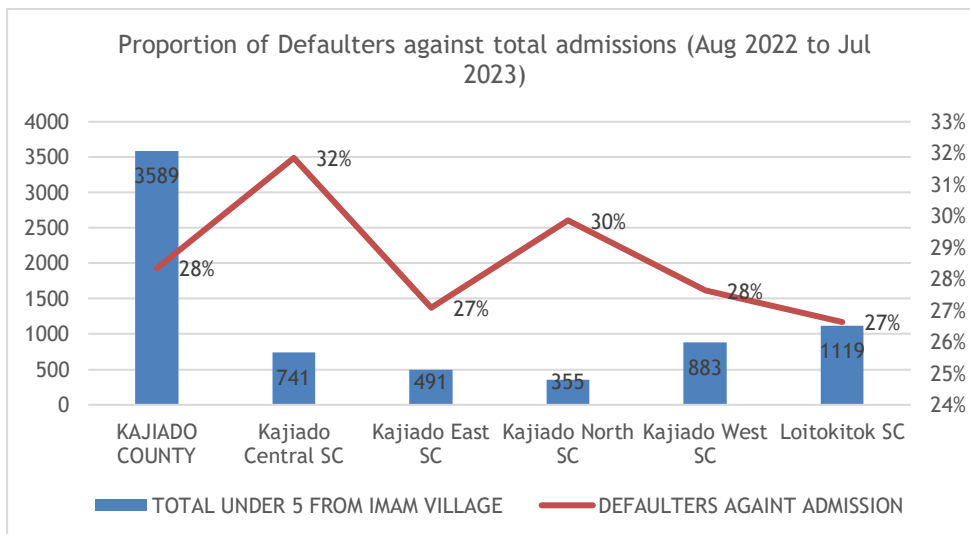


Figure 51: Proportion of children defaulting from OTP against Admissions

High proportion of children defaulting from OTP compared to the total admissions health facilities in **Kajiado Central**. The health facilities with the highest proportion are *Emotoroki*, *Imarba*, *Kajiado CRH*, *Kumpa CMF* and *Olleshwa*, an indication of poor client retention mechanisms.

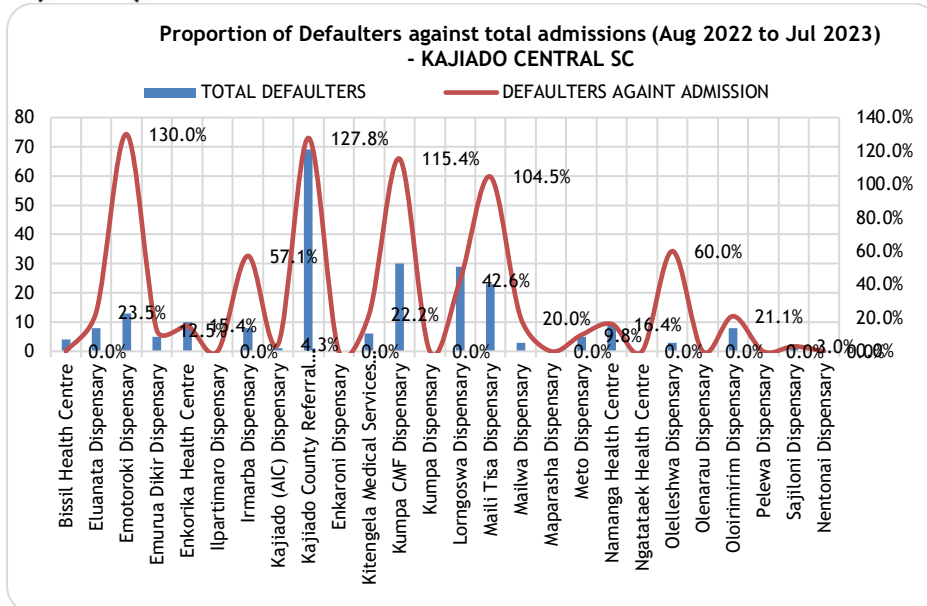


Figure 52: Proportion of children defaulting from OTP against Admissions in KAJIADO CENTRAL

High proportion of children defaulting from OTP compared to the total admissions H/Facilities in Kajiado East. The only health facilities with the highest proportion are Enkirgirri, Ereteti, Lempei, Merueshi and Osarai, an indication of poor client retention mechanisms.

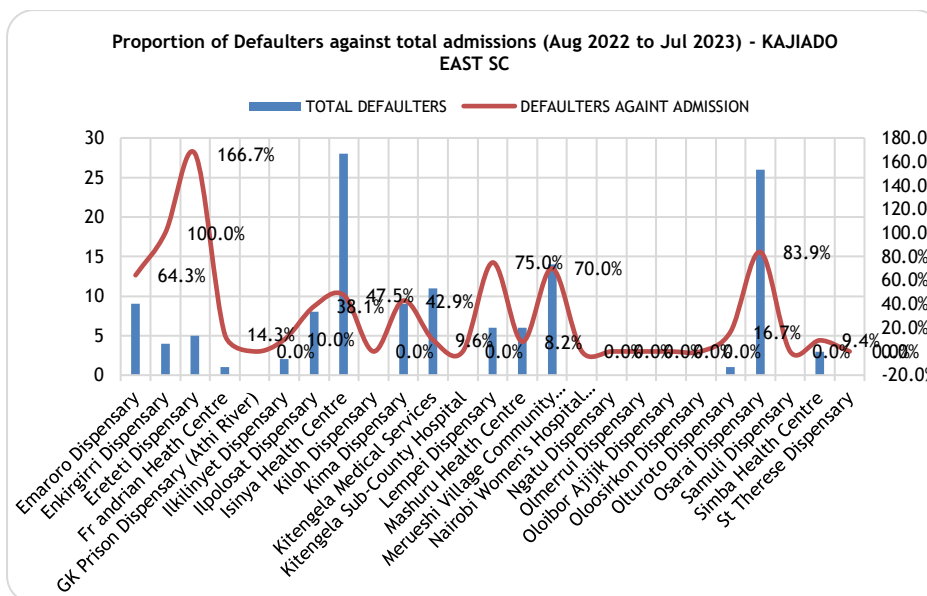


Figure 53: Proportion of children defaulting from OTP against Admissions in KAJIADO EAST

High proportion of children defaulting from OTP compared to the total admissions health facilities in North Sub County. The health facilities with the highest proportion are Matasia, Ngong' SC, Ololua and Ongata Rongai. The high proportion of defaulting are an indication of poor client retention mechanisms in the health facilities.

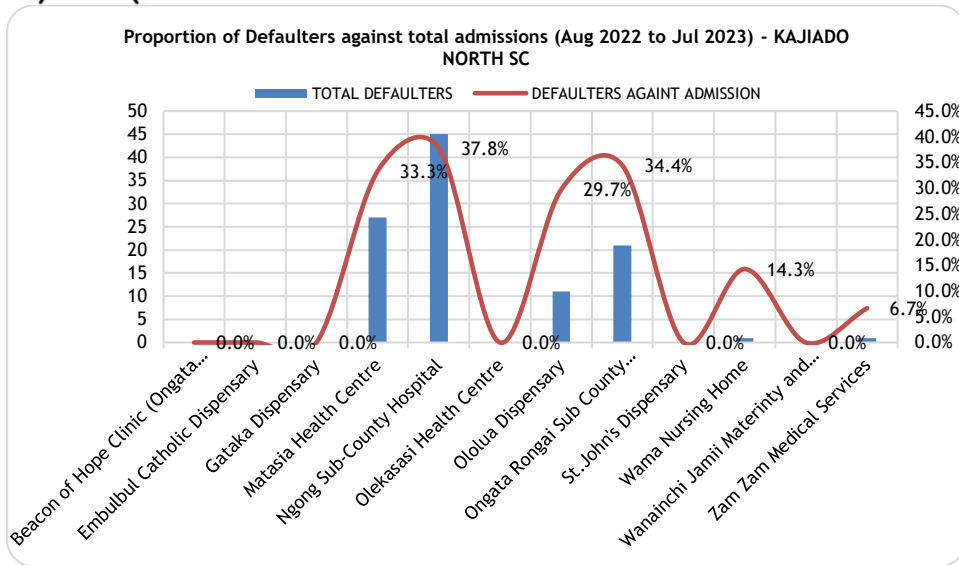


Figure 54: Proportion of children defaulting from OTP against Admissions in KAJIADO NORTH

High proportion of children defaulting from OTP compared to the total admissions H/Facilities in Kajiado West Sub County. The H/Fs with the highest proportion are Murantawa, Olooltepes, Saikeri and St. Mary's H/C. The high proportion of defaulting are an indication of poor client retention mechanisms in the health facilities.

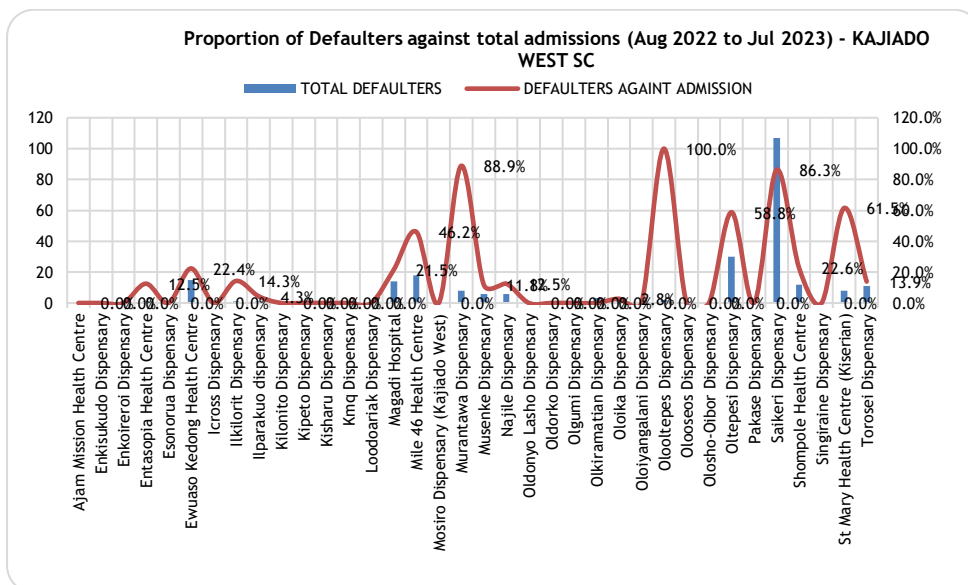


Figure 55: Proportion of children defaulting from OTP against Admissions in KAJIADO WEST

High proportion of children defaulting from OTP compared to the total admissions H/Facilities in Loitoktok Sub County. The H/Fs with the highest proportion are Immurtot H/C, Emumwenyi, Entarara, Lang'ata Enkima and Oloolakir. The high proportion of defaulting are an indication of poor client retention mechanisms in the health facilities.

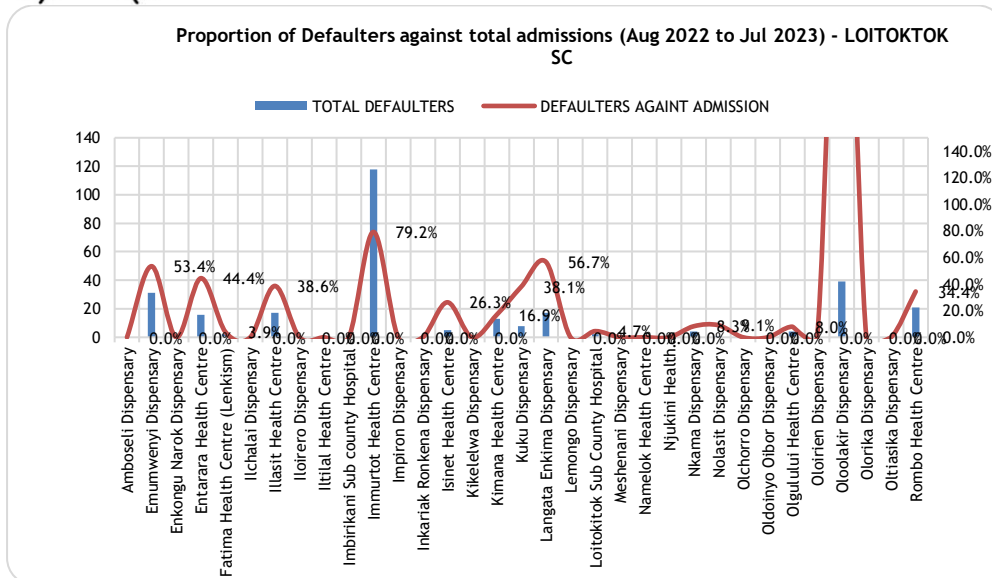


Figure 56: Proportion of children defaulting from OTP against Admissions in LOITOKTOK SC

## SUPPLEMENTARY FEEDING PROGRAM

### Mode of Referral into SFP

Referrals into SFP majorly done by Health care workers when children come for Out-patient department services. Some more cases of self-referral observed in Central, West and Loitokitok attributed to pockets of CUs implementing the Family MUAC approach.

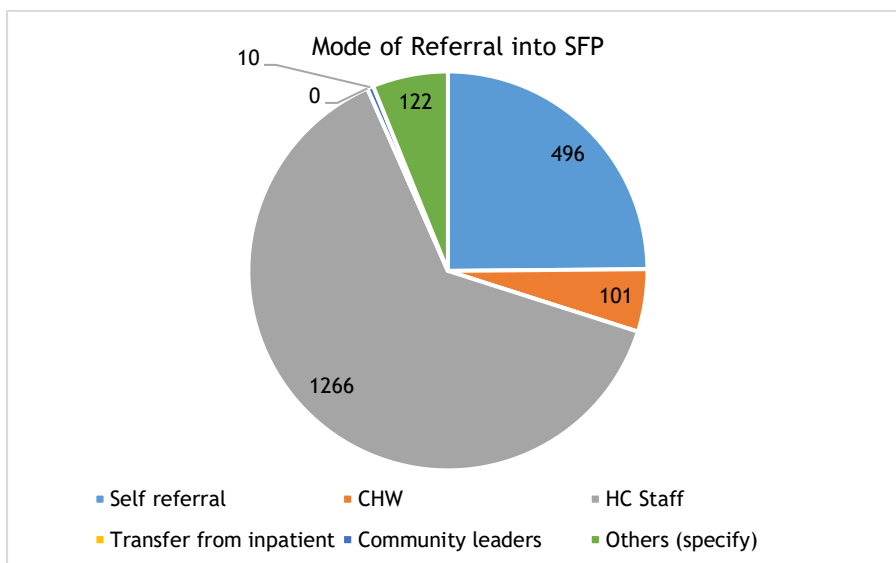


Figure 57: Referral mode into SFP in Kajiado County

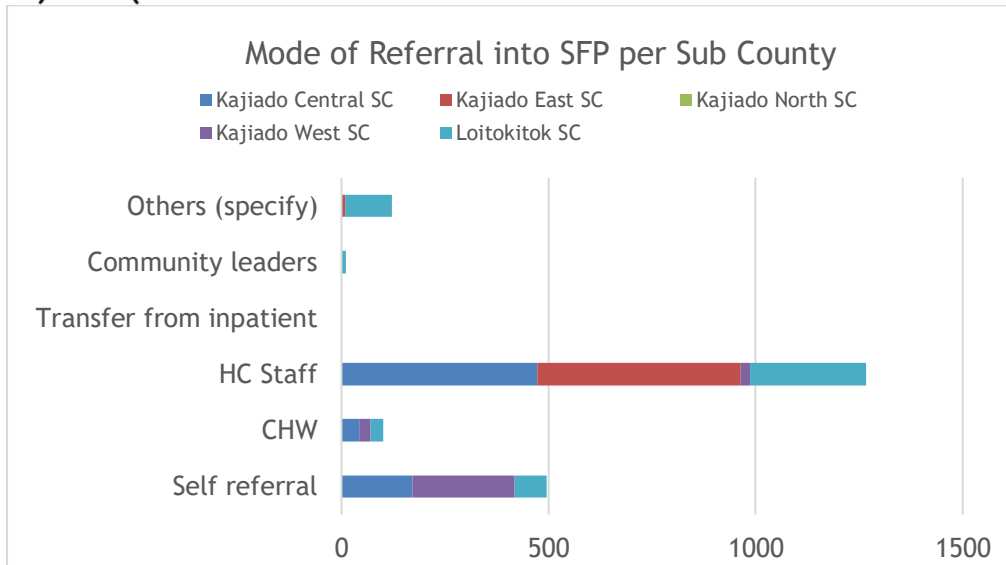


Figure 58: Referral mode into SFP per Sub County

## SFP Admissions

### Proportion of SFP Admissions out of the U5 population per Sub County

Kajiado West had more SFP admissions than the rest of the Sub counties

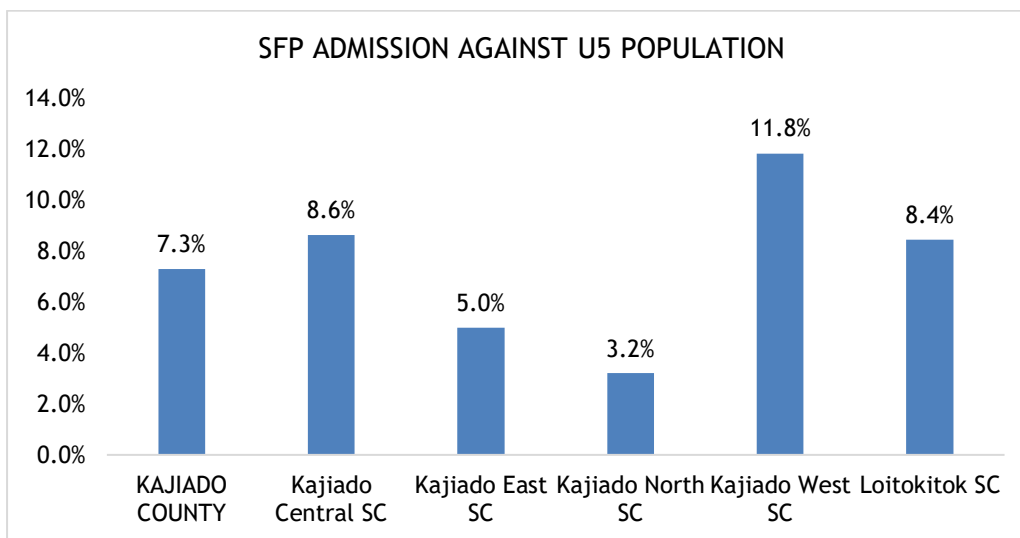


Figure 59: Proportion of children admitted into SFP out of the U5 population per Sub County

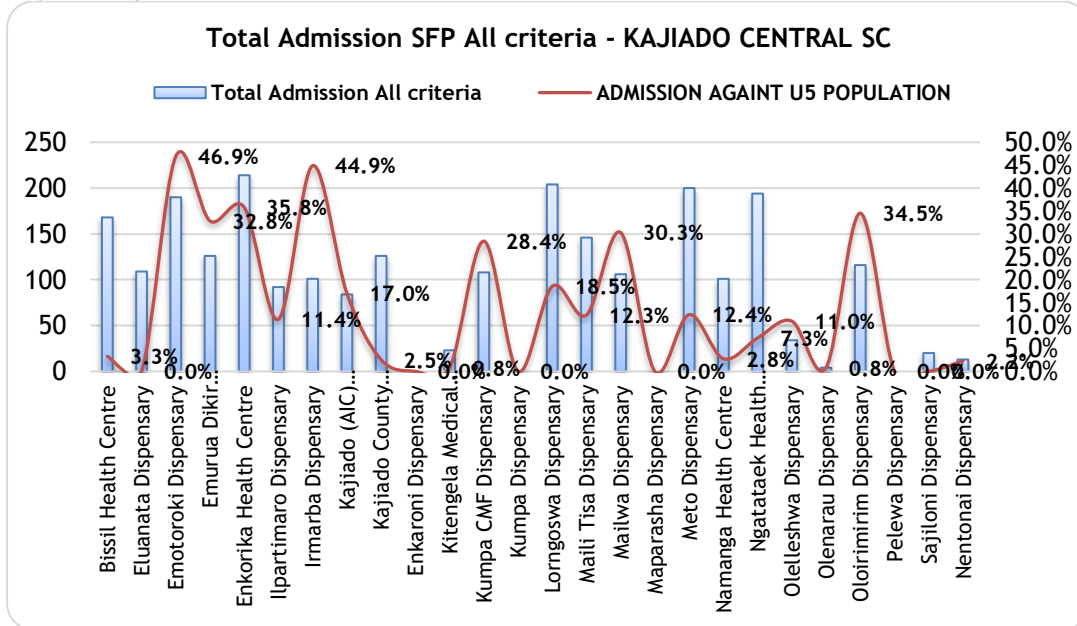


Figure 60: Proportion of children admitted into SFP out of the U5 population per H/Facility in Central

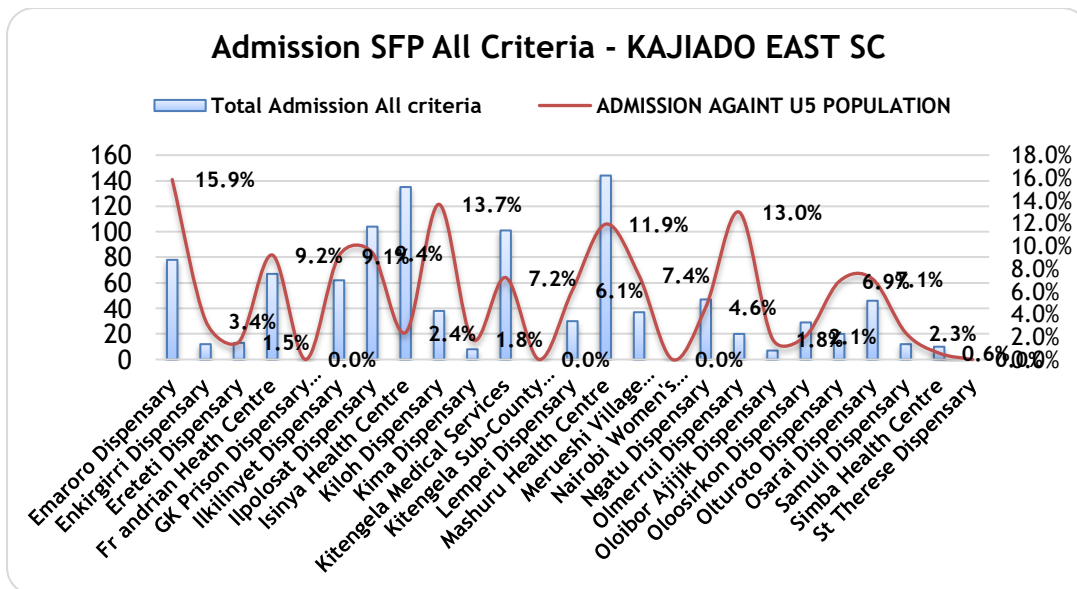


Figure 61: Proportion of children admitted into SFP out of the U5 population per H/Facility in East

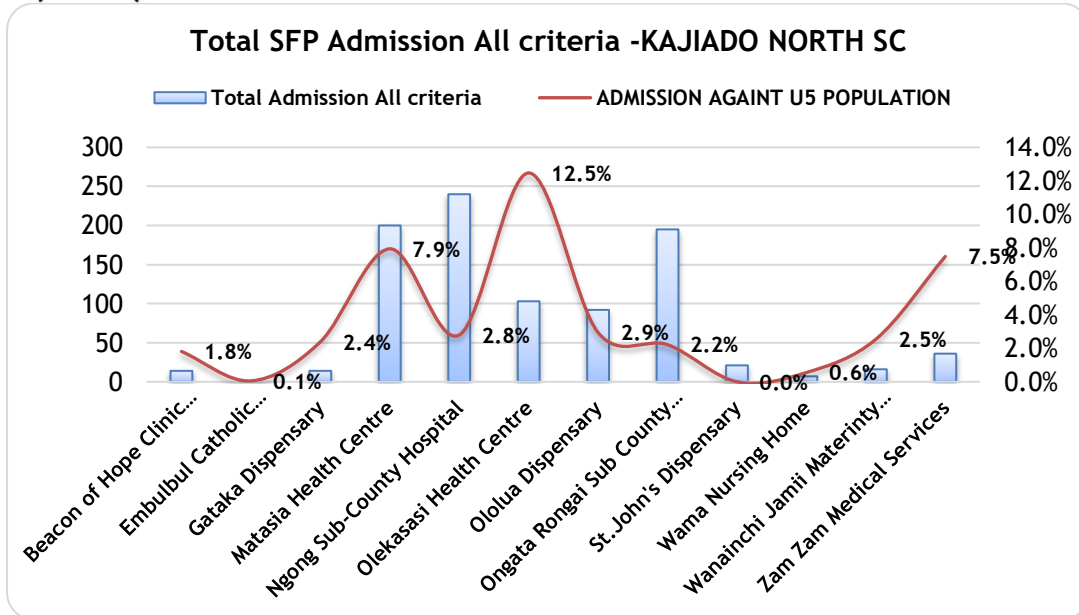


Figure 62: Proportion of children admitted into SFP out of the U5 population per H/Facility in North

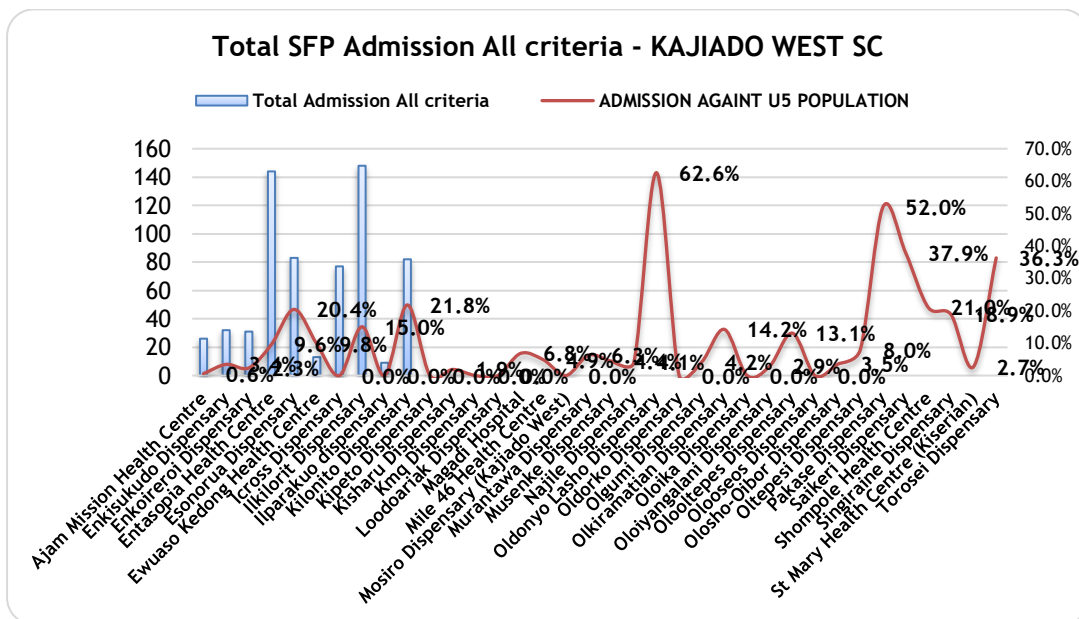


Figure 63: Proportion of children admitted into SFP out of the U5 population per H/Facility in West



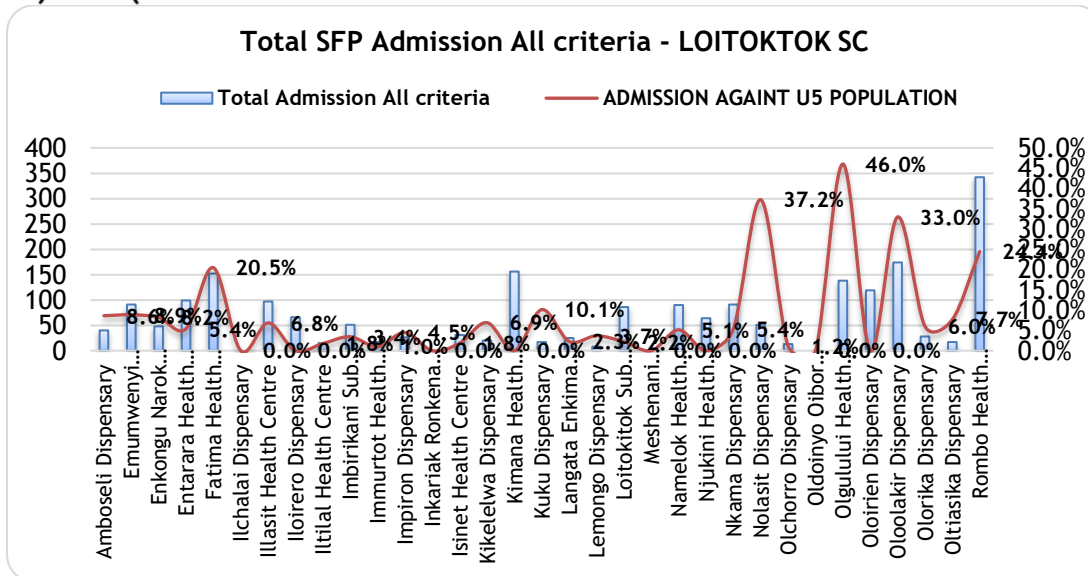
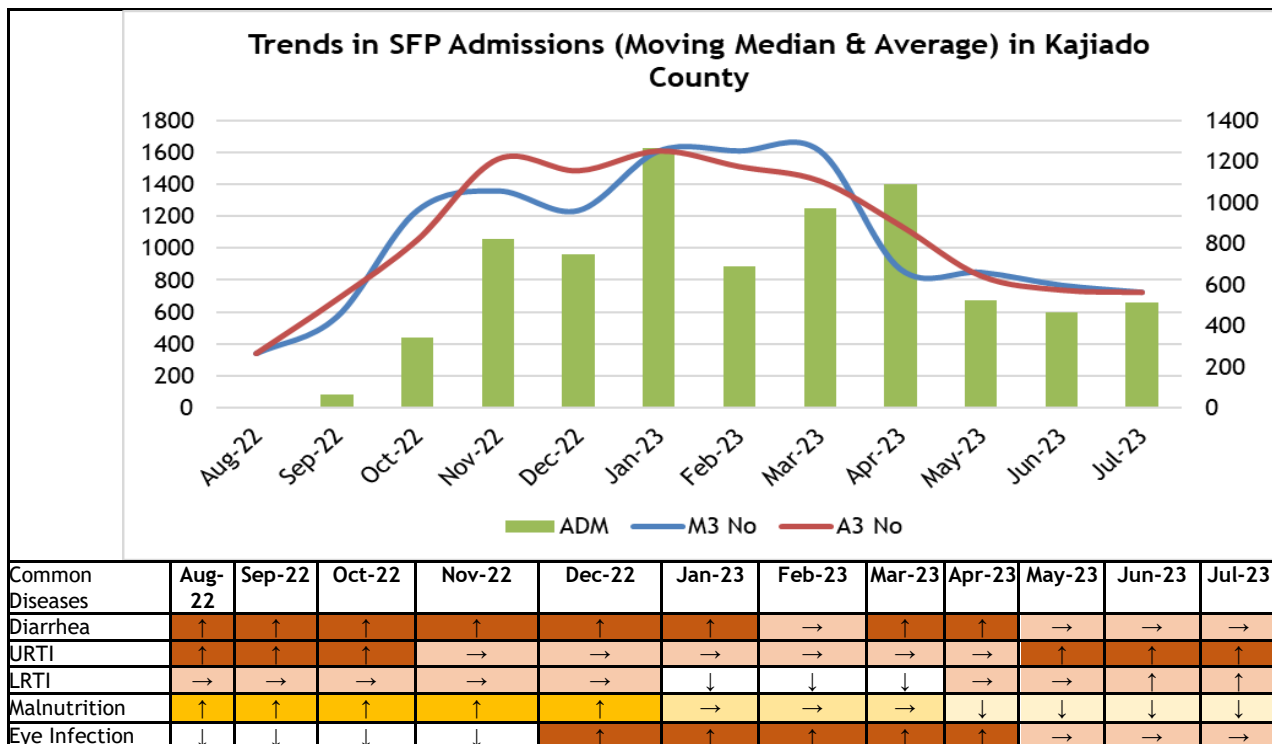


Figure 64: Proportion of children admitted into SFP out of the U5 population per H/Facility in Loitokitok

### Trends in SFP Admissions

Just like the OTP program, increased admission of New cases in the SFP program was observed in 2022 compared to the previous years, attributed to the prolonged drought season, with a downward decrease of cases being in May, June and July 2023. Between May 2022 to April 2023, increasing admissions over time were observed, with the peak being from Sept 2022 to April 2023. Majorly attributed to heightened case finding through mass screening, family MUAC and outreach activities, which were part of the scaled-up drought response activities.





Common foods (maize flour, rice and beans, milk) prices	H	L	M	M	M	M	L	M	M	M	M	M
Planting & weeding	L	L	H	H	H	L	L	L	H	H	L	L
Harvesting												
In-Migration	L	H	H	L	L	L	H	H	H	H	H	H
Out-Migration	H	H	H	H	M	M	M	M	M	M	M	M
Drought / famine	H	H	H	H	M	M	H	H	L	L	L	L

Figure 65: Moving Median & Average for SFP Admission Trends in Kajiado County

### WHZ score at Admission into SFP

Most admissions were within the recommended admission guidelines for moderate acute malnutrition as shown by the median WHZ score at Admission into SFP,  $< -2$  SD to  $= -2$  SD with the median value being 2,427. Late admissions into SFP program were observed across the sub-counties except in Kajiado North.

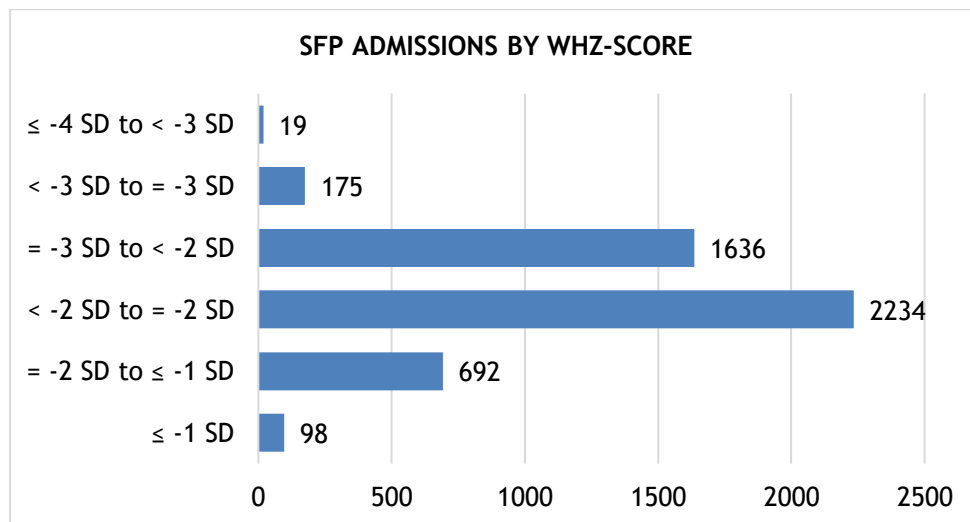


Figure 66: Median WHZ score at Admission into SFP in Kajiado County

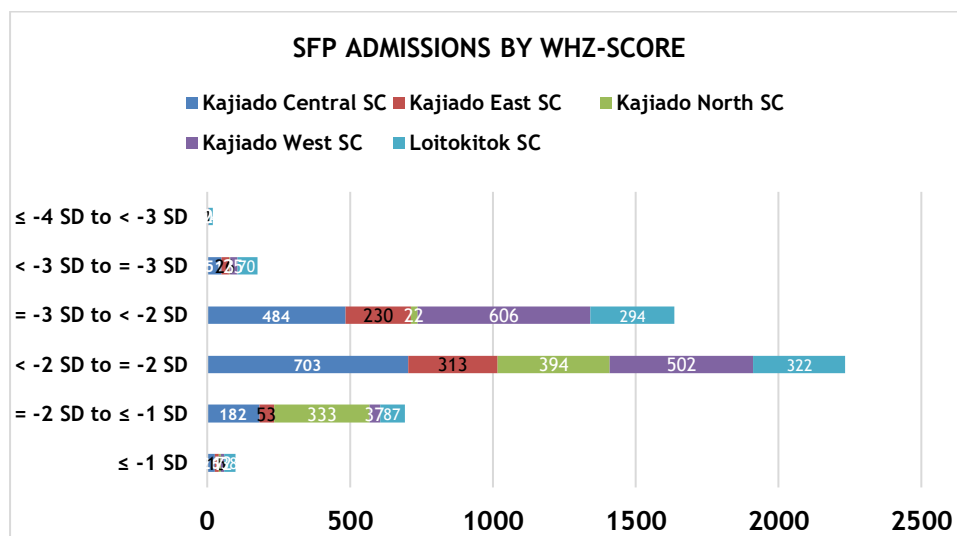


Figure 67: WHZ score at Admission into SFP per Sub County

### MUAC at Admission into SFP



The MUAC at Admission into SFP in Kajiado County is 12.2cm (median value being 2,171) indicating early admission. Some cases admitted with MUAC <11.5cm indicating wrong admissions; majorly observed in Loitokitok, Kajiado Central and Kajiado West.

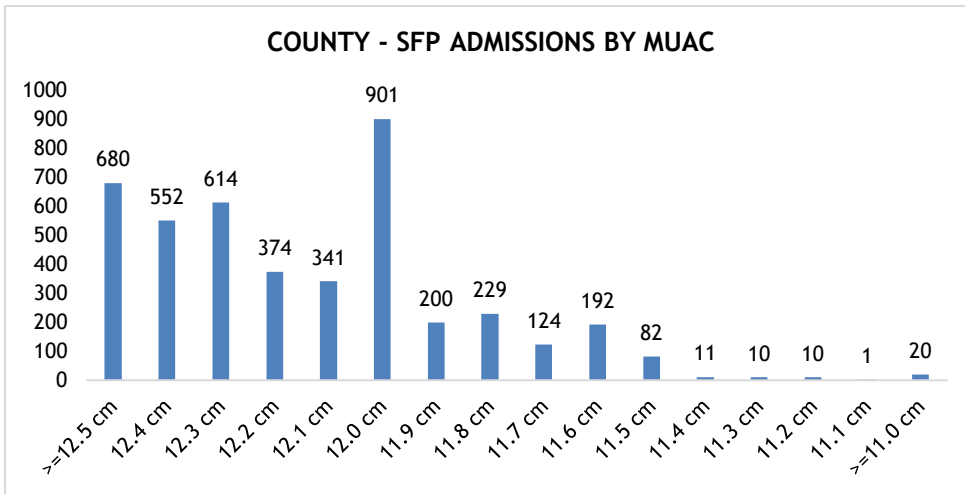


Figure 68: Median MUAC at Admission into SFP

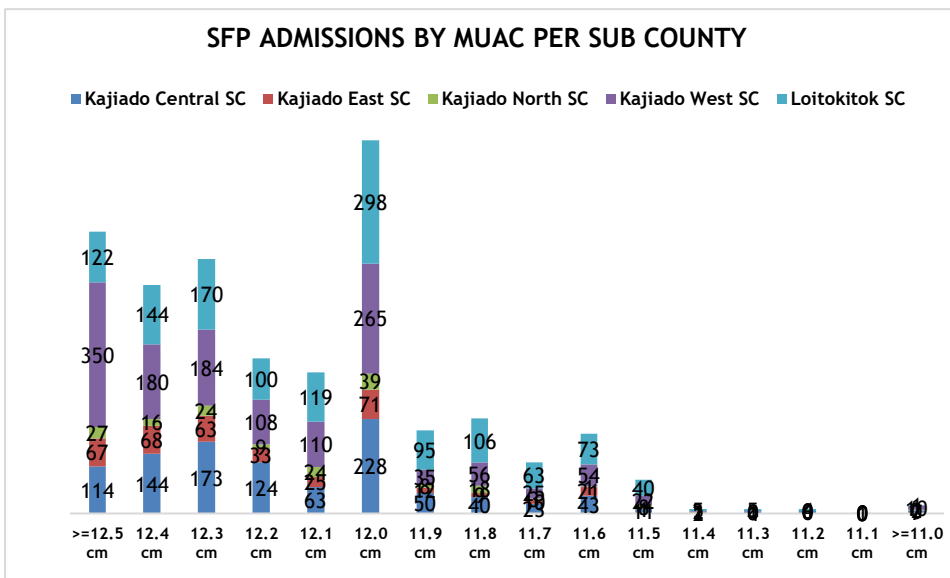


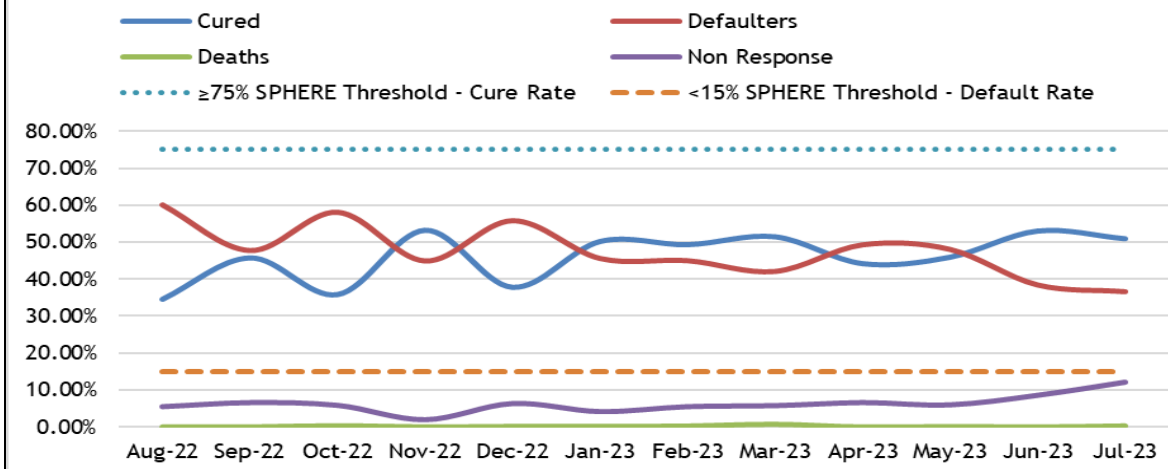
Figure 69: MUAC at Admission into SFP per Sub County

### SFP Exit Outcomes

Kajiado County has poor exit outcomes in SFP throughout the assessment period with cured rates of <75% and defaulter rates of >15% SPHERE thresholds. All the sub counties affected by the high defaulter rates. High default rates were attributed to migration and maternal workload, with little follow up of health services by caregivers and inadequate case finding by CHVs.



### Trends in SFP Exit Outcomes in Kajiado County



Common Diseases	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Diarrhea	↑	↑	↑	↑	↑	↑	→	↑	↑	→	→	→
URTI	↑	↑	↑	→	→	→	→	→	→	↑	↑	↑
LRTI	→	→	→	→	→	↓	↓	↓	→	→	↑	↑
Malnutrition	↑	↑	↑	↑	↑	→	→	→	↓	↓	↓	↓
Eye Infection	↓	↓	↓	↓	↑	↑	↑	↑	↑	→	→	→
Common foods (maize flour, rice and beans, milk) prices	H	L	M	M	M	M	L	M	M	M	M	M
Planting & weeding	L	L	H	H	H	L	L	L	H	H	L	L
Harvesting												
In-Migration	L	H	H	L	L	L	H	H	H	H	H	H
Out-Migration	H	H	H	H	M	M	M	M	M	M	M	M
Drought / famine	H	H	H	H	M	M	H	H	L	L	L	L

Figure 70: Trends in SFP Outcomes in Kajiado County

Poor exit outcomes observed across the sub counties

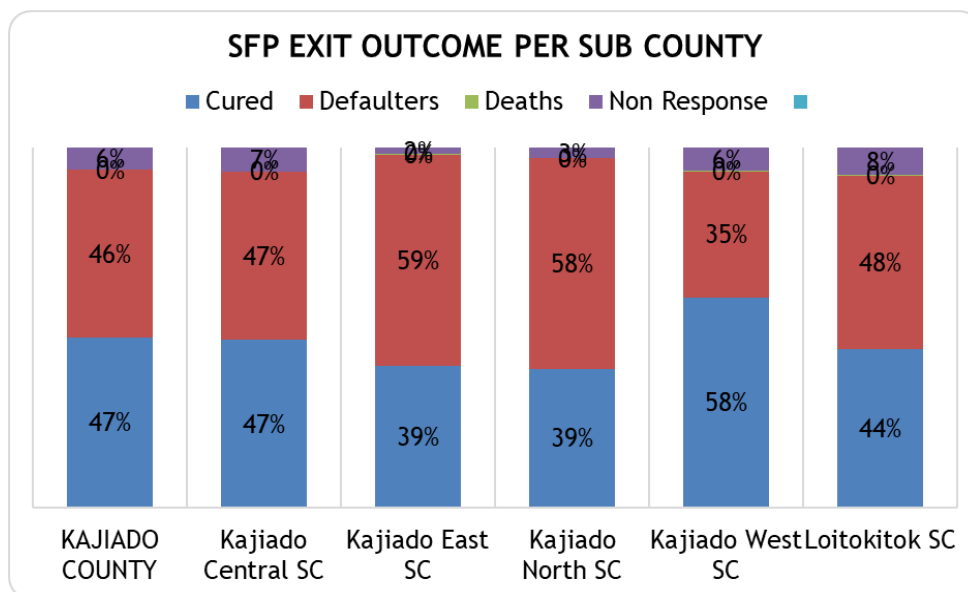


Figure 71: SFP Exit outcome per Sub County



Poor exit outcomes across the health facilities in Kajiado Central with the most affected ones being Emurua Dikir, Ilpartimaro, Imarba, Kajiado AIC, Kajiado CRH, KMS (Kajiado), Kumpa CMF, Lrongoswa, Mailwa, Ngataaek, Olelleshwa and Oloirimirim.

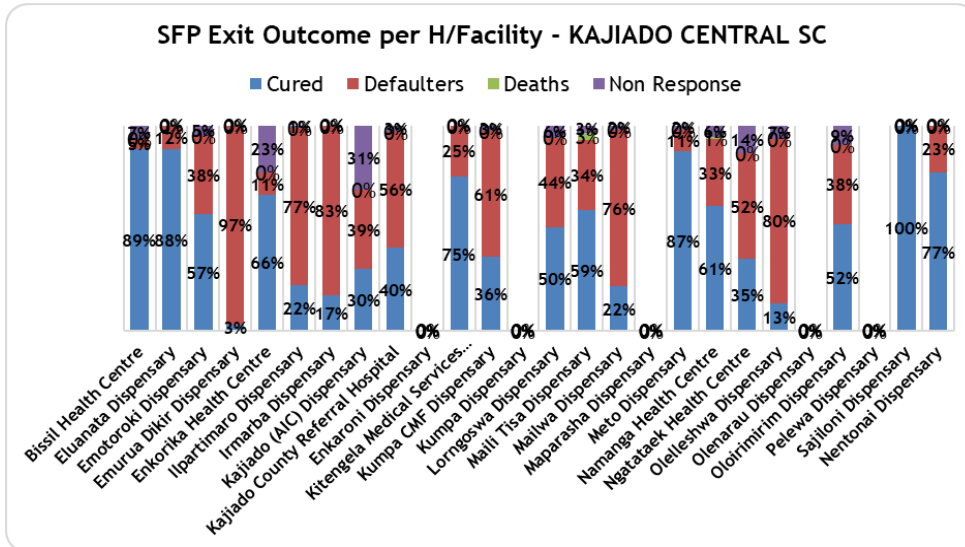


Figure 72: SFP Exit outcome per H/Facility in Kajiado Central Sub County

Poor exit outcomes across the health facilities in Kajiado Central with the most affected one being Emaroro, Enkingirri, Fr. Adrian, Ilkilinyet, Ipolosat, Isinya, Kiloh, Kima, Olmerrui, Oloibor Ajijik, Olturoto and Osarai.

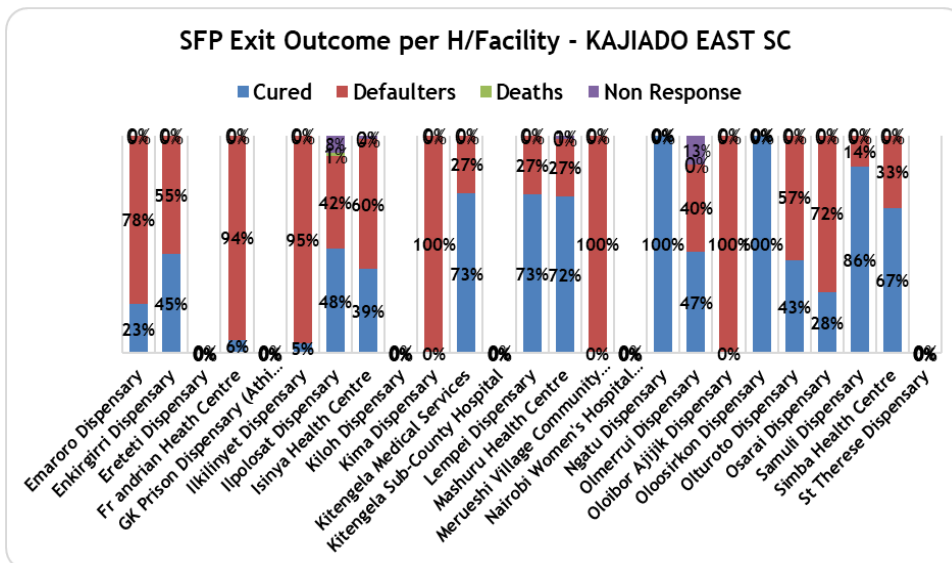


Figure 73: SFP Exit outcome per H/Facility in Kajiado East Sub County

Poor exit outcomes across the H/Facilities in Kajiado North with the most affected H/Fs are Embulbul, Matasia, Ngong', Ololua, Ongata Rongai, Wama Nursing Home and St. John's.

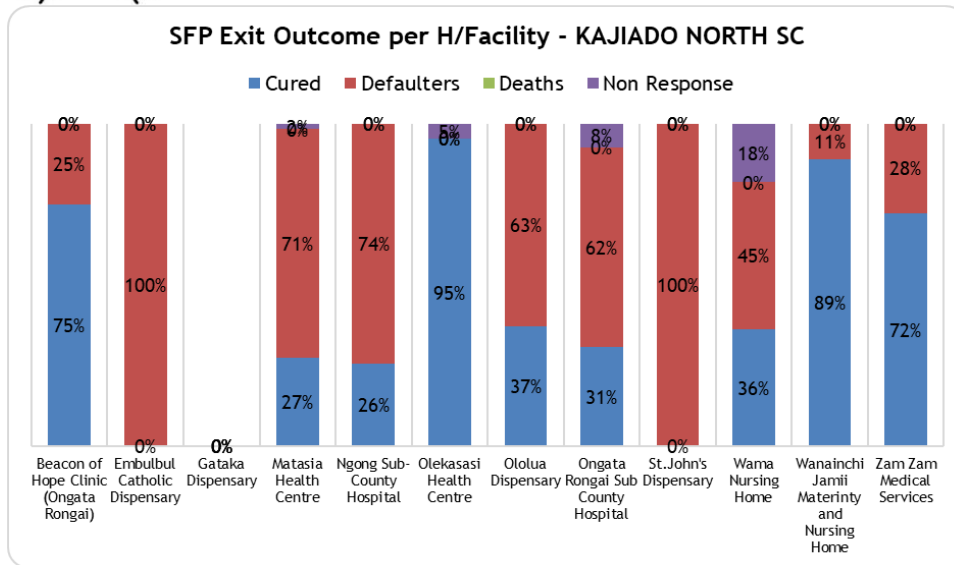


Figure 74: SFP Exit outcome per H/Facility in Kajiado North Sub County

Poor exit outcomes across the H/Facilities in Kajiado West. The most affected H/Fs are Enkoireroi, Entasopia, Esonorua, Kilomito, Kmq, Ewuaso Kedong', Mile 46, Najile, Olgumi, Olkiramatian, Olooltepes, Oltepesi, Saikeri and St. Mary Health Center.

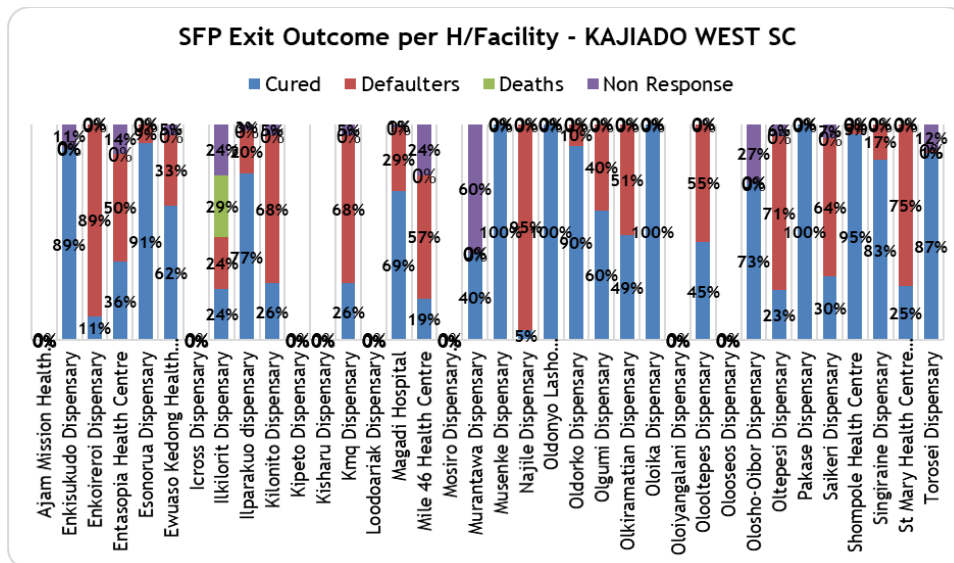


Figure 75: SFP Exit outcome per H/Facility in Kajiado West Sub County

Poor exit outcomes across the H/Facilities in Loitoktok. Most affected H/Fs are Emumwenyi, Entarara, Illasit, Imbirikani, Immurtot, Kuku, Langa'ta Enkima, Namelok, Olchorro, Olgulului, Oloolakir, Olorika, Oltiasika and Rombo Health Center.

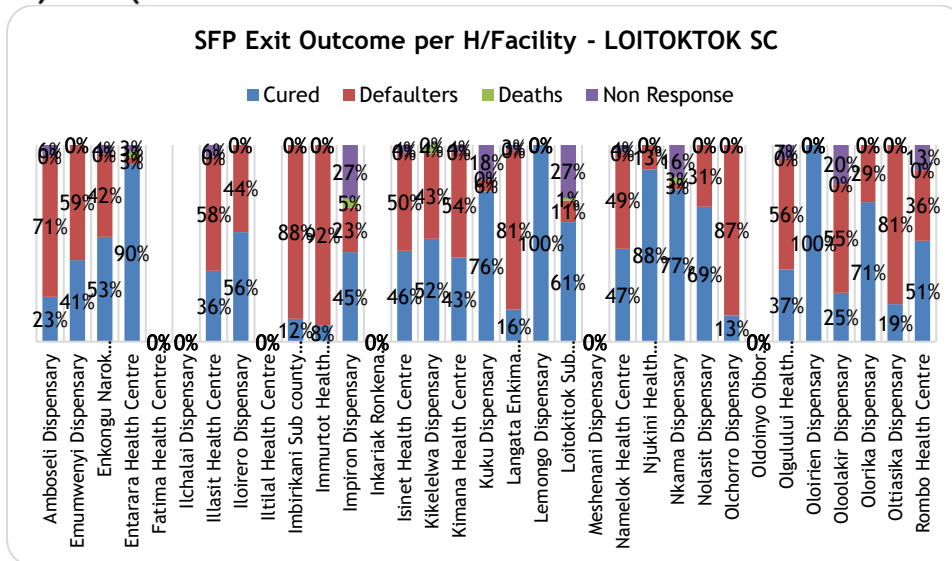


Figure 76: SFP Exit outcome per H/Facility in Loitokitok Sub County

### SFP Exit Outcome - Cured

The proportion of cases being discharged from SFP as cured against admissions was generally low across the sub counties, lowest in Kajiado North and the highest being Kajiado West.

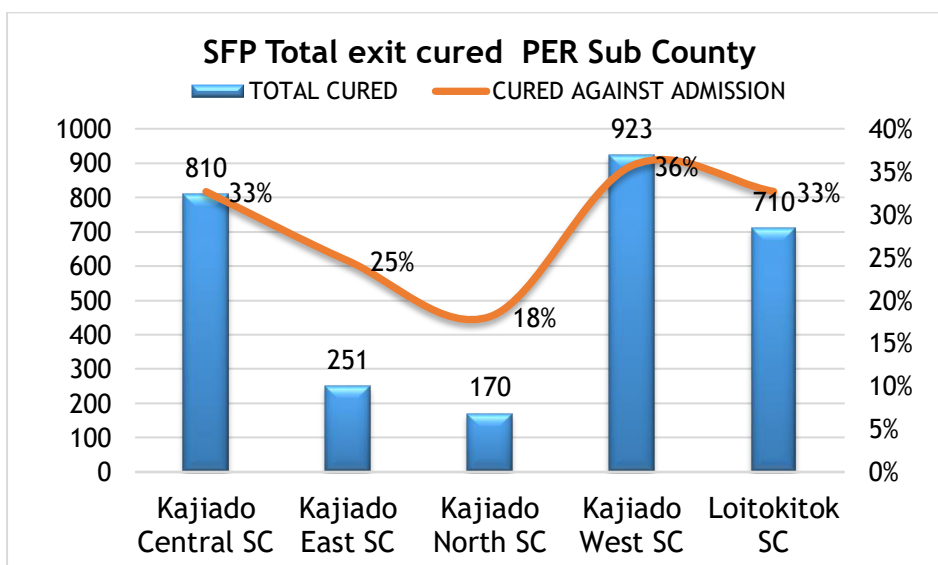


Figure 77: Proportion of SFP Exits cured against admissions per Sub County

More than half of the H/Facilities in Kajiado Central Sub County had a low proportion (<75%) of cases being discharged as cured against admissions. The best performing ones were Meto and Nentonai.

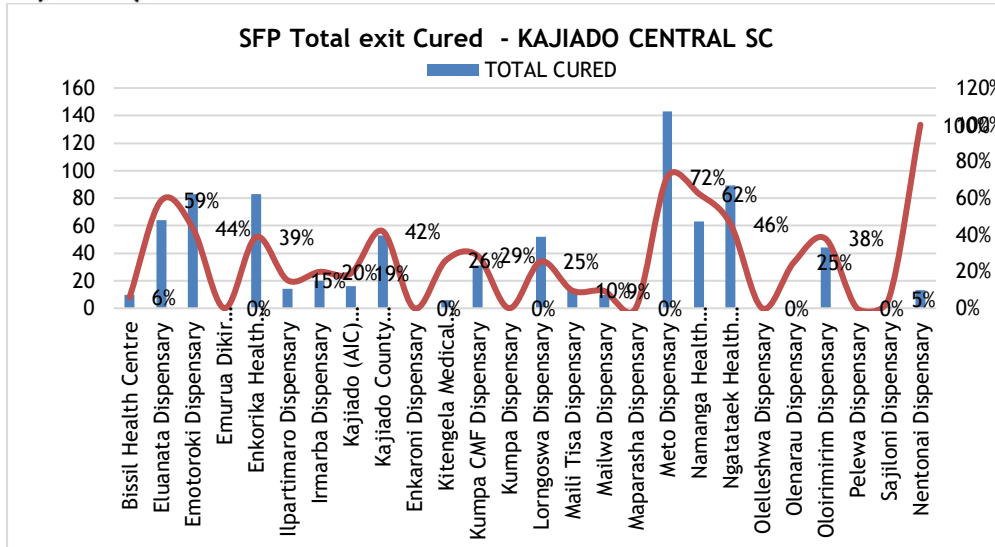


Figure 78: Proportion of SFP Exits cured against admissions per H/Facility in CENTRAL SC

Almost all the H/Facilities in Kajiado East Sub County had a low proportion (<75%) of cases being discharged from SFP as cured against admissions, except Erereti Dispensary.

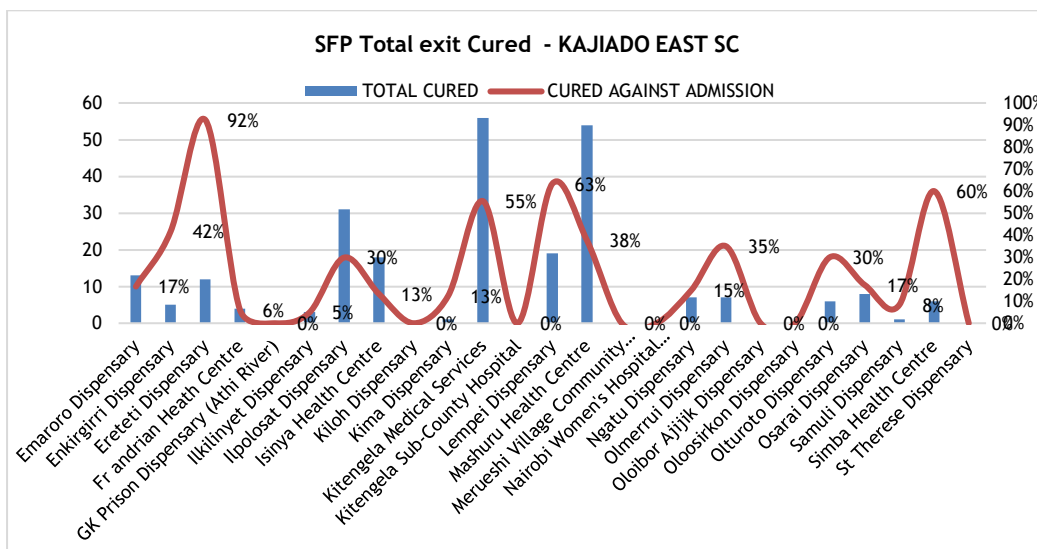


Figure 79: Proportion of SFP Exits cured against admissions per H/Facility in EAST SC

Almost all the H/Facilities in Kajiado North Sub County had a low proportion (<75%) of cases being discharged as cured against admissions. Only ZamZam Medical Services is better though still <75% threshold.



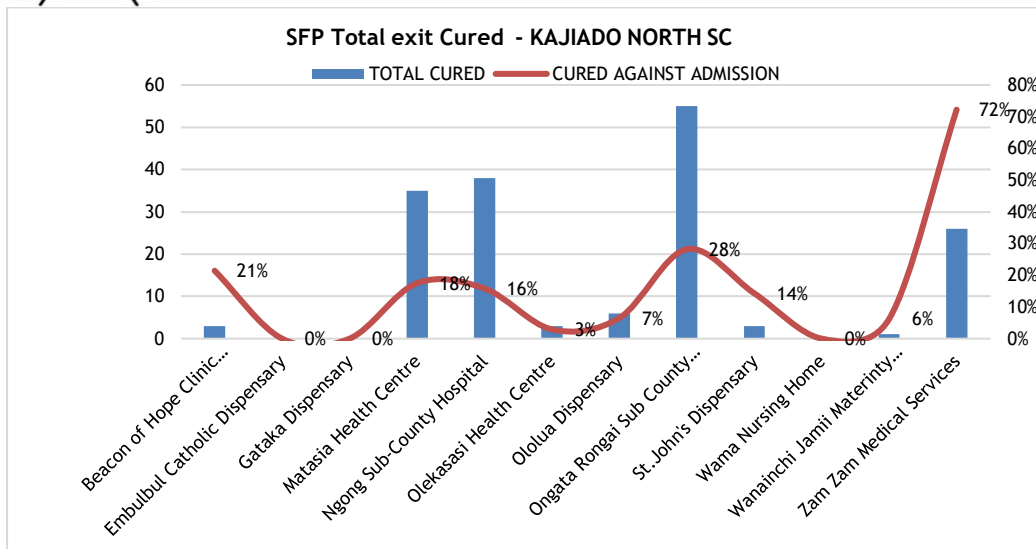


Figure 80: Proportion of SFP Exits cured against admissions per H/Facility in NORTH SC

Almost all the H/Facilities in Kajiado West Sub County had a low proportion (<75%) of cases being discharged as cured against admissions, except Magadi and Najjile.

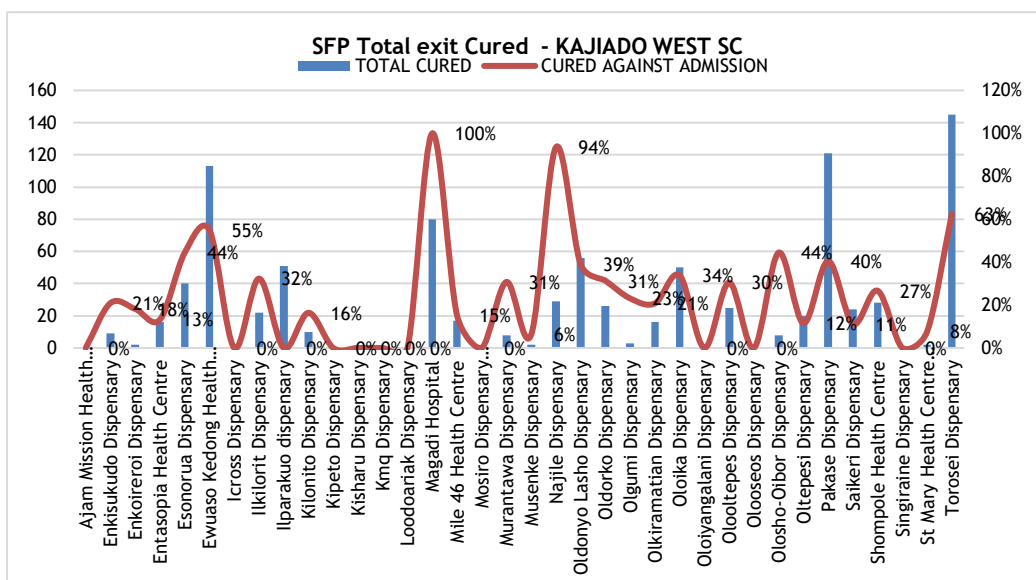


Figure 81: Proportion of SFP Exits cured against admissions per H/Facility in WEST SC

Almost all the H/Facilities in Loitoktok Sub County had a low proportion (<75%) of cases being discharged as cured against admissions, except Iltital Health Center.

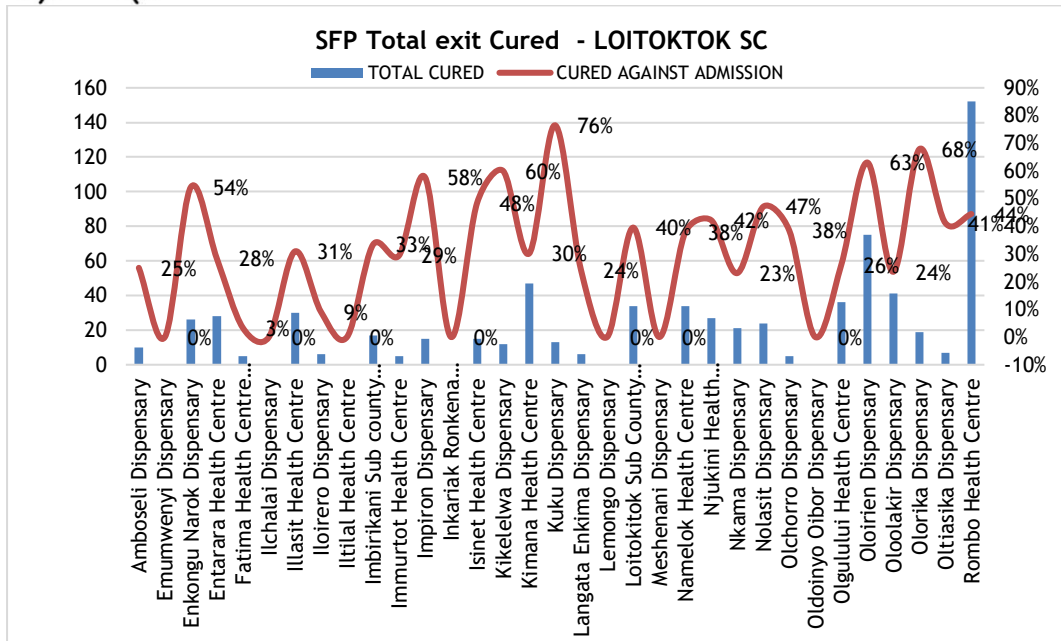


Figure 82: Proportion of SFP Exits cured against admissions per H/Facility in LOITOKTOK SC

### WHZ Score and MUAC at Exit Cured from SFP

The median value for exit cured from SFP for WHZ score admissions is <-2SD to = -2SD (median value being 439.5) indicating that cases were being discharged when already cured. Early discharge from program when cases are still severely malnourished attributed to a mix up of the discharge criteria and inadequate capacity on discharge criteria.

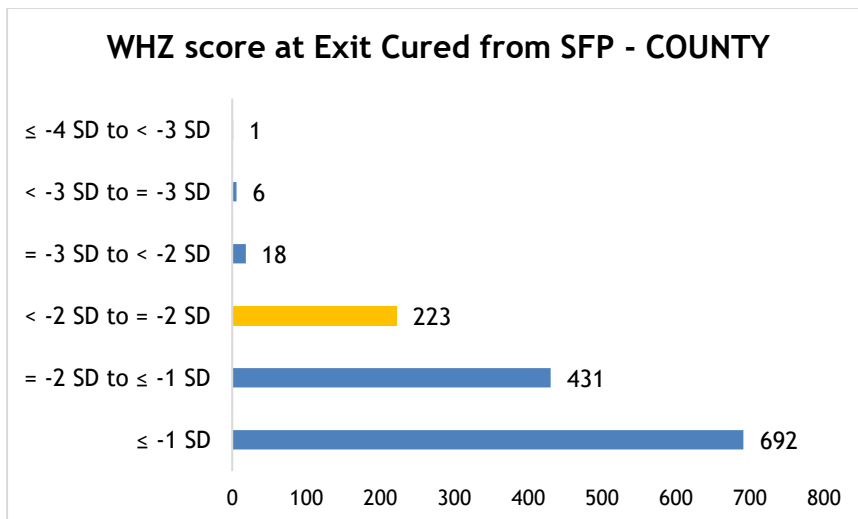


Figure 83: Median WHZ score at Exit Cured from SFP - COUNTY

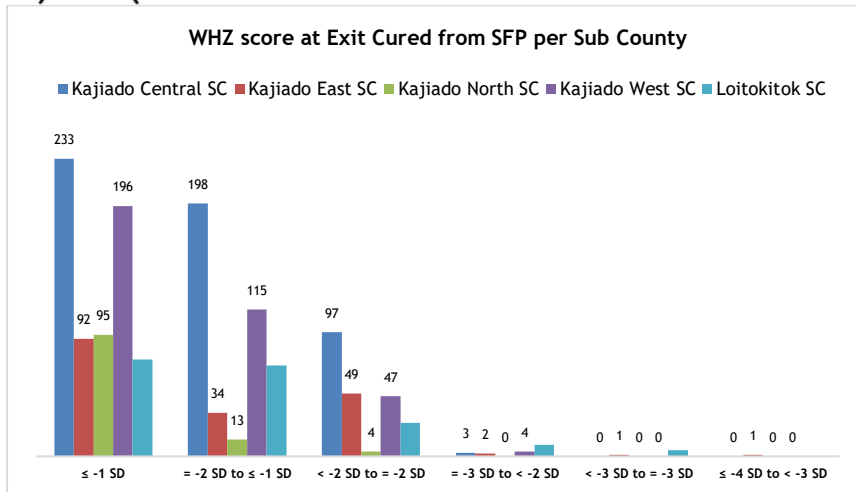


Figure 84: WHZ score at Exit Cured from SFP per Sub County

The median value for MUAC at discharge cured from SFP is 12.8cm median value being 746.5. Some cases were SC discharged before cure (<12.5cm), indicating poor adherence to treatment protocol.

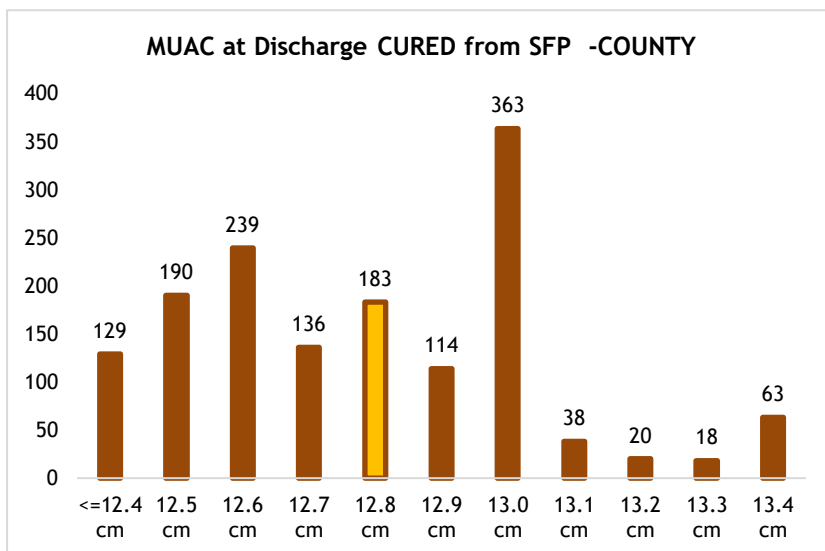


Figure 85: Median MUAC at Exit cured from SFP

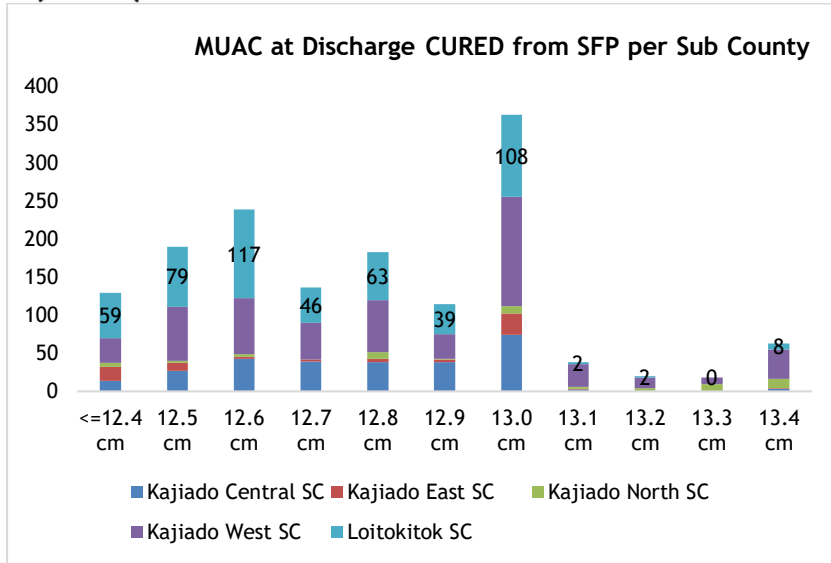


Figure 86: MUAC at Exit cured from SFP per Sub County

### Length of Stay (LoS) at Exit Cured from SFP

The median value for LoS at discharge cured from SFP is 10 weeks (median value being 1346). Very early discharges observed across the sub counties as indicated by LoS of <4 weeks, which could contribute to relapses.

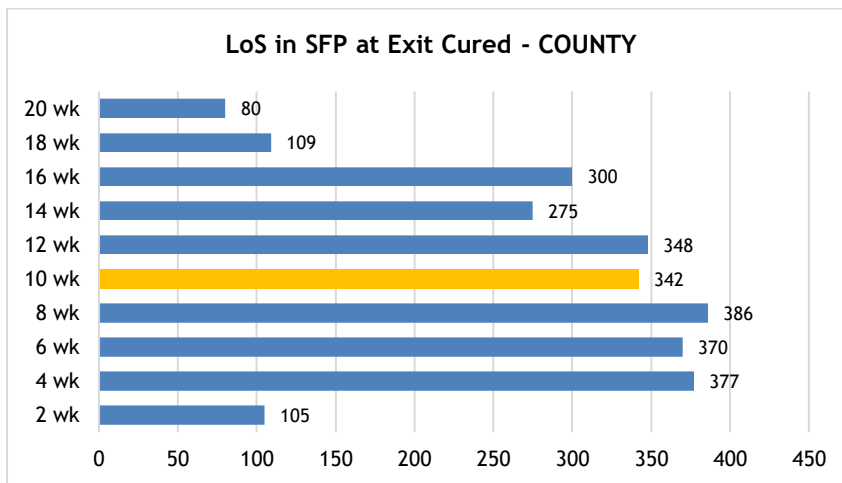


Figure 87: Median LoS in SFP at Exit cured

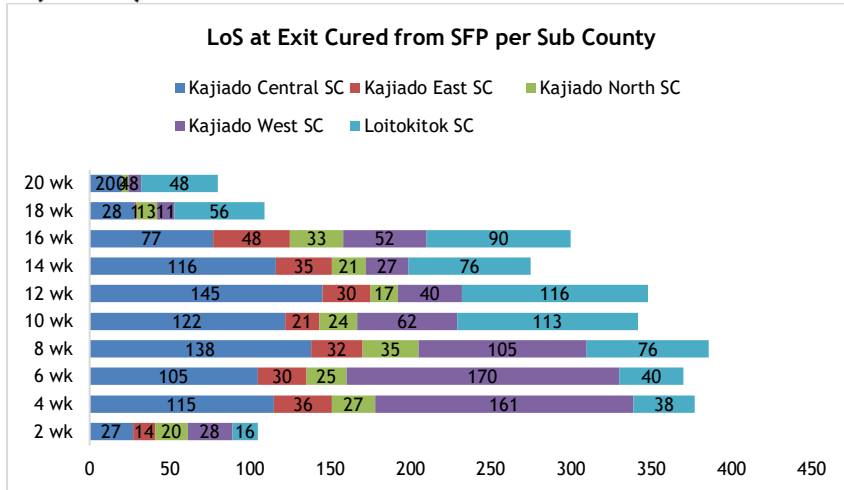


Figure 88: LoS in SFP at Exit cured per Sub County

### SFP Exit Outcome - Defaulting

#### WHZ Score and MUAC at Default

The median value for WHZ score at the time of defaulting  $< -2SD$  to  $= -2SD$  (median value being 695) indicating that more than 50% of the cases were defaulting while still MAM by WHZ score. Early defaulting is observed across all the sub counties in Kajiado County.

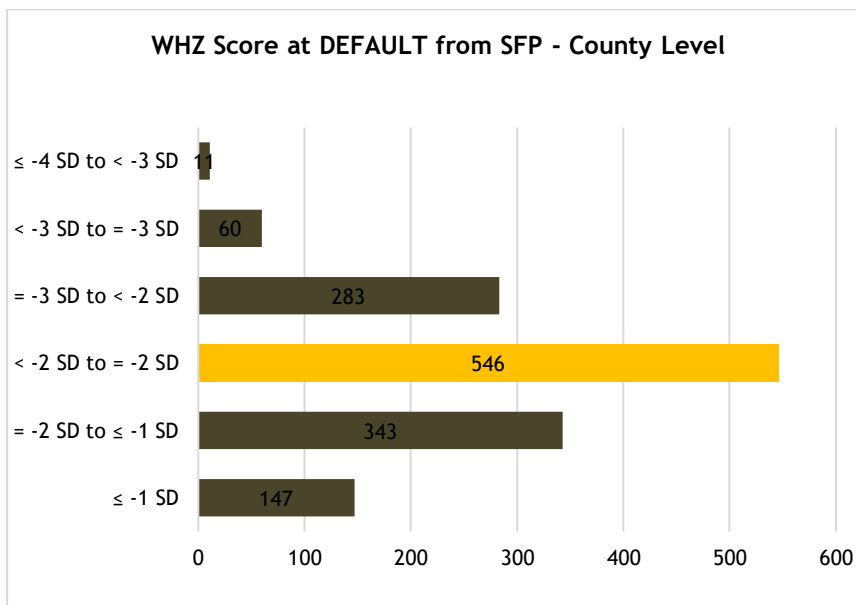


Figure 89: Median WHZ Score at Default in Kajiado County

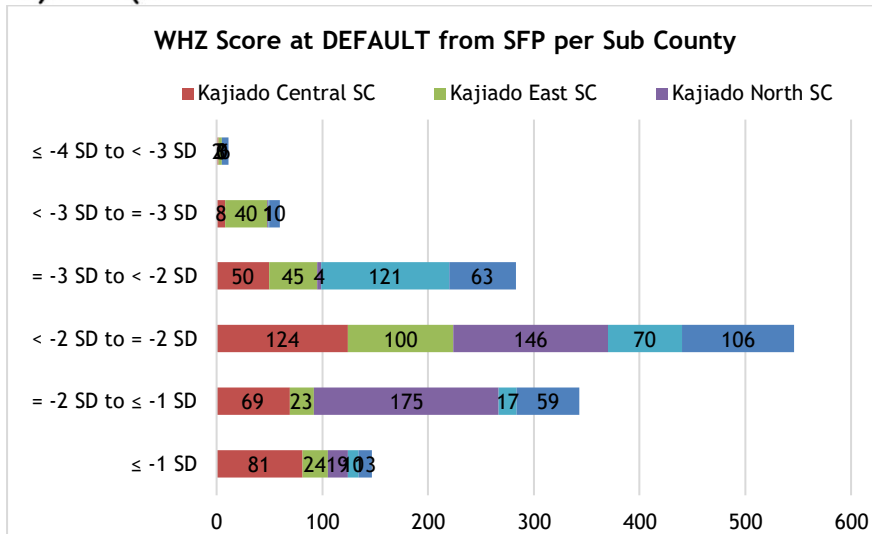


Figure 90: WHZ Score at Default per Sub County

The median value for MUAC at defaulting from SFP is 12.2cm median value being 553; this shows that more than 50% cases defaulted while still MAM by MUAC.

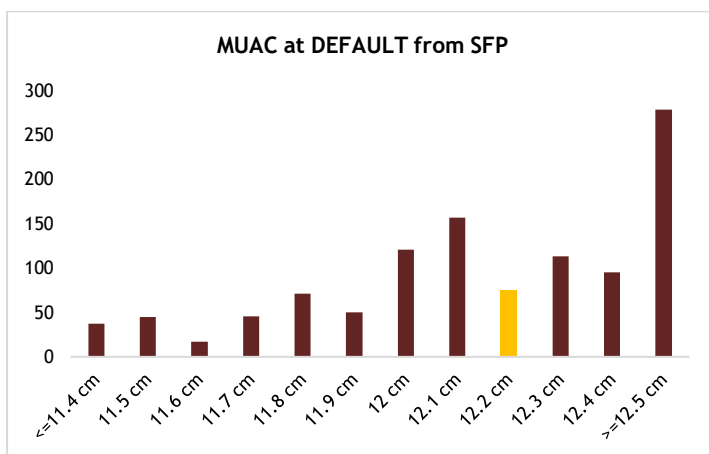


Figure 91: MUAC at Default from SFP in Kajiado County

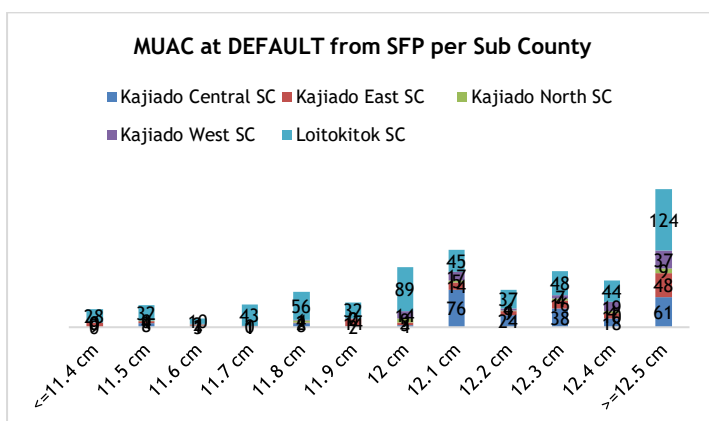


Figure 92: MUAC at Default from SFP per Sub County

## Length of Stay in SFP at Default



The median value for LoS at discharge cured from SFP is 6 weeks i.e., on the 3<sup>rd</sup> visit (median value being 1141). Very early discharges observed across the sub counties as indicated by LoS of <4 weeks, which indicates poor adherence to IMAM treatment protocol.

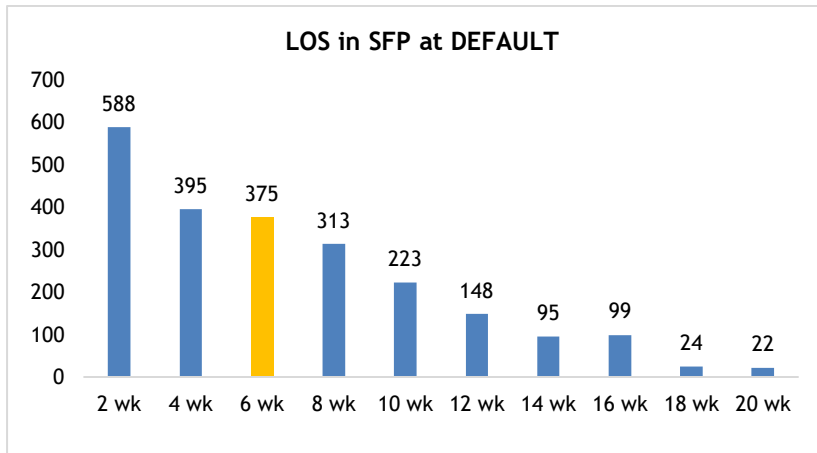


Figure 93: Median Length of Stay in SFP at Default in Kajiado County

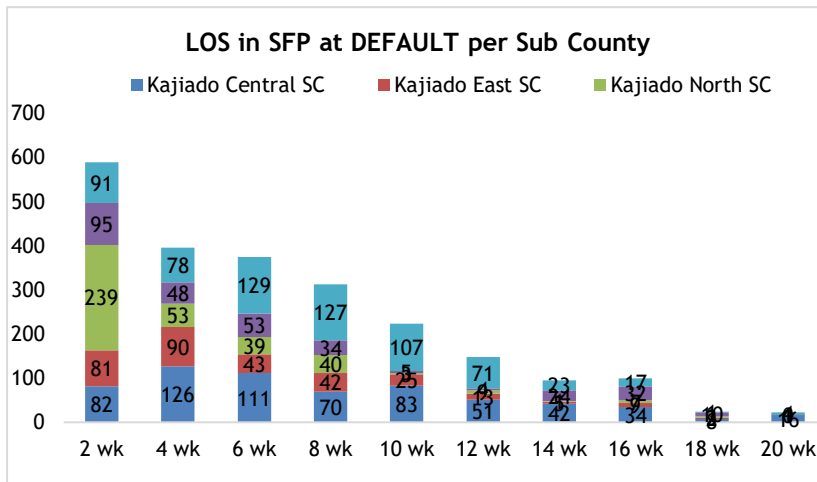


Figure 94: Length of Stay in SFP at Default per Sub County

### Exit Outcome - Defaulting

#### *Proportion of Children Defaulting against Total Admissions*

High proportion of children defaulting from SFP compared to the total admissions in Kajiado County. All Sub counties performing poorly except Kajiado West. High proportion of defaulting is an indication of poor client retention mechanisms in the health facilities.

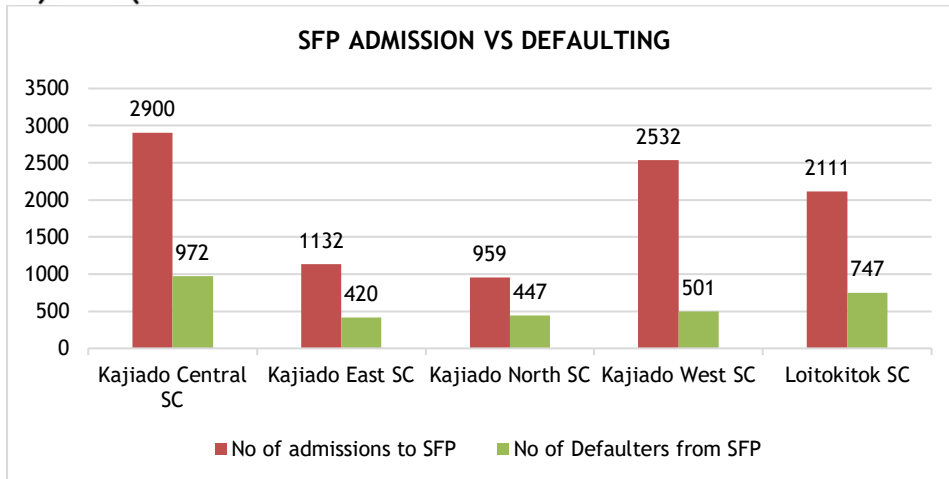


Figure 95: Number of cases admitted versus those defaulting from SFP

Table 7: Proportion Defaulting out of those admitted in SFP

Sub County	%Defaulting from SFP out of those admitted
Central	34%
East	37%
North	47%
West	20%
Loitokitok	35%

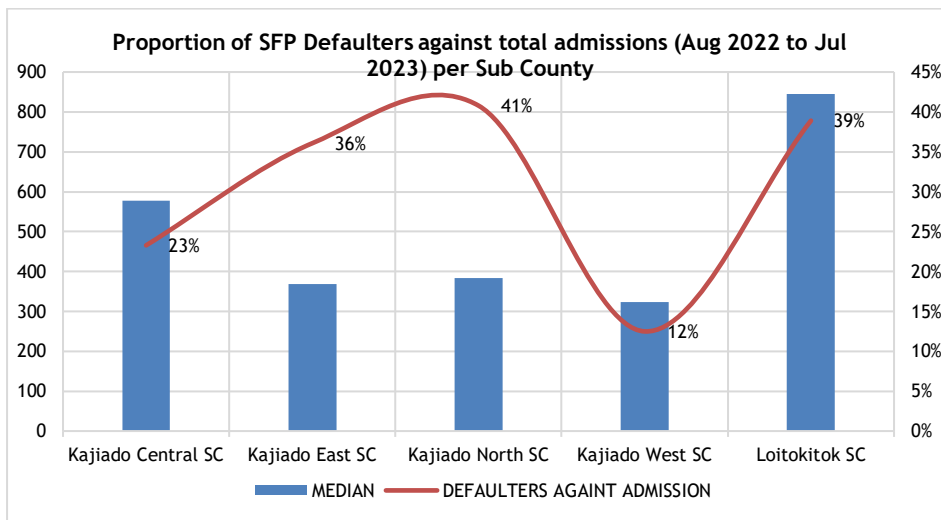


Figure 96: Proportion of SFP Defaulters against total admissions (Aug 2022 to Jul 2023)

High proportion of children defaulting from SFP compared to the total admissions health facilities in Kajiado Central. The health facilities with the highest proportion are Emotoroki, Imarba, Kajiado CRH, Kumpa CMF and Olelleshwa. This is an indication of poor client retention mechanisms in the health facilities.



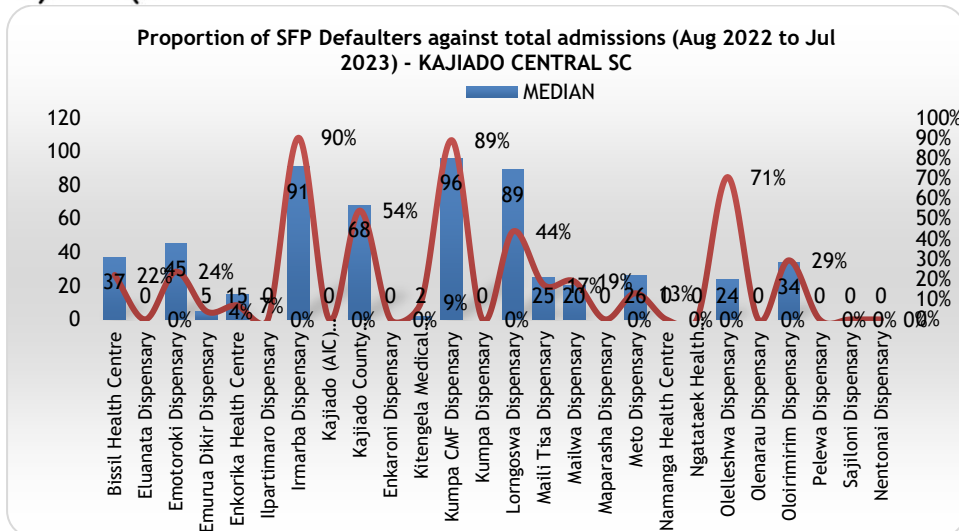


Figure 97: Proportion of SFP Defaulters against total admissions (Aug 2022 to Jul 2023) - CENTRAL SC

High proportion of children defaulting from SFP compared to the total admissions Health Facilities in Kajiado East. The facilities with the highest proportion are Emaroro, Ilkilinyet, Ereteti, Isinya, Kima, Merueshi, Oloibor Ajjik and Olturoto. High defaulting is an indication of poor client retention mechanisms in the health facilities.

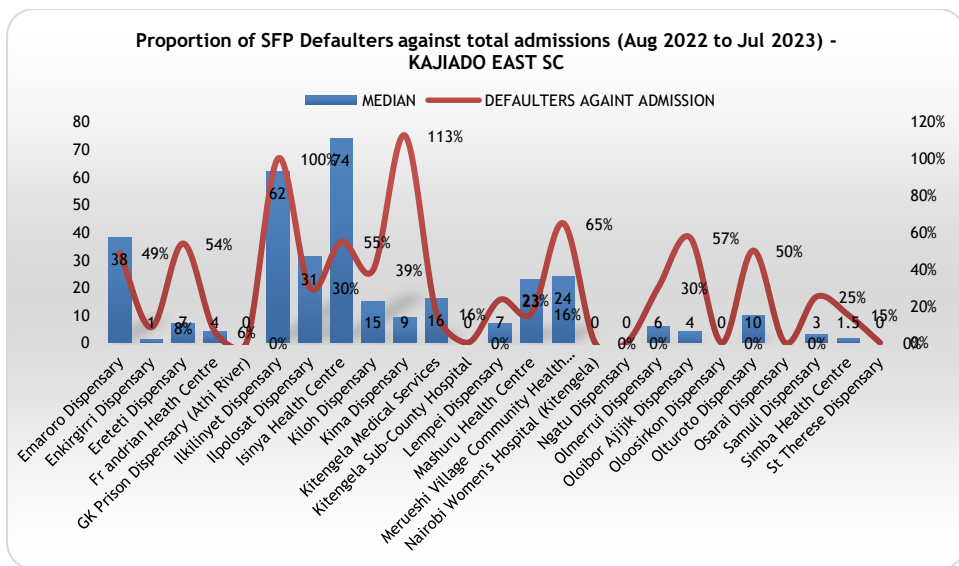


Figure 98: Proportion of SFP Defaulters against total admissions (Aug 2022 to Jul 2023) - EAST SC

High proportion of children defaulting from SFP compared to the total admissions Health Facilities in North Sub County. The H/Fs with the highest proportion are Embulbul, Matasia and Ngong' SCH. The high proportion of defaulting are an indication of poor client retention mechanisms in the health facilities.

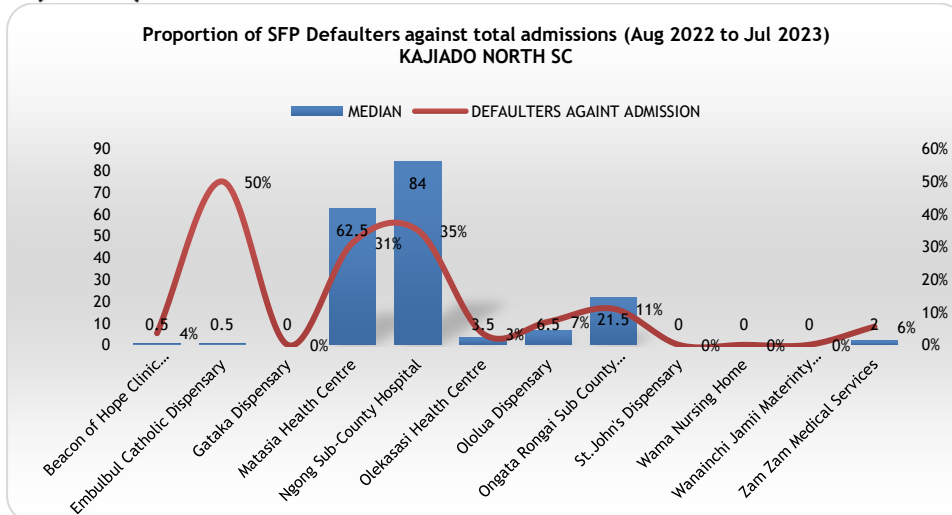


Figure 99: Proportion of SFP Defaulters against total admissions (Aug 2022 to Jul 2023) - NORTH SC

High proportion of children defaulting from SFP compared to the total admissions in Health Facilities in Kajiado West Sub County. The Health Facilities with the highest proportion are Kilonito, Ewuaso Kedong', Mile 46 and St. Mary's Health Center. The high proportion of defaulting are an indication of poor client retention mechanisms in the health facilities.

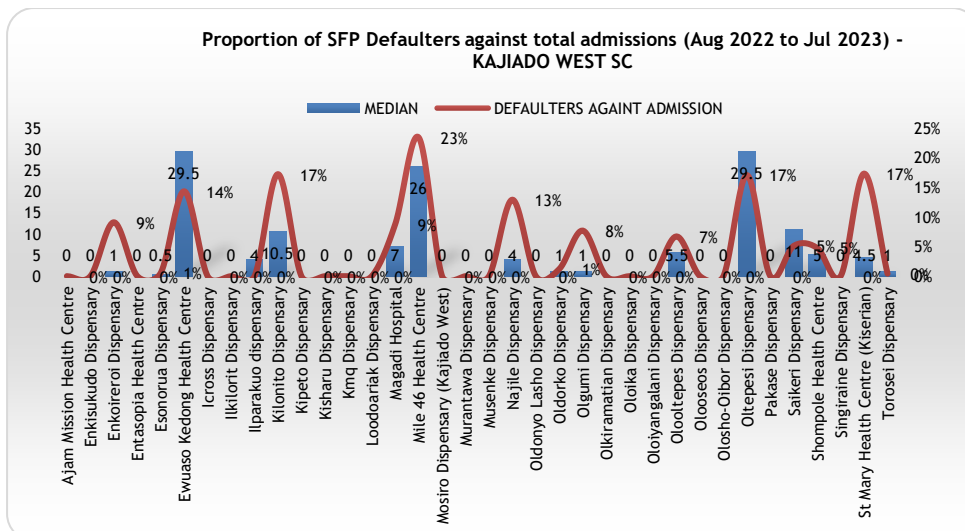


Figure 100: Proportion of SFP Defaulters against total admissions (Aug 2022 to Jul 2023) - WEST SC

High proportion of children defaulting from SFP compared to the total admissions Health Facilities in Loitoktok Sub County. The Health Facilities with the highest proportion are Immurtot H/C, Emumwenyi, Entarara, Lang'ata Enkima and Oloolakir. The high proportion of defaulting are an indication of poor client retention mechanisms in the health facilities.

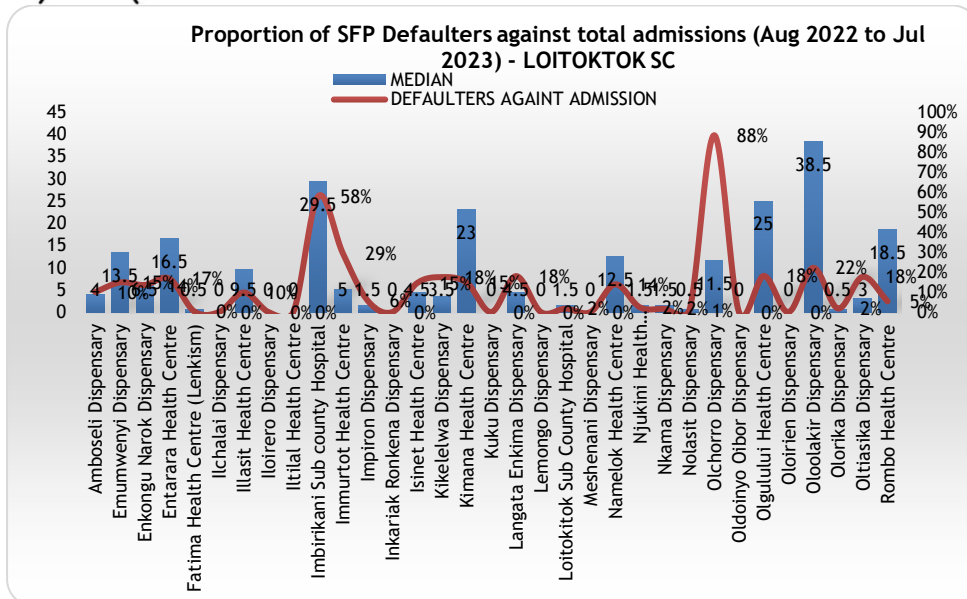


Figure 101: Proportion of SFP Defaulters against total admissions (Aug 2022 to Jul 2023) - LOITOKTOK

## IMAM PROGRAM COMMODITY STOCK STATUS

Availability of commodities for management of acute malnutrition in the service delivery point directly affects IMAM program coverage. Frequent commodity stock outs are highly associated with absenteeism and defaulting, hence poor program outcome. ACT, RUSF and CSB commodities had a high average stock out in weeks during the reporting period. RUSF and CSB commodities had the highest no. of weeks of stock out at an average of 4.8 and 6.9 weeks respectively (August 2022 to July 2023). Cumulatively, 28 and 68 health facilities in Kajiado County reported RUTF and RUSF stock out at least once in the past twelve months (August 2022 and July 2023).

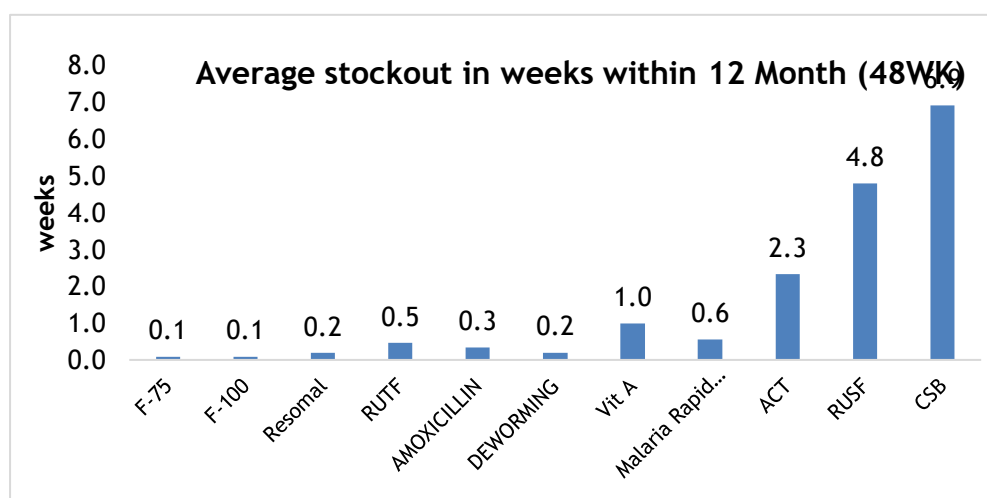


Figure 102: Average stock out in weeks within 12 months

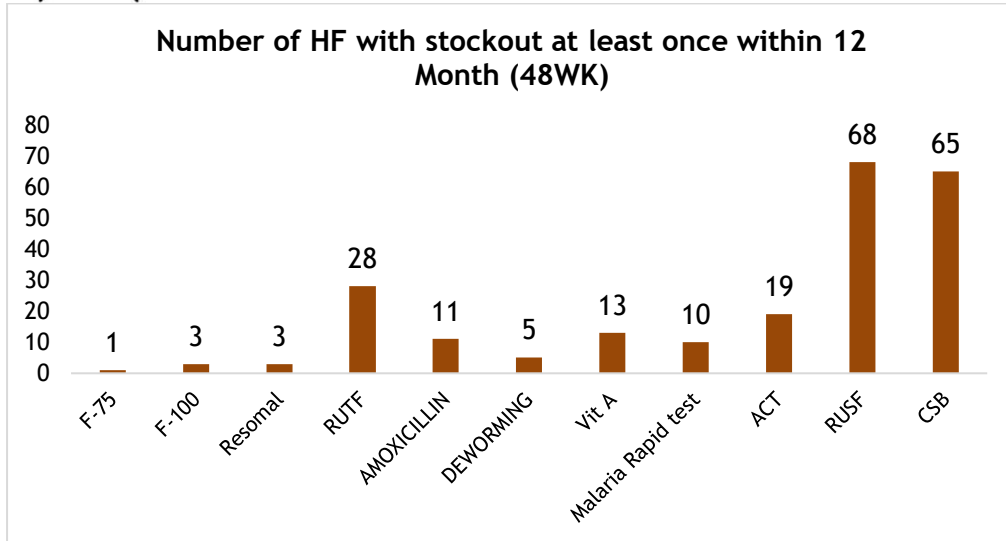


Figure 103: HF with stock out at least once within 12 Month

### RUTF Stock Status

**Kajiado Central** majorly reported RUTF stock out in August and September 2022, and Jun 2023. The health facilities reporting stock out in **Kajiado Central** were *Kitengela Medical*. The health facilities reporting stock out in **Kajiado East** is *Mashuru and Oloosirkon*. Those reporting stock out in **Kajiado North** is *Embulbul and Ongata Rongai*. health facilities reporting stock out in **Kajiado West** is *Enkoireroi, Murantawa, Oloiyangalani, Singiraine* H/Fs reporting stock out in **Loitokitok** is *Kikelelwa*.

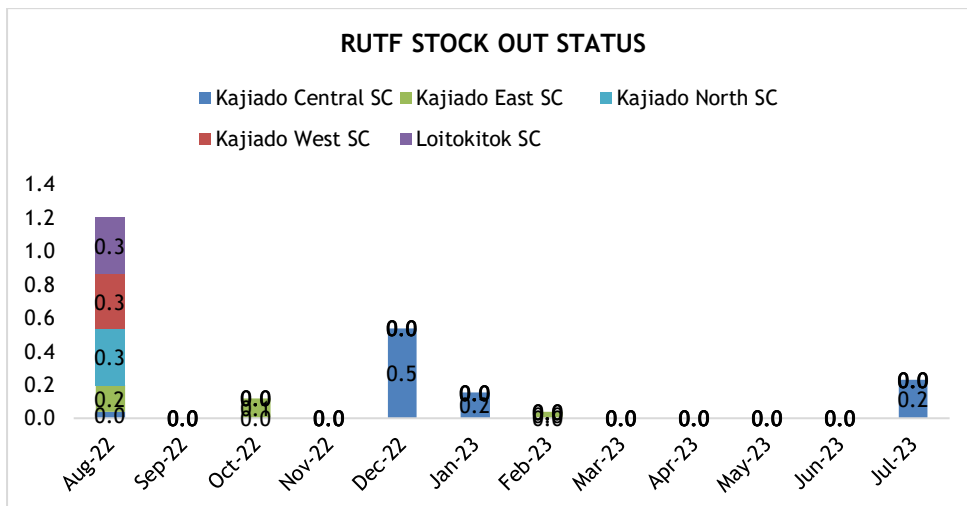


Figure 104: RUTF Stock status - Aug 2022 to July 2023

### RUSF Stock Status

All the sub counties reported some RUSF stockout with major stockouts being reported in August & September 2022. Health facilities reporting stock out in **Kajiado Central** were *Emurua Dikir, Enkorika, Ilpartimaro, Imarba, Kajiado (AIC), Kajiado CRH, KMS, Kumpa CMF, Longoswa, Maili Tisa, Maliwa, Meto, Ngatataek, Olenarau, Olorimrim, Sajilioni, Nentonai, Emaroro, Kitengela Medical*. Health facilities reporting stock out in **Kajiado East** is *Mashuru, Ngatu, Oloosirkon*. Health facilities reporting stock out in **Kajiado North** is *Embulbul, Matasia, Ongata Rongai, Wama Nursing Home*. Health facilities reporting stock out in **Kajiado West** is *Enkisukudo, Mile 46, Oloiyangalani, Singiraine, Torosei, Saikeri*. Health



facilities reporting stock out in **Loitokitok is Amboseli, Enkong', Fatima HC, Iloirero, Imbirikani, Kikelelwa, Loitokitok SCH, Namelok HC, Nkama, Olchorro, Oloolakiri, Olorika.**

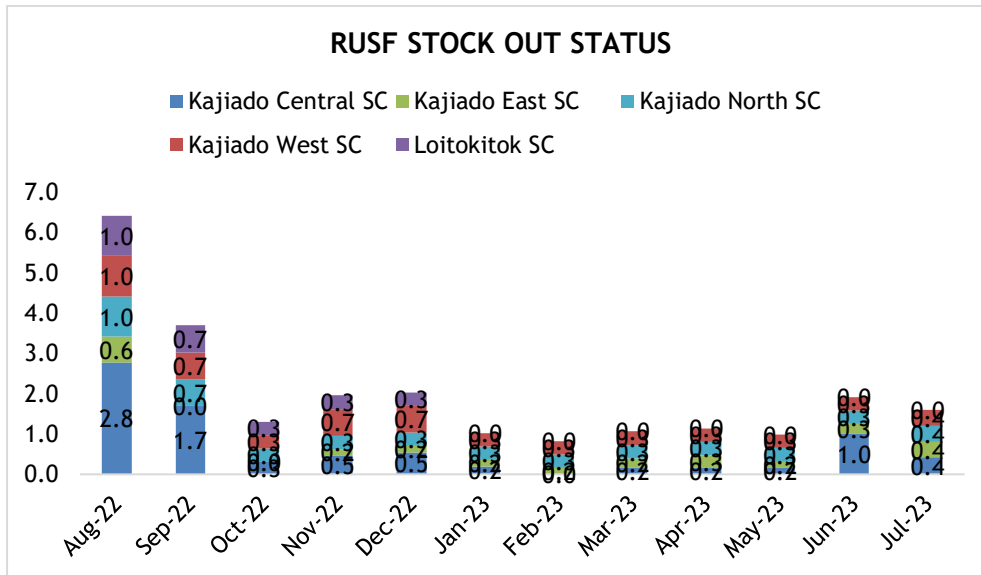


Figure 105: RUSF Stock status - Aug 2022 to July 2023

## QUANTITATIVE DATA ANALYSIS

### Overview of the Qualitative Data Analysis Process

Qualitative data was collected through different methods using structured questions to investigate the patterns identified in the Quantitative data from different sources in the community. A variation of methods was used for triangulation to ensure reliability of information acquired therefore, establishing the barriers and boosters to access to treatment / of program coverage. Observations were also made during the investigation process to further confirm information received through interviews conducted. Data was further organized using the Boosters, Barriers, and Question (BBQ) approach, where questions were the issues that needed further investigation to be classified as either boosters or barriers.

### Sampling for Data Collection

Purposive sampling was used based on the findings of Quantitative data analysis on areas of High and Low Coverage. Data was collected through triangulation by source and method from the sampled sites. Boosters and barriers to IMAM program coverage were established through the BBQ (Boosters, Barriers and Questions) tool. The following areas were covered;

- Understanding of malnutrition and knowledge of the signs of malnutrition
- Pathways to health care and Knowledge on the existence of treatment
- Appreciation of the service and quality of the care
- Community mobilization
- Barriers and boosters to access and coverage
- Perception of coverage



**Table 8: Sites sampled for Qualitative Data collection**

	CENTRAL	SOUTH	EAST	WEST	NORTH
<i>Level 5 facilities</i>	KCRH				
<i>Level 4 facilities</i>		MBIRIKANNIHC LOITOTOK SC	MASHUURU KITENGELA SC		RONGAI SCRH NGONG SC
<i>Level 3 facilities</i>	BISSIL HC NAMANGA NGATATAEK	KIMANA ENTARARA		EWASO HC ENTASOPIA HC SHOMPOLE	OLEKASASI MATASIA
<i>Level 2 facilities</i>	EMURUA DIKIRR IMARBA AIC KAJIADO METO	ENKEJU NAROK ISINET OLCHORRO OLORIKA	IMARORO ILKILUNYETI KIMA SAMULI	ILOIRERO ESONORUA MARANTAWUA MUSENKENKE	EMBULBUL OLOLUA GATAKA WAMA

**Organization of the teams and sites to visit during data collection process**

Nine (9) teams were organized to conduct the qualitative data collection in 37 sites across Kajiado County for a period of four days. Daily meetings after a day's data collection were held by the teams to discuss the findings and listing of the Boosters, Barriers and Questions (BBQ). From the plenary sharing of experiences and areas to improve in data collection skills, it was found out that there were scenarios of missed opportunities for probing. Listing of the BBQs from the data collected enabled triangulation of data by source and method. Each booster and barrier were marked with symbols for the sources and abbreviations for the methods used to collect the data to ensure that the findings have been validated. Questions and issues that need to be resolved by additional data collection, including findings that have not been confirmed by triangulation were listed in Question section.

**Table 9: Local Terms for malnutrition and IMAM commodities**

<i>Local Terms for Malnutrition - Maasai Language</i>	<i>Local Names of Nutrition Commodities</i>
Mamboleo - Marasmus Esas - Wasting Enkutu/Enkunyenyeye - Malnutrition Kenana - Weak Kwashokoo - Kwashiakor Keshal - Lethargy Kerongai - Slim Kenyaala - Sickly Menati - Moderate Acute Malnutrition Enkumanke - Stunted Growth Kebebek - Weak Entiamput - Malnutrition	Blambinats - Somali Lambalamba - RUSF/RUTF/LNS Chokobaa - RUSF/RUTF/LNS Peanut - RUSF/RUTF/LNS Enkurma Oo Ngera/CSB Enkurma Oloshoro - Uji Sintila - RUSF/RUTF/LNS Plambusus - RUSF/RUTF/LNS Naitil - LNS Biskuti - RUSF/RUTF/LNS Naironyuni - RUSF/RUTF/LNS Eilata Eeh Nkerai Namelok-Sweet Plambinet - RUSF/RUTF/LNS



## Qualitative Data Analysis findings - Boosters and Barriers definition compilation

**Table 10: Legends for qualitative data source and method**

Key	Source	Key	Method
A	Caregiver Of U5	1	Key Informant Interview (KII)
B	Carer Of SAM In Program	2	Focused Group Discussion (FGD)
C	Carer Of MAM In Program	3	Observation
D	Carer Of SAM Cured	4	Informal Group Discussion (IGD)
E	Carer Of MAM Cured	5	In-depth Interview (IDI)
F	Carer Of SAM Defaulter	6	Semi Structured Interview (SSI)
G	Carer Of MAM Defaulter		
H	Carer Of SAM Non-Respondent		
I	Carer Of MAM Non-Respondent		
J	MtMSGs		
K	Community Leaders (Chief, MCA, Ward Admin, Village Elder, <i>Nyumba kumi</i> )		
L	Religious Leader/Pastor/Sheikh		
M	Lay Person (Shop Attendant, Grocery Attendant, Bodaboda)		
N	CHP (CHV)		
O	HCP (Nutritionist, Nurse, CHA)		
P	HPM (SCNO, SCHRIO, Med Sup)		
Q	TBA/THP		
R	Chemist		
S	Teacher		
T	UN/NGO Field Staff		

**Table 11: A summary of the interviews conducted by Source and Method**

Source	Method	Day 1	Day 2	Day 3
Health Program Manager (HPM)	KII	2	8	9
Health Care Provider (HCP)	KII	8	12	11
CHV - Community Based	KII	12	18	16
CHV - Facility Based	KII	8	12	10
Carer - SAM Beneficiary - Individual	IDI	9	9	9
Carer - SAM Beneficiary - Group	FGD	2	9	9
Carer - MAM Beneficiary - Individual	IDI	10	14	16
Carer - MAM Beneficiary - Group	FGD	3	9	9
Carer - Cured SAM Beneficiary - Individual	IDI	3	6	9
Carer - Cured MAM Beneficiary - Individual	IDI	1	2	0
Carer - Defaulted SAM case - Individual	IDI	3	12	10
Carer - Defaulted MAM case - Individual	IDI	6	8	12
Carer - Non-Respondent SAM Case - Individual	IDI	2	3	7
Carer - Non-Respondent MAM Case - Individual	IDI	8	6	9
Carer of any Under-five - Individual	KII	12	14	9



Lay person - mother/father/Retired Teacher or police	KII	5	8	7
MtMSG Women	FGD	0	2	3
Traditional Healing Practitioner or Birth Attendant (THP/TBA)	SSI	9	6	8
Religious Leader	SSI	9	9	6
Community Leaders (Chief/Elder/Nyumba Kumi/Ward Rep)	SSI	10	9	8
Shop Attendant	KII	2	1	2
Chemist Attendant	KII	2	1	4

**Table 12: Definition of the Identified Boosters in Kajiado IMAM Program**

Booster	Source (Method)
<b>HEALTH SEEKING BEHAVIOUR</b>	
1. Some TBAs observed to promote positive health care practices including support for IMAM attendance, referral of some cases and child spacing. TBAs accompanying caregivers to the H/F and pregnant mothers to deliver in the H/F	Q <sup>6</sup> (1), N <sup>4</sup> (1)
<b>AWARENESS OF MALNUTRITION &amp; MALNUTRITION SIGNS</b>	
2. Community members can identify malnutrition and signs	N <sup>42</sup> (1,2), A <sup>2</sup> (5), C <sup>11</sup> (2),
3. some caregivers were said to be informing CHVs/HCWs of malnourished children in the community	C <sup>10</sup> (2), E <sup>2</sup> (5), L <sup>7</sup> (1), S <sup>4</sup> (1), K <sup>7</sup> (1), R, Q <sup>5</sup> .
<b>AWARENESS OF MALNUTRITION TREATMENT (PROGRAM, BASIC TREATMENT CRITERIA)</b>	
4. Community members (TBAs, Chiefs, Village Admin, mothers aware of IMAM treatment program	Q <sup>1</sup> (1), B <sup>5</sup> (1), C <sup>3</sup> (1), D <sup>4</sup> (1), E <sup>6</sup> (1), K <sup>5</sup> (1), R <sup>3</sup> (1), S <sup>2</sup> (1)
5. Awareness creation on IMAM program to the community (by CHVs and HCWs, through community barazas, in the H/Fs, through Radios - Mayian FM)	A <sup>5</sup> (5), K <sup>6</sup> (6), N <sup>44</sup> (5), O <sup>29</sup> (1)
6. Caregivers getting information on IMAM program from peers (other caregivers, carers of current beneficiaries or cured cases)	B <sup>4</sup> (5), C <sup>5</sup> (4), D <sup>1</sup> (1), E <sup>1</sup> (1)
<b>AVAILABILITY AND ACCESSIBILITY OF IMAM SERVICES</b>	
7. Nearness to the IMAM sites especially in Urban settlements	B <sup>7</sup> (4), C <sup>26</sup> (1,2), E <sup>4</sup> (1), F <sup>1</sup> (5), G <sup>2</sup> (5), I <sup>1</sup> (5), A <sup>1</sup> (1), N <sup>3</sup> (1), K <sup>1</sup> (1), L <sup>1</sup> (1), 3
8. Availability of outreach activities in the hard-to-reach areas	N <sup>14</sup> (1), A <sup>4</sup> (1), O <sup>8</sup> (1), B <sup>8</sup> (5), E <sup>3</sup> (5)
<b>CASE IDENTIFICATION/REFERRAL/ENROLLMENT/TRANFERS/FOLLOW UP STRATEGY</b>	
9. Implementation of the family MUAC approach in some CUs promoting self-referral	C <sup>28</sup> (1,2), B <sup>4</sup> (1,2),
10. Exhaustive Mass screening during the drought emergency helped identify cases	O <sup>23</sup> (1), N <sup>29</sup> (1), P <sup>5</sup> (1), B <sup>3</sup> (5), C <sup>5</sup> (2,5)
11. CHVs have MUAC tapes for screening malnutrition	N <sup>34</sup> (1,2), A <sup>11</sup> (1), B <sup>13</sup> (2,5), C <sup>39</sup> (2,5), K <sup>8</sup> (6), J <sup>16</sup> (2), Q <sup>4</sup> (1), L <sup>1</sup> (1)
<b>REFERRALS AND FOLLOW UP</b>	
12. In some areas CHVs accompanying clients to health facility	N <sup>27</sup> (1), Q <sup>3</sup> (1)
13. Caregivers return of the referral slip to the CHV as evidence of visit to Health Facility	O <sup>8</sup> (1), N <sup>7</sup> (1), K <sup>3</sup> (6), L <sup>5</sup> (1)
14. Use of local administration to enhance referrals: in some areas, community leaders avail resources like transport	N <sup>5</sup> (1), K <sup>8</sup> (6), L <sup>2</sup> (1)
<b>COMMUNICATION</b>	
<b>CLIENT RETENTION STRATEGY</b>	
15. Some defaulter tracing	





<ul style="list-style-type: none"> <li>There is a list of defaulters developed and shared with CHVs for follow up</li> <li>HCW Document contacts of caregivers, their spouses/CHVs/neighbors for follow up</li> <li>Some key opinion leaders are involved in defaulter tracing</li> </ul>	O <sup>11</sup> (1),(3), O <sup>1</sup> (1), (3), B <sup>1</sup> (5), C <sup>2</sup> (5), G <sup>1</sup> (5), K <sup>6</sup> (6)
16. In some health facilities IMAM clients are given 1 <sup>st</sup> priority for treatment.	O <sup>1</sup> (1), C <sup>2</sup> (5)
17. There is some flexibility on IMAM service delivery days: when caregivers come for services	O <sup>18</sup> (1), C <sup>30</sup> (2,5),
<b>OPINION OF IMAM SERVICES IN THE COMMUNITY</b>	
18. Appreciation from the community that IMAM services are free and closer to the community	O <sup>16</sup> (1), C <sup>47</sup> (5), N <sup>49</sup> (1), K <sup>8</sup> (6), Q <sup>5</sup> (1), L <sup>5</sup> (1), D <sup>9</sup> (5), P <sup>8</sup> (1)
19. Caregivers appreciating the information and treatment they received from HCW during IMAM treatment.	C <sup>13</sup> (2,5), J <sup>21</sup> (2), B <sup>9</sup> (2)
20. IMAM program is curing children: Reports of improvement of the health condition of the beneficiaries i.e., weight gain, improved appetite and developmental milestones. Caregivers promoting the benefits of the program since it has helped them	O <sup>18</sup> (1), C <sup>58</sup> (2,5), N <sup>49</sup> (1), K <sup>8</sup> (6), Q <sup>5</sup> (1), L <sup>5</sup> (1), E <sup>2</sup> (5), D <sup>13</sup> (5), P <sup>8</sup> (1)
21. Consistent availability of IMAM commodities in the health facilities	B <sup>9</sup> (5), C <sup>28</sup> (2,5), D <sup>6</sup> (5), E <sup>11</sup> (2,5), G <sup>5</sup> (5), I <sup>1</sup> (5), O <sup>17</sup> (1)
<b>CAPACITY OF THE HEALTH FACILITY TO PROVIDE QUALITY SERVICE</b>	
22. Most HCW trained/sensitized and experienced on IMAM service delivery	O <sup>23</sup> (1), P <sup>5</sup> (1)
23. Most CHVs sensitized on IMAM services	N <sup>7</sup> (1)
24. Availability of nutritionists dedicatedly supporting IMAM service delivery in the facility	A <sup>2</sup> (1), O <sup>2</sup> (1), C <sup>19</sup> (2,5), B <sup>6</sup> (2)
25. Regular support supervision of the HCPs from the SCHMT & CHMT	O <sup>26</sup> (1), P <sup>5</sup> (1)

**Table 13: Definition of the Identified Barriers in Kajiado IMAM Program**

Barrier	Source (Method)
<b>HEALTH SEEKING BEHAVIOUR</b>	
1. Self-medication/ buying medicine at the chemist as reported by most caregivers	B <sup>17</sup> (2,5), C <sup>23</sup> (2,5), R <sup>9</sup> (5), N <sup>8</sup> (1)
2. THPs treating children with severe malnutrition before referral using herbs: treatment characterized with Brutal/lethal treatment including skin cutting, use of goat urine and steaming with herbs. THPs referring severely malnourished cases to other THPs for further consultation: Children with severe wasting are referred to Tanzania as well as caregivers are also advised by peers to refer their children with Complicated SAM to THPs	Q <sup>6</sup> (1), B <sup>2</sup> (5), C <sup>3</sup> (5), M <sup>4</sup> (1), K <sup>5</sup> (6)
3. THPs discourage caregivers from using Conventional medicines. THPs claim that the medicines are full of chemicals and so caregivers are discouraged to avoid mixing of medicines with herbs	Q <sup>6</sup> (1), A <sup>7</sup> (1), B <sup>2</sup> (5), C <sup>3</sup> (5)
4. Some caregivers prefer taking their children for prayers first before being taken to the health facility	A <sup>2</sup> (6), B(2), L <sup>3</sup> (6), M <sup>1</sup> (6), N <sup>2</sup> (6), 3
<b>AWARENESS OF MALNUTRITION &amp; MALNUTRITION SIGNS</b>	
5. Some community members are not aware of malnutrition	Q <sup>2</sup> , L <sup>7</sup> (1), S <sup>2</sup> (1)
6. A lot of stigma associated with malnutrition <ul style="list-style-type: none"> <li>Mothers perceived not able to take care of their children</li> <li>Associated with laziness</li> <li>Associated with HIV positive people</li> <li>Associated with a particular community *Turkana people*</li> <li>Associated with marital 'unfaithfulness'</li> <li>Poor households</li> </ul>	S <sup>2</sup> (1), C <sup>2</sup> (2), L <sup>3</sup> (1), K <sup>4</sup> (6), N <sup>3</sup> (1), Q(5), A <sup>4</sup> (1)



<ul style="list-style-type: none"> <li>Malnutrition is a curse - children have to undergo cleansing</li> <li>In some communities, children with malnutrition are not supposed to be brought out as they are a 'bad luck' to the community</li> </ul>	
<b>7. Negligence/ignorance by caregivers</b> <ul style="list-style-type: none"> <li>child left under the care of their grandmother</li> <li>alcoholic mothers</li> <li>Most malnourished cases found in day cares, slum-like settlements, casual workers in industries/schemes</li> <li>Refusal by partner to go to the health facility to access IMAM services</li> </ul>	L <sup>2</sup> (1), P <sup>1</sup> (1), C <sup>1</sup> (5), S <sup>1</sup> (1), K <sup>4</sup> (6),
<b>AWARENESS OF MALNUTRITION TREATMENT (PROGRAM, BASIC TREATMENT CRITERIA)</b>	
<b>8. Community members</b> (Religious Leaders, Chemist attendant, Teachers, THPs, local leaders, lay persons) <b>not aware of basic IMAM treatment protocols</b>	Q <sup>10</sup> (1), S <sup>4</sup> (5), M <sup>8</sup> (1), K <sup>3</sup> (6), R <sup>2</sup> (1)
<b>9. Community leaders not sensitized on, neither are they involved in IMAM activities</b>	K <sup>26</sup> (6), S <sup>1</sup> (1), L <sup>16</sup> (1)
<b>10. Malnutrition services are not prioritized in the community HEDU</b>	K <sup>8</sup> (6), L <sup>7</sup> (1), M <sup>10</sup> (1)
<b>AVAILABILITY AND ACCESSIBILITY OF IMAM SERVICES</b>	
<b>11. Long distance to the IMAM sites</b>	B <sup>26</sup> (2,5), C <sup>35</sup> (2,5), D <sup>13</sup> (1), E <sup>10</sup> (1), F <sup>12</sup> (5), G <sup>10</sup> (5), I(5), N <sup>18</sup> (1,2), O <sup>16</sup> (1), K <sup>10</sup> (6), L(1), Q <sup>1</sup> (1)
<b>12. Inconsistent outreach activities and closure of some of the sites due to short term donor funding</b>	B <sup>2</sup> (5), L <sup>1</sup> (1), O <sup>10</sup> (1), N <sup>34</sup> (1,2), F <sup>10</sup> (5), G <sup>8</sup> (5),
<b>13. High treatment cost</b> <ul style="list-style-type: none"> <li>Some claim to pay for the services</li> <li>High transport cost to and from the sites</li> <li>Opportunity cost - time spent to seek for IMAM services could be channeled to other priorities</li> </ul>	A <sup>26</sup> (1), B <sup>8</sup> (5), C <sup>60</sup> (5), E <sup>5</sup> (1), F <sup>12</sup> (5), G <sup>12</sup> (5), H <sup>2</sup> (5), I <sup>1</sup> (5), K <sup>9</sup> (1), L <sup>3</sup> (1), S <sup>1</sup> (1), M <sup>6</sup> (1), O <sup>15</sup> (1), N <sup>36</sup> (1), P <sup>6</sup> (1)
<b>14. Maternal Workload</b> <ul style="list-style-type: none"> <li>No one to leave the other children with</li> <li>Caregivers have to take the animals to grazing and water fetching</li> <li>Working mothers (employed, casual)</li> <li>Pregnancy versus distance:</li> <li>Spouse sick and cannot be left alone</li> <li>Household chores</li> </ul>	B <sup>1</sup> (5), F <sup>1</sup> (5), O <sup>1</sup> (1), C <sup>19</sup> (2,5), I(5), G <sup>3</sup> (5), F <sup>1</sup> (5), O(1), H <sup>1</sup> (5), S <sup>1</sup> (1)
<b>15. Human wildlife conflict</b>	K <sup>1</sup> (1), A <sup>1</sup> (1), O <sup>2</sup> (1), N <sup>2</sup> (1), B <sup>2</sup> (5), C <sup>5</sup> (5), S <sup>1</sup> (1), Q <sup>1</sup> (1)
<b>16. Carer too ill to take child for revisit clinics</b>	C <sup>13</sup> (1,2), F <sup>1</sup> (5), A <sup>1</sup> (1)
<b>17. Program not flexible for school going children</b>	G <sup>1</sup> (5), C <sup>1</sup> (5), N <sup>2</sup> (1)
<b>18. Migration especially among the nomadic community and movement to other towns</b>	O <sup>10</sup> (1), G <sup>2</sup> (5), B <sup>2</sup> (5), N <sup>7</sup> (1), K <sup>2</sup> (6), A <sup>1</sup> (1), F <sup>1</sup> (5), P <sup>1</sup> (1)
<b>19. Cross boarder/common boarder challenges;</b> beneficiaries defaulting from one IMAM site and becoming new admissions in another site. Some are active beneficiaries in more than one site	P <sup>1</sup> (1), O <sup>6</sup> (1), N <sup>7</sup> (1), 3
<b>20. Poor infrastructure</b> (road cut off during rainy season) affecting access to IMAM sites	K <sup>3</sup> (1), L <sup>1</sup> (1), G <sup>4</sup> (5), M <sup>2</sup> (1), C <sup>2</sup> (5), B <sup>2</sup> (5) N <sup>2</sup> (1), O <sup>1</sup> (1)
<b>CASE FINDING BY CHVs AND ENROLLMENT</b>	
<b>21. Most CHVs not conducting regular screening for malnutrition:</b> most caregivers and community leaders not able to recall last contact with CHV	I <sup>2</sup> (1), F <sup>2</sup> (1), C <sup>16</sup> (1), O <sup>6</sup> (1), D <sup>3</sup> (1), E <sup>2</sup> (5), A <sup>2</sup> (1), M <sup>3</sup> (1), Q <sup>1</sup> (1), G <sup>2</sup> (5), N <sup>29</sup> (1), N <sup>22</sup> (1), O <sup>24</sup> (1), P <sup>6</sup> (1)
<b>22. Most CHVs not trained neither sensitized on IMAM service delivery;</b> CHVs recommended for training and refresher training	
<b>23. Hostility from some communities and inaccessibility of some households by CHVs especially to gated communities in the urban areas.</b> Others facing hostility from some of the community thinking that CHVs are biased especially when not targeted for cash transfer program. Other	N <sup>15</sup> (1,2), J <sup>35</sup> (5), B <sup>25</sup> (1,2), C <sup>44</sup> (1,2),



caregivers want incentives whenever CHVs do mobilization for mass screening, MtMSG, etc.	
24. CHVs not having adequate resources (transport, airtime, stipend) to carry out their duties. CHVs not having access to tools for screening and referral	N <sup>58</sup> (1,2)
<b>REFERRALS/ follow up</b>	
25. CHVs biasness towards actively supporting programs with incentives (HIV/AIDS, TB, Malaria etc.)	N <sup>42</sup> (1,2)
26. Wrong referrals to the clinic/knowledge gap on admission/discharge criteria	N <sup>11</sup> (1), O <sup>18</sup> (1),P <sup>1</sup> (1)
<b>COMMUNICATION</b>	
27. No regular meetings between CHVs and HCPs concerning IMAM with little emphasis is given in IMAM program upon contact between CHVs and HCWs	N <sup>45</sup> (1), O <sup>5</sup> (1)
<b>CLIENT RETENTION STRATEGY</b>	
28. Long waiting hours for IMAM services	O <sup>5</sup> (1), C <sup>8</sup> (5), B <sup>4</sup> (2), G <sup>1</sup> (5),
30. No defaulter tracing in the facility	(3), O <sup>7</sup> (1), G <sup>4</sup> (5), F <sup>1</sup> (5), N <sup>4</sup> (1)
31. Non-existent or non-functional community health units	O <sup>3</sup> (1),P <sup>1</sup> (1),S <sup>1</sup> (1),K <sup>1</sup> (6)(3),
<b>OPINION OF IMAM SERVICES IN THE COMMUNITY</b>	
32. Perception that RUTF causes diarrhea, allergies	O <sup>1</sup> (1), C <sup>1</sup> (5), F <sup>1</sup> (5), B <sup>3</sup> (5),
33. Misuse of ration i.e. sharing and selling; Most community members not appreciating commodity as medicine	B <sup>4</sup> (5), C <sup>33</sup> (2,5), I <sup>3</sup> (5), H <sup>1</sup> (5), N <sup>4</sup> (1), 5(1), M <sup>5</sup> (1), K <sup>1</sup> (6), 3, A <sup>7</sup> (1), J <sup>15</sup> (2), Q <sup>6</sup> (1),
34. Caregiver feeling that the child is not improving	F <sup>1</sup> (5), B <sup>4</sup> (5) C <sup>2</sup> (5), G <sup>2</sup> (5)
<b>CAPACITY OF THE HEALTH FACILITY TO PROVIDE A QUALITY SERVICE</b>	
35. Understaffing with high workload: fewer staff	O <sup>17</sup> (1), P <sup>8</sup> (1), N <sup>1</sup> (1), N <sup>10</sup> (1), O <sup>12</sup> (1), K(6) <sup>1</sup>
36. Absenteeism of health care workers	C <sup>8</sup> (2,5), L <sup>1</sup> (1), P <sup>1</sup> (1), B <sup>5</sup> (5)
37. Poor documentation - wrongly filled registers and incomplete details	3, O <sup>12</sup> (1), P <sup>1</sup> (1)
38. Lack of program ownership by the health care workers	O <sup>1</sup> (1), P <sup>3</sup> (1)

### BBQ Analysis for Severe Acute Malnutrition Treatment Program:

Table 14: The List of Boosters in SAM Treatment Program

Booster	Source (Method)	Weight (0 - 4)
1. Some TBAs observed to promote positive health care practices	Q <sup>6</sup> (1), N <sup>4</sup> (1)	1
2. Community members can identify malnutrition and signs, and inform CHVs/HCWs of malnourished children in the community	N <sup>42</sup> (1,2), A <sup>2</sup> (5), C <sup>11</sup> (2), C <sup>10</sup> (2), E <sup>2</sup> (5), L <sup>7</sup> (1), S <sup>4</sup> (1), K <sup>7</sup> (6), R <sup>2</sup> (1), Q <sup>6</sup> (6)	3
3. Community members are aware of IMAM treatment program	Q <sup>1</sup> (1), B <sup>5</sup> (5), C <sup>3</sup> (5), D <sup>4</sup> (5), E <sup>6</sup> (5), K <sup>5</sup> (6), R <sup>3</sup> (1), S <sup>2</sup> (1)	3
Awareness creation on IMAM program to the community	A <sup>5</sup> (5), K <sup>6</sup> (6), N <sup>44</sup> (5), O <sup>29</sup> (1)	2
5. Caregivers getting information on IMAM program from peers	B <sup>4</sup> (5), C <sup>5</sup> (4), D <sup>1</sup> (1), E <sup>1</sup> (1)	2
6. Nearness to the IMAM sites especially in Urban settlements	B <sup>7</sup> (4), C <sup>26</sup> (1,2), E <sup>4</sup> (1), F <sup>1</sup> (5), G <sup>2</sup> (5), I <sup>1</sup> (5), A <sup>1</sup> (1), N <sup>3</sup> (1), K <sup>1</sup> (1), L <sup>1</sup> (1)	4
7. Availability of outreach activities in the hard-to-reach areas	N <sup>14</sup> (1), A <sup>4</sup> (1), O <sup>8</sup> (1), B <sup>8</sup> (5), E <sup>3</sup> (5)	4
8. Implementation of the family MUAC promoting self-referral	C <sup>28</sup> (1,2), B <sup>4</sup> (1,2),	3
9. Exhaustive Mass screening helped identify cases	O <sup>23</sup> (1), N <sup>29</sup> (1), P <sup>5</sup> (1), B <sup>3</sup> (5), C <sup>5</sup> (2,5)	3
10. CHVs have MUAC tapes for screening malnutrition	N <sup>34</sup> (1,2), A <sup>11</sup> (1), B <sup>13</sup> (2,5), C <sup>39</sup> (2,5), K <sup>8</sup> (6), J <sup>16</sup> (2), Q <sup>4</sup> (1), L <sup>1</sup> (1)	2



11. In some areas CHVs accompanying clients to health facility	N <sup>27</sup> (1), Q <sup>3</sup> (1)	2
12. Caregivers return of the referral slip to the CHV	O <sup>8</sup> (1), N <sup>7</sup> (1), K <sup>3</sup> (6), L <sup>5</sup> (1)	2
13. Use of local administration to enhance referrals	N <sup>5</sup> (1), K <sup>8</sup> (6), L <sup>2</sup> (1)	2
14. Some defaulter tracing	O <sup>11</sup> (1), (3), O <sup>1</sup> (1), (3), B <sup>1</sup> (5), C <sup>2</sup> (5), G <sup>1</sup> (5), K <sup>6</sup> (6), O <sup>1</sup> (1), C <sup>2</sup> (5)	1
15. In some facilities IMAM clients are prioritized for treatment	G <sup>1</sup> (5), K <sup>6</sup> (6), O <sup>1</sup> (1), C <sup>2</sup> (5)	2
16. Some flexibility on IMAM service delivery days	O <sup>18</sup> (1), C <sup>30</sup> (2,5),	2
17. Appreciation that IMAM services are free and closer to the community	O <sup>16</sup> (1), C <sup>47</sup> (5), N <sup>49</sup> (1), K <sup>8</sup> (6), Q <sup>5</sup> (1), L <sup>5</sup> (1), D <sup>9</sup> (5), P <sup>8</sup> (1)	2
18. Caregivers appreciating the information and treatment they received from HCPs during IMAM treatment.	C <sup>13</sup> (2,5), J <sup>21</sup> (2), B <sup>9</sup> (2)	2
19. Community appreciated that IMAM program is curing children	O <sup>18</sup> (1), C <sup>58</sup> (2,5), N <sup>49</sup> (1), K <sup>8</sup> (6), Q <sup>5</sup> (1), L <sup>5</sup> (1), E <sup>2</sup> (5), D <sup>13</sup> (5), P <sup>8</sup> (1)	2
20. Consistent availability of IMAM commodities in the health facilities	B <sup>9</sup> (5), C <sup>28</sup> (2,5), D <sup>6</sup> (5), E <sup>11</sup> (2,5), G <sup>5</sup> (5), I <sup>1</sup> (5), O <sup>17</sup> (1)	2
21. Most HCPs trained/sensitized and experienced on IMAM service delivery	O <sup>23</sup> (1), P <sup>5</sup> (1)	3
22. Most CHVs sensitized on IMAM services	N <sup>7</sup> (1)	2
23. Availability of nutritionists dedicatedly supporting IMAM service delivery in the health facilities	A <sup>2</sup> (1), O <sup>2</sup> (1), C <sup>19</sup> (2,5), B <sup>6</sup> (2)	3
24. Regular support supervision of the HCPs from the C/SCHMT	O <sup>26</sup> (1), P <sup>5</sup> (1)	2
	<b>TOTAL</b>	<b>56</b>

**Table 15: The List of Barriers in SAM Treatment Program**

Barrier	Source (Method)	Weighted (0 - 3)
1. Self-medication/ buying medicine at the chemist	B <sup>17</sup> (2,5), C <sup>23</sup> (2,5), R <sup>9</sup> (5), N <sup>8</sup> (1)	1
2. THPs treating children with severe malnutrition using herbs and referring them to other THPs	Q <sup>6</sup> (1), B <sup>2</sup> (5), C <sup>3</sup> (5), M <sup>4</sup> (1), K <sup>5</sup> (6)	2
3. THPs discourage caregivers from using Conventional medicines	Q <sup>6</sup> (1), A <sup>7</sup> (1), B <sup>2</sup> (5), C <sup>3</sup> (5)	2
4. Some caregivers seeking prayers first before being taken to the health facility	A <sup>2</sup> (6), B(2), L <sup>3</sup> (6), M <sup>1</sup> (6), N <sup>2</sup> (6), 3	2
5. Some community members are not aware of malnutrition	Q <sup>2</sup> , L <sup>7</sup> (1), S <sup>2</sup> (1)	2
6. A lot of stigma associated with malnutrition	S <sup>2</sup> (1), C <sup>2</sup> (2), L <sup>3</sup> (1), K <sup>4</sup> (6), N <sup>3</sup> (1), Q(5), A <sup>4</sup> (1)	2
7. Negligence/ignorance by caregivers on child care	L <sup>2</sup> (1), P <sup>1</sup> (1), C <sup>1</sup> (5), S <sup>1</sup> (1), K <sup>4</sup> (6),	2
8. Community members not aware of basic IMAM treatment protocols	Q <sup>10</sup> (1), S <sup>4</sup> (5), M <sup>8</sup> (1), K <sup>3</sup> (6), R <sup>2</sup> (1)	2
9. Community leaders neither sensitized nor involved in IMAM activities	K <sup>26</sup> (6), S <sup>1</sup> (1), L <sup>16</sup> (1)	2
10. Malnutrition services are not prioritized in the community HEDU	K <sup>8</sup> (6), L <sup>7</sup> (1), M <sup>10</sup> (1)	2
11. Long distance to the IMAM sites	B <sup>26</sup> (2,5), C <sup>35</sup> (2,5), D <sup>13</sup> (1), E <sup>10</sup> (1), F <sup>12</sup> (5), G <sup>10</sup> (5), I(5), N <sup>18</sup> (1,2), O <sup>16</sup> (1), K <sup>10</sup> (6), L(1), Q <sup>1</sup> (1)	3
12. Inconsistent outreach activities and closure of some of the sites due to short term donor funding	B <sup>2</sup> (5), L <sup>1</sup> (1), O <sup>10</sup> (1), N <sup>34</sup> (1,2), F <sup>10</sup> (5), G <sup>8</sup> (5),	3
13. High treatment cost - transport, time, some fee in private facilities	A <sup>26</sup> (1), B <sup>8</sup> (5), C <sup>60</sup> (5), E <sup>5</sup> (1), F <sup>12</sup> (5), G <sup>12</sup> (5), H <sup>2</sup> (5), I <sup>1</sup> (5), K <sup>9</sup> (1), L <sup>3</sup> (1), S <sup>1</sup> (1), M <sup>6</sup> (1), O <sup>15</sup> (1), N <sup>36</sup> (1), P <sup>6</sup> (1)	1
14. High Maternal Workload affecting health care seeking	B <sup>1</sup> (5), F <sup>1</sup> (5), O <sup>1</sup> (1), C <sup>19</sup> (2,5), I(5), G <sup>3</sup> (5), F <sup>1</sup> (5), O(1), H <sup>1</sup> (5), S <sup>1</sup> (1)	2



15. Human wildlife conflict	K <sup>1</sup> (1), A <sup>1</sup> (1), O <sup>2</sup> (1), N <sup>2</sup> (1), B <sup>2</sup> (5), C <sup>5</sup> (5), S <sup>1</sup> (1), Q <sup>1</sup> (1)	2
16. Carer too ill to take child for revisit clinics	C <sup>13</sup> (1,2), F <sup>1</sup> (5), A <sup>1</sup> (1)	1
17. Program not flexible for school going children	G <sup>1</sup> (5), C <sup>1</sup> (5), N <sup>2</sup> (1)	1
18. Migration especially among the nomadic community and movement to other towns	O <sup>10</sup> (1), G <sup>2</sup> (5), B <sup>2</sup> (5), N <sup>7</sup> (1), K <sup>2</sup> (6), A <sup>1</sup> (1), F <sup>1</sup> (5), P <sup>1</sup> (1)	2
19. Cross (county and country) border challenges; beneficiaries become defaulters in one site while others enrolled twice	P <sup>1</sup> (1), O <sup>6</sup> (1), N <sup>7</sup> (1), 3	2
20. Poor infrastructure affecting access to IMAM sites	K <sup>3</sup> (1), L <sup>1</sup> (1), G <sup>4</sup> (5), M <sup>2</sup> (1), C <sup>2</sup> (5), B <sup>2</sup> (5)N <sup>2</sup> (1), O <sup>1</sup> (1)	2
21. Most CHVs not conducting regular screening for malnutrition	I <sup>2</sup> (1), F <sup>2</sup> (1), C <sup>16</sup> (1), O <sup>6</sup> (1), D <sup>3</sup> (1), E <sup>2</sup> (5), A <sup>2</sup> (1), M <sup>3</sup> (1), Q <sup>1</sup> (1),	3
22. Most CHVs not trained neither sensitized on IMAM service delivery	G <sup>2</sup> (5), N <sup>29</sup> (1), O <sup>24</sup> (1), P <sup>6</sup> (1)	2
23. Hostility from some communities and inaccessibility of some households by CHVs especially to gated communities	N <sup>15</sup> (1,2), J <sup>35</sup> (5), B <sup>25</sup> (1,2), C <sup>44</sup> (1,2),	2
24. CHVs not having adequate resources to carry out their duties	N <sup>58</sup> (1,2)	2
25. CHVs biasness towards programs with incentives	N <sup>42</sup> (1,2)	2
26. Wrong referrals with knowledge gap on admission & discharge criteria	N <sup>11</sup> (1), O <sup>18</sup> (1), P <sup>1</sup> (1)	2
27. No regular meetings between CHVs and HCPs concerning IMAM	N <sup>45</sup> (1), O <sup>5</sup> (1)	2
28. Long waiting hours for IMAM services	O <sup>5</sup> (1), C <sup>8</sup> (5), B <sup>4</sup> (2), G <sup>1</sup> (5),	2
29. No defaulter tracing in the facility	(3), O <sup>7</sup> (1), G <sup>4</sup> (5), F <sup>1</sup> (5), N <sup>4</sup> (1)	3
30. Non-existent or non-functional community health units	O <sup>3</sup> (1), P <sup>1</sup> (1), S <sup>1</sup> (1), K <sup>1</sup> (6)(3),	3
31. Perception that RUTF causes diarrhea, allergies	O <sup>1</sup> (1), C <sup>1</sup> (5), F <sup>1</sup> (5), B <sup>3</sup> (5),	1
32. Misuse of RUTF	B <sup>4</sup> (5), C <sup>33</sup> (2,5), I <sup>3</sup> (5), H <sup>1</sup> (5), N <sup>4</sup> (1), O <sup>5</sup> (1), M <sup>5</sup> (1), K <sup>1</sup> (6), 3, A <sup>7</sup> (1), J <sup>15</sup> (2), Q <sup>6</sup> (1),	3
33. Caregiver feeling that the child is not improving in program	F <sup>1</sup> (5), B <sup>4</sup> (5) C <sup>2</sup> (5), G <sup>2</sup> (5)	2
34. Understaffing with high workload: fewer staff	O <sup>17</sup> (1), P <sup>8</sup> (1), N <sup>1</sup> (1), N <sup>10</sup> (1), O <sup>12</sup> (1), K <sup>6</sup> (1)	3
35. Absenteeism of health care workers	C <sup>8</sup> (2,5), L <sup>1</sup> (1), P <sup>1</sup> (1), B <sup>5</sup> (5)	2
36. Poor documentation	3, O <sup>12</sup> (1), P <sup>1</sup> (1)	2
37. Lack of program ownership by the HCPs	O <sup>1</sup> (1), P <sup>3</sup> (1)	2
	TOTAL	76

### BBQ Analysis for Severe Acute Malnutrition Treatment Program:

Table 16: The List of Boosters in MAM Treatment Program

Booster	Source (Method)	Weight (0 - 4)
1. Some TBAs observed to promote positive health care practices	Q <sup>6</sup> (1), N <sup>4</sup> (1)	1
2. Community members can identify malnutrition and signs, and inform CHVs/HCWs of malnourished children in the community	N <sup>42</sup> (1,2), A <sup>2</sup> (5), C <sup>11</sup> (2), C <sup>10</sup> (2), E <sup>2</sup> (5), L <sup>7</sup> (1), S <sup>4</sup> (1), K <sup>7</sup> (6), R <sup>2</sup> (1), Q <sup>5</sup> (6)	3
3. Community members are aware of IMAM treatment program	Q <sup>1</sup> (1), B <sup>5</sup> (5), C <sup>3</sup> (5), D <sup>4</sup> (5), E <sup>6</sup> (5), K <sup>5</sup> (6), R <sup>3</sup> (1), S <sup>2</sup> (1)	3
4. Awareness creation on IMAM program to the community	A <sup>5</sup> (5), K <sup>6</sup> (6), N <sup>44</sup> (5), O <sup>29</sup> (1)	2
5. Caregivers getting information on IMAM program from peers	B <sup>4</sup> (5), C <sup>5</sup> (4), D <sup>1</sup> (1), E <sup>1</sup> (1)	2
6. Nearness to the IMAM sites especially in Urban settlements	B <sup>7</sup> (4), C <sup>26</sup> (1,2), E <sup>4</sup> (1), F <sup>1</sup> (5), G <sup>2</sup> (5), I <sup>1</sup> (5), A <sup>1</sup> (1), N <sup>3</sup> (1), K <sup>1</sup> (1), L <sup>1</sup> (1)	4



7. Availability of outreach activities in the hard-to-reach areas	N <sup>14</sup> (1), A <sup>4</sup> (1), O <sup>8</sup> (1), B <sup>8</sup> (5), E <sup>3</sup> (5)	4
8. Implementation of the family MUAC promoting self-referral	C <sup>28</sup> (1,2), B <sup>4</sup> (1,2),	3
9. Exhaustive Mass screening helped identify cases	O <sup>23</sup> (1), N <sup>29</sup> (1), P <sup>5</sup> (1), B <sup>3</sup> (5), C <sup>5</sup> (2,5)	3
10. CHVs have MUAC tapes for screening malnutrition	N <sup>34</sup> (1,2), A <sup>11</sup> (1), B <sup>13</sup> (2,5), C <sup>39</sup> (2,5), K <sup>8</sup> (6), J <sup>16</sup> (2), Q <sup>4</sup> (1), L <sup>1</sup> (1)	2
11. In some areas CHVs accompanying clients to health facility	N <sup>27</sup> (1), Q <sup>3</sup> (1)	2
12. Caregivers return of the referral slip to the CHV	O <sup>8</sup> (1), N <sup>7</sup> (1), K <sup>3</sup> (6), L <sup>5</sup> (1)	2
13. Use of local administration to enhance referrals	N <sup>5</sup> (1), K <sup>8</sup> (6), L <sup>2</sup> (1)	2
14. Some defaulter tracing	O <sup>11</sup> (1), (3), O <sup>1</sup> (1), (3), B <sup>1</sup> (5), C <sup>2</sup> (5), G <sup>1</sup> (5), K <sup>6</sup> (6), O <sup>1</sup> (1), C <sup>2</sup> (5)	1
15. In some facilities IMAM clients are prioritized for treatment	G <sup>1</sup> (5), K <sup>6</sup> (6), O <sup>1</sup> (1), C <sup>2</sup> (5)	2
16. Some flexibility on IMAM service delivery days	O <sup>18</sup> (1), C <sup>30</sup> (2,5),	2
17. Appreciation that IMAM services are free and closer to the community	O <sup>16</sup> (1), C <sup>47</sup> (5), N <sup>49</sup> (1), K <sup>8</sup> (6), Q <sup>5</sup> (1), L <sup>5</sup> (1), D <sup>9</sup> (5), P <sup>8</sup> (1)	2
18. Caregivers appreciating the information and treatment they received from HCPs during IMAM treatment.	C <sup>13</sup> (2,5), J <sup>21</sup> (2), B <sup>9</sup> (2)	2
19. Community appreciated that IMAM program is curing children	O <sup>18</sup> (1), C <sup>58</sup> (2,5), N <sup>49</sup> (1), K <sup>8</sup> (6), Q <sup>5</sup> (1), L <sup>5</sup> (1), E <sup>2</sup> (5), D <sup>13</sup> (5), P <sup>8</sup> (1)	2
20. Consistent availability of IMAM commodities in the health facilities	B <sup>9</sup> (5), C <sup>28</sup> (2,5), D <sup>6</sup> (5), E <sup>11</sup> (2,5), G <sup>5</sup> (5), I <sup>1</sup> (5), O <sup>17</sup> (1)	2
21. Most HCPs trained/sensitized and experienced on IMAM service delivery	O <sup>23</sup> (1), P <sup>5</sup> (1)	3
22. Most CHVs sensitized on IMAM services	N <sup>7</sup> (1)	2
23. Availability of nutritionists dedicatedly supporting IMAM service delivery in the health facilities	A <sup>2</sup> (1), O <sup>2</sup> (1), C <sup>19</sup> (2,5), B <sup>6</sup> (2)	3
24. Regular support supervision of the HCPs from the C/SCHMT	O <sup>26</sup> (1), P <sup>5</sup> (1)	2
<b>TOTAL</b>		<b>56</b>

Table 17: The List of Barriers in MAM Treatment Program

Barrier	Source (Method)	Weighted (0 - 3)
1. Self-medication/ buying medicine at the chemist	B <sup>17</sup> (2,5), C <sup>23</sup> (2,5), R <sup>9</sup> (5), N <sup>8</sup> (1)	1
2. THPs treating children with severe malnutrition using herbs and referring them to other THPs	Q <sup>6</sup> (1), B <sup>2</sup> (5), C <sup>3</sup> (5), M <sup>4</sup> (1), K <sup>5</sup> (6)	2
3. THPs discourage caregivers from using Conventional medicines	Q <sup>6</sup> (1), A <sup>7</sup> (1), B <sup>2</sup> (5), C <sup>3</sup> (5)	2
4. Some caregivers seeking prayers first before being taken to the health facility	A <sup>2</sup> (6), B(2), L <sup>3</sup> (6), M <sup>1</sup> (6), N <sup>2</sup> (6), 3	2
5. Some community members are not aware of malnutrition	Q <sup>2</sup> , L <sup>7</sup> (1), S <sup>2</sup> (1)	2
6. A lot of stigma associated with malnutrition	S <sup>2</sup> (1), C <sup>2</sup> (2), L <sup>3</sup> (1), K <sup>4</sup> (6), N <sup>3</sup> (1), Q(5), A <sup>4</sup> (1)	2
7. Negligence/ignorance by caregivers on child care	L <sup>2</sup> (1), P <sup>1</sup> (1), C <sup>1</sup> (5), S <sup>1</sup> (1), K <sup>4</sup> (6),	2
8. Community members not aware of basic IMAM treatment protocols	Q <sup>10</sup> (1), S <sup>4</sup> (5), M <sup>8</sup> (1), K <sup>3</sup> (6), R <sup>2</sup> (1)	2
9. Community leaders neither sensitized nor involved in IMAM activities	K <sup>26</sup> (6), S <sup>1</sup> (1), L <sup>16</sup> (1)	2



10. Malnutrition services are not prioritized in the community HEDU	K <sup>8</sup> (6), L <sup>7</sup> (1), M <sup>10</sup> (1)	2
11. Long distance to the IMAM sites	B <sup>26</sup> (2,5), C <sup>35</sup> (2,5), D <sup>13</sup> (1), E <sup>10</sup> (1), F <sup>12</sup> (5), G <sup>10</sup> (5), I(5), N <sup>18</sup> (1,2), O <sup>16</sup> (1), K <sup>10</sup> (6), L(1), Q <sup>1</sup> (1)	3
12. Inconsistent outreach activities and closure of some of the sites due to short term donor funding	B <sup>2</sup> (5), L <sup>1</sup> (1), O <sup>10</sup> (1), N <sup>34</sup> (1,2), F <sup>10</sup> (5), G <sup>8</sup> (5),	3
13. High treatment cost - transport, time, some fee in private facilities	A <sup>26</sup> (1), B <sup>8</sup> (5), C <sup>60</sup> (5), E <sup>5</sup> (1), F <sup>12</sup> (5), G <sup>12</sup> (5), H <sup>2</sup> (5), I <sup>1</sup> (5), K <sup>9</sup> (1), L <sup>3</sup> (1), S <sup>1</sup> (1), M <sup>6</sup> (1), O <sup>15</sup> (1), N <sup>36</sup> (1), P <sup>6</sup> (1)	1
14. High Maternal Workload affecting health care seeking	B <sup>1</sup> (5), F <sup>1</sup> (5), O <sup>1</sup> (1), C <sup>19</sup> (2,5), I(5), G <sup>3</sup> (5), F <sup>1</sup> (5), O(1), H <sup>1</sup> (5), S <sup>1</sup> (1)	2
15. Human wildlife conflict	K <sup>1</sup> (1), A <sup>1</sup> (1), O <sup>2</sup> (1), N <sup>2</sup> (1), B <sup>2</sup> (5), C <sup>5</sup> (5), S <sup>1</sup> (1), Q <sup>1</sup> (1)	2
16. Carer too ill to take child for revisit clinics	C <sup>13</sup> (1,2), F1(5), A <sup>1</sup> (1)	1
17. Program not flexible for school going children	G <sup>1</sup> (5), C <sup>1</sup> (5), N <sup>2</sup> (1)	1
18. Migration especially among the nomadic community and movement to other towns	O <sup>10</sup> (1), G <sup>2</sup> (5), B <sup>2</sup> (5), N <sup>7</sup> (1), K <sup>2</sup> (6), A <sup>1</sup> (1), F <sup>1</sup> (5), P <sup>1</sup> (1)	2
19. Cross (county and country) border challenges; beneficiaries become defaulters in one site while others enrolled twice	P <sup>1</sup> (1), O <sup>6</sup> (1), N <sup>7</sup> (1), 3	2
20. Poor infrastructure affecting access to IMAM sites	K <sup>3</sup> (1), L <sup>1</sup> (1), G <sup>4</sup> (5), M <sup>2</sup> (1), C <sup>2</sup> (5), B <sup>2</sup> (5), N <sup>2</sup> (1), O <sup>1</sup> (1)	2
21. Most CHVs not conducting regular screening for malnutrition	I2(1), F2(1), C16(1), O6(1), D3(1), E2(5), A2(1), M3(1), Q1(1),	3
22. Most CHVs not trained neither sensitized on IMAM service delivery	G2(5), N29(1), O24(1), P6(1)	2
23. Hostility from some communities and inaccessibility of some households by CHVs especially to gated communities	N15(1,2), J35(5), B25(1,2), C44(1,2),	2
24. CHVs not having adequate resources to carry out their duties	N58(1,2)	2
25. CHVs biasness towards programs with incentives	N42(1,2)	2
26. Wrong referrals with knowledge gap on admission & discharge criteria	N11(1), O18(1), P1(1)	2
27. No regular meetings between CHVs and HCPs concerning IMAM	N45(1), O5(1)	2
28. Long waiting hours for IMAM services	O5(1), C8(5), B4(2), G1(5),	2
29. No defaulter tracing in the facility	(3), O7(1), G4(5), F1(5), N4(1)	3
30. Non-existent or non-functional CUs	O3(1), P1(1), S1(1), K1(6)(3),	3
31. Misuse of RUSF & LNS	B4(5), C33(2,5), I3(5), H1(5), N4(1), O5(1), M5(1), K1(6), 3, A7(1), J15(2), Q6(1),	3
32. Understaffing with high workload: fewer staff	O17(1), P8(1), N1(1), N10(1), O12(1), K(6)1	2
33. Absenteeism of health care workers	C8(2,5), L1(1), P1(1), B5(5)	2
34. Poor documentation	3, O12(1), P1(1)	2
35. Lack of program ownership by the HCPs	O1(1), P3(1)	2
	<b>TOTAL</b>	<b>72</b>



## Reasons for Defaulting in IMAM program

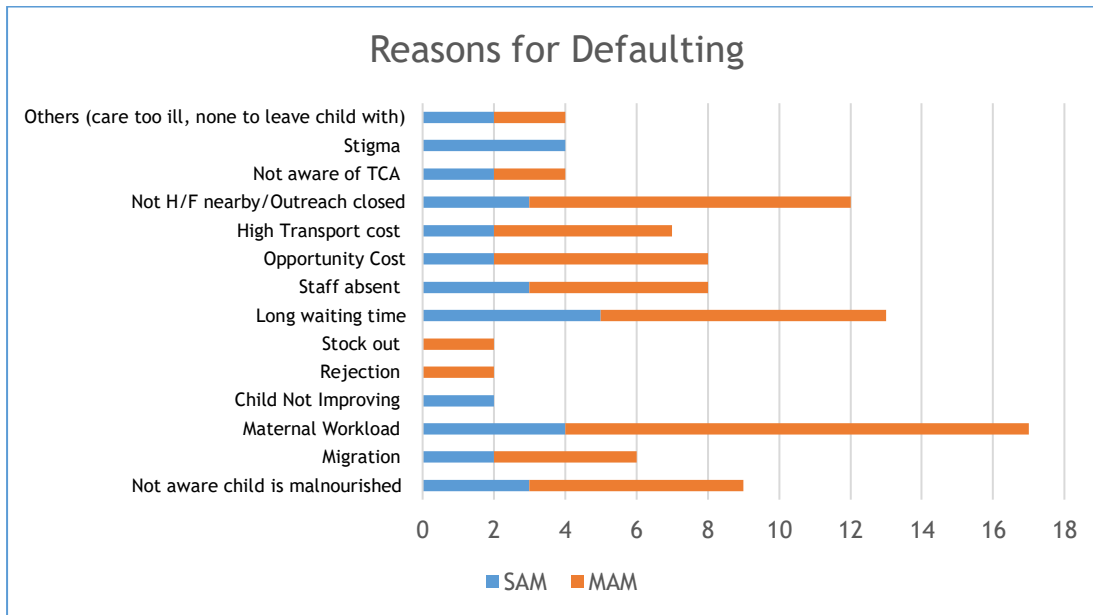


Figure 106: Some of the reasons given by caregivers of defaulting cases

## Concept Maps

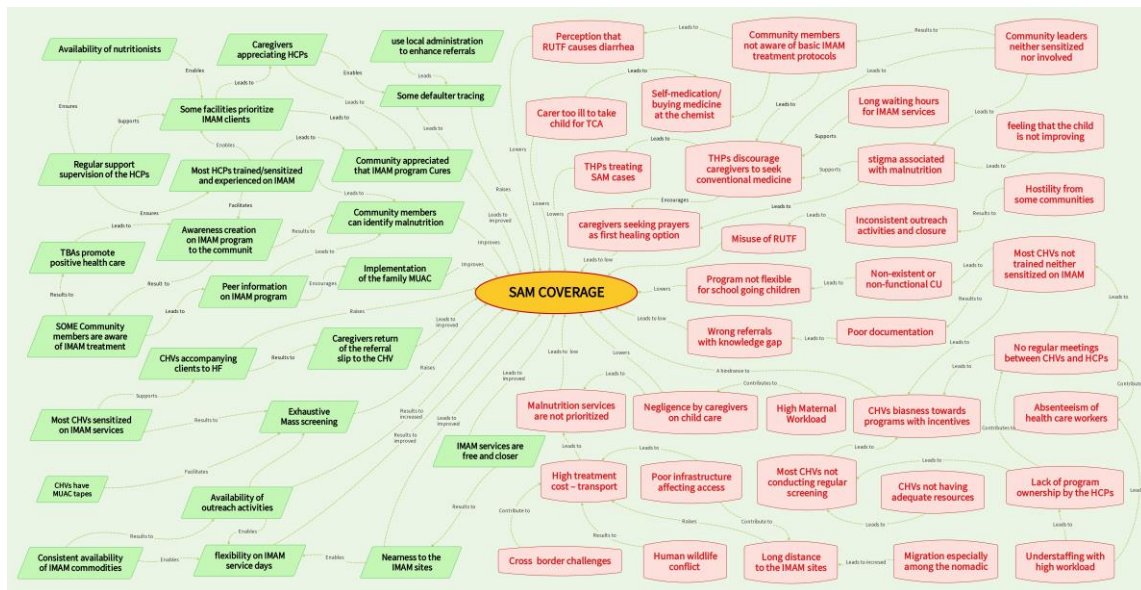


Figure 107: A Concept Map showing the positive and negative links that affect SAM Coverage



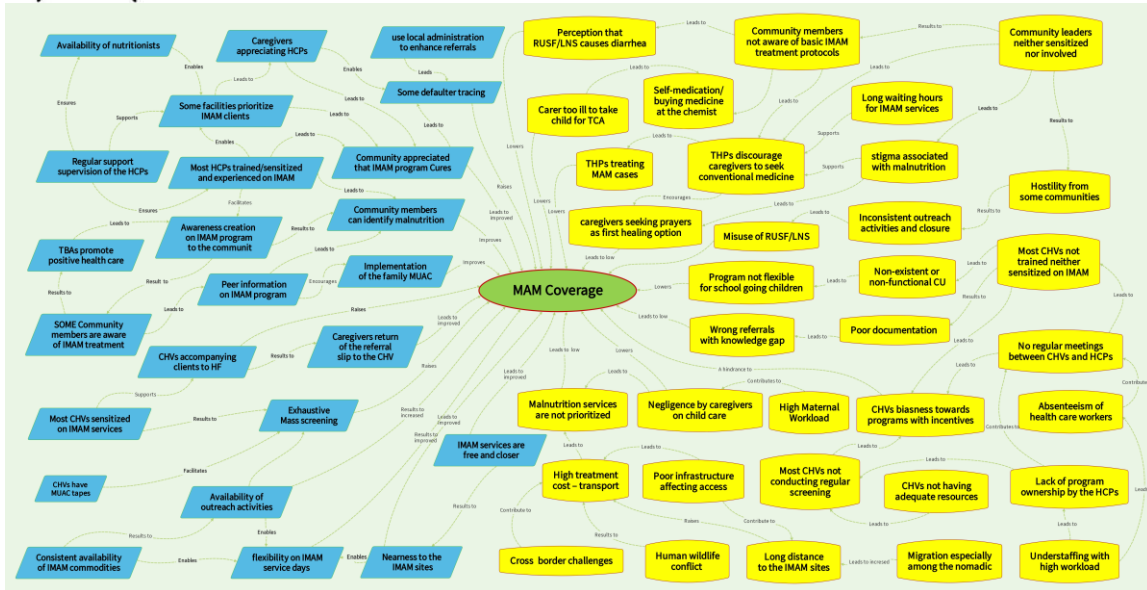


Figure 108: A Concept Map showing the positive and negative links that affect MAM Coverage

### Summary of Possible Recommendations

- Strengthen community sensitization on Malnutrition signs and appropriate health seeking behaviors
- Enhance awareness of IMAM program at the community level
- Increase and strengthen existing outreach sites
- Ensure IMAM program flexibility
- Strengthen case identification, referral, enrollment and follow up
- Enhance CHPs/CHVs support to conduct community activities
- Strengthen linkage of IMAM with other program targeting under-fives (CWC, KEPI, TB/HIV)
- Strengthen facility to facility and community linkage or communication
- Strengthen the capacity of the health facility to offer quality IMAM services
- Strengthen the IMAM client retention strategy to reduce defaulting



## Recommendations and Action Plan

Table 18: Recommendations and Action Plan

Recommendation	Justification	Barrier/Evidence	Strategy/Purpose	Activity	Performance Indicator	Responsible
Strengthen community sensitization on Malnutrition signs and appropriate health seeking behaviors	<p>Inadequate community awareness of malnutrition signs and appropriate health seeking reducing coverage</p> <p>Inadequate involvement of the community gatekeepers on issues of malnutrition</p>	<ul style="list-style-type: none"> <li>- Self-medication/ buying medicine at the chemist</li> <li>- Some community members are not aware of malnutrition signs</li> <li>- THPs treating children with SAM before referral using herbs and even referring cases to other THPs for further consultation</li> <li>- Malnutrition is a curse - children have to undergo cleansing</li> <li>- Stigma associated with malnutrition</li> <li>- THPs discourage caregivers from using Conventional medicines</li> <li>- Refusal by partner to go to</li> </ul>	<p><b>Community involvement on malnutrition issues - awareness of signs and appropriate health-seeking</b></p> <ul style="list-style-type: none"> <li>- To raise awareness on malnutrition</li> <li>- To reduce malnutrition-related stigma</li> <li>- To raise awareness on appropriate health seeking behavior.</li> </ul>	<ul style="list-style-type: none"> <li>- Conduct health education sessions targeting the public (community) on malnutrition through Barazas, dialogue days, churches, MtMSGs meetings CMSG meetings and monthly CHPs meetings</li> <li>- Conduct Health talks on malnutrition signs and treatment at the health facilities.</li> <li>- Use of Mass Media and social media (e.g., Radio, TV, Facebook, Twitter).</li> </ul>	<ul style="list-style-type: none"> <li>- No. of health education (HEDU) sessions conducted on malnutrition signs and the appropriate health seeking behaviours.</li> <li>- No. of Radio spots on malnutrition signs and treatment conducted through local FMs</li> <li>- No of media interviews conducted on malnutrition.</li> </ul>	CHEWs, CHAs, CHPs
			<p><b>Key community gatekeepers' engagement</b></p> <ul style="list-style-type: none"> <li>- Involve community influencers on malnutrition identification and referral</li> </ul>	<ul style="list-style-type: none"> <li>- Sensitize key opinion leaders on malnutrition signs and appropriate treatment through the sensitization sessions</li> <li>- Document successful stories on IMAM managed case.</li> <li>- Formation of Father-to-Father Support Groups (FtFSGs), MtMSGs</li> <li>- Conduct MtMSGs, CMSGs, FtFSGs, meetings at the community levels.</li> </ul>	<ul style="list-style-type: none"> <li>- No. of key opinion leaders reached through the sensitization sessions</li> <li>- No. of sensitization sessions conducted</li> <li>- No. of documented successful stories on IMAM managed case.</li> <li>- No. of MtMSGs, CMSGs and FtFSGs sessions held with malnutrition signs and management as an agenda conducted.</li> <li>- No. of key influencers creating awareness of</li> </ul>	CHMT, SCHMTs, HEWs, CHAs, SCCSFPs, CHPs, Health care workers, Implementing Partners





		<p>the health facility to access IMAM services</p> <ul style="list-style-type: none"> <li>- Some caregivers prefer taking their children for prayers first before being taken to the health facility</li> <li>- Negligence/ignorance of caregivers on child care</li> </ul>	<p><b>Improved pipeline for essential drugs</b></p> <ul style="list-style-type: none"> <li>- To ensure consistency and availability of drugs and services in Public Health facilities</li> <li>- To equip health facilities with essential drugs to ensure all services are available</li> </ul>	<ul style="list-style-type: none"> <li>- Conduct gap assessment to identify health facilities with shortage of essential drugs</li> <li>- Conduct public participation on health facility improvement needs</li> <li>- Conduct advocacy sessions with the stakeholders on the gaps observed and needs from the public participation</li> <li>- Conduct regular monitoring to all the health facilities targeting the supply chain</li> </ul>	<p>malnutrition signs and appropriate treatment at the community level</p> <ul style="list-style-type: none"> <li>- No. of facilities assessed and gaps identified</li> <li>- No. of public participations done and recommendations made</li> <li>- No. of advocacy sessions conducted</li> <li>- No. of H/Fs prioritized for equipping based on the gaps/needs</li> <li>- No. of monitoring visits conducted to assess the supply chain</li> <li>- No. of H/Fs reporting improved essential drugs and equipment supply chain</li> </ul>	<p>CHMT, SCHMTs, HEWs, CHAs, SCCSFPs, CHPs, Health care workers,</p> <p>Implementing Partners</p>
Recommendation	Justification	Barrier/Evidence	Strategy/Purpose	Activity	Performance Indicator	Responsible
Enhance awareness of IMAM program at the community level	Inadequate awareness by the community members on IMAM program and basic treatment protocol	<ul style="list-style-type: none"> <li>- Community members not aware of basic IMAM treatment protocols</li> <li>- Community leaders not sensitized on, neither are they involved in IMAM activities</li> <li>- Malnutrition services are not prioritized in the community HEDU</li> </ul>	<p><b>Community engagement to raise awareness on IMAM program and basic treatment protocol</b></p> <ul style="list-style-type: none"> <li>- To raise awareness on IMAM program</li> <li>- To increase uptake of IMAM services</li> </ul> <p><b>Community engagement in acknowledgement that nutrition</b></p>	<ul style="list-style-type: none"> <li>- Mapping of the sites that will targeted for enhanced community sensitization on IMAM</li> <li>- Sensitize community on malnutrition through Barazas, dialogue days, churches</li> <li>- Conduct Health talks on malnutrition at the health facilities.</li> <li>- Conduct community health education through barazas, community dialogues</li> <li>- Conduct HEDU at the health facility level and outreach sites</li> </ul>	<ul style="list-style-type: none"> <li>- No. of community sensitization sessions that included malnutrition signs</li> <li>- No of health talks on malnutrition.</li> <li>- Increased number of admissions</li> <li>- No. of barazas held</li> <li>- No. of community health sessions held</li> <li>- No. of HH visited</li> <li>- No. of IEC materials distributed</li> </ul>	<p>ScNOs, HCWs, CHAs &amp; CHPs, SCCSFP, CHA, Nutritionist and Implementing partners</p> <p>CHPs &amp; CHA</p>



			<p><b>commodities are medicines</b></p> <ul style="list-style-type: none"> <li>- Increase awareness of commodities as medicines</li> <li>- Increase awareness on IMAM treatment protocol</li> </ul>	<ul style="list-style-type: none"> <li>- Conduct awareness meetings with key opinion leaders with IMAM as a key discussion</li> <li>- Conduct HH visits to do sensitizations on IMAM services</li> <li>- Distribute IEC materials in the community</li> <li>- Sensitization of the support groups on IMAM</li> <li>- Conduct community sensitization on IMAM commodities through community Barazas, Dialogue days, MtMSGs sessions</li> <li>- Continuous education targeting all community members frequenting the H/F on basic IMAM treatment protocol</li> </ul>	<ul style="list-style-type: none"> <li>- No. of sensitization sessions held</li> <li>- No. of sensitization sessions held for women/fathers</li> <li>- Conduct monitoring and evaluation on IMAM services</li> <li>- No. of community members sensitized</li> <li>-</li> </ul>	
	Poor opinion of IMAM program contributing to low coverage	- Not appreciating commodity as medicine	<p><b>Community engagement in acknowledgement that nutrition commodities are medicines</b></p> <ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct community sensitization on IMAM commodities through community Barazas, Dialogue days</li> <li>• Conduct CHE on basic IMAM treatment protocol through community Barazas, Dialogue days, MtMSGs sessions</li> <li>• Continuous HEDU sessions at the H/F targeting all community members frequenting the H/F on basic IMAM treatment protocol</li> </ul>	<ul style="list-style-type: none"> <li>• Number of community sensitized</li> <li>• Number of community dialogues and community Barraza done.</li> <li>• Number of CHEs, MtMSGs, HEDU sessions carried out.</li> </ul>	SCNO, HCPs, CHAs,
		- Perception that RUTF causes diarrhea, allergies	<p><b>Caregiver involvement in management of malnutrition</b></p>	<ul style="list-style-type: none"> <li>• Promote hygiene practices among caregivers of children with SAM</li> <li>• Demonstrate how to feed the baby</li> <li>• conduct counselling sessions on good hygiene practices</li> <li>• Involve pediatrician on cases of allergic reaction to RUTF</li> </ul>	<ul style="list-style-type: none"> <li>• No. of claims reported on RUTF related diarrhea cases.</li> <li>• No. of community sensitization session with malnutrition treatment as part of agenda conducted</li> </ul>	HCPs, CHAs, CHPs, CHVs



		<ul style="list-style-type: none"> <li>- Misuse of ration i.e. sharing and selling</li> </ul>	<ul style="list-style-type: none"> <li>• Continue sensitizing caregivers on appropriate IMAM treatment protocol including proper utilization of RUTF/RUSF/LNS</li> </ul>	<p><b>Caregiver involvement in management of malnutrition</b></p> <ul style="list-style-type: none"> <li>• Conduct adequate individual education to caregivers on proper utilization of RUTF/RUST through barazas, dialogue days etc.</li> <li>• Conduct community sensitization on proper malnutrition treatment protocol</li> <li>• Involve local authorities in identifying RUTF/RUSF misuse and theft cases</li> </ul>	<ul style="list-style-type: none"> <li>• No. of RUTF/RUSF theft/misuse cases reported and handled by local leaders</li> <li>• No. of community sensitization session with malnutrition treatment as part of agenda conducted</li> <li>• No. of RUTF/RUSF theft/misuse cases reported and handled by local leaders</li> </ul>	
		<ul style="list-style-type: none"> <li>- Caregiver feeling that the child is not improving</li> </ul>	<ul style="list-style-type: none"> <li>• Promote proper use of IMAM commodities.</li> <li>• Probe on knowledge on commodity use and sharing.</li> </ul>	<ul style="list-style-type: none"> <li>• Involve pediatrician in cases of medical complications.</li> <li>• Conduct counseling on how to use the commodities and discourage commodity sharing.</li> </ul>	<ul style="list-style-type: none"> <li>• No. of children cured</li> <li>• No. of pediatrics referrals.</li> <li>• No. of children gaining weight in subsequent visits</li> </ul>	HCPs, CHVs, CHPs, CHA.
Recommendation	Justification	Barrier/Evidence	Strategy/Purpose	Activity	Performance Indicator	Responsible
Increase and strengthen existing outreach sites	In the hard to reach areas, there is little program awareness to distance as evident by poor perception of causes of what malnutrition is, late treatment	<ul style="list-style-type: none"> <li>- Long distance to the IMAM sites</li> <li>- Late treatment seeking</li> <li>- Inconsistent outreach activities and closure of some of the sites due to short term donor funding</li> </ul>	<p><b>Improved availability and accessibility of IMAM services</b></p> <ul style="list-style-type: none"> <li>- Support for consistent outreach activities to increase coverage of IMAM services.</li> <li>- Extension of IMAM services in the</li> </ul>	<ul style="list-style-type: none"> <li>- Advocate for Budgetary Allocations for Community outreaches by the county Technical Nutrition strategy and Partner support.</li> <li>- Hold Advocacy Meetings with the S/CHMT and Local leaders to discuss on how to mobilize resources.</li> <li>- Mobilize Funds to equip facilities with Motorbikes and fuel or transport allowance</li> </ul>	<ul style="list-style-type: none"> <li>- Action Plans of the advocacy meetings held, Minutes.</li> <li>- Action Plans of the meetings held</li> <li>- Memos from the CHMT and scaled down to the facility in-charges.</li> <li>- No. of active outreach sites</li> <li>- No. of new sites formed</li> </ul>	<p>CNS, SCNCs, Partners.</p> <p>CNC to be involved in ACSM with the local leadership</p> <p>CHMT through the CNC and to be scaled</p>



	seeking and defaulting	<ul style="list-style-type: none"> <li>- IMAM services not integrated in some Outreach sites</li> <li>- High treatment cost               <ul style="list-style-type: none"> <li>- Some claim to pay for the services</li> <li>- High transport cost to and from the sites</li> </ul> </li> <li>- Opportunity cost - time spent to seek for IMAM services could be channeled to other priorities</li> <li>- Poor infrastructure</li> </ul>	<p>hard-to-reach areas</p> <ul style="list-style-type: none"> <li>- To advocate for budgetary increment for outreaches to be consistent</li> <li>- To improve early detection of cases</li> <li>- To raise awareness of malnutrition</li> <li>- To reduce distance to the health facility</li> <li>- To reduce defaulters</li> </ul>	<ul style="list-style-type: none"> <li>- Communication to the HCWs/In-charges to take this into consideration,</li> <li>- Budgetary Allocations for Community outreaches by the county Technical Nutrition strategy and Partner support</li> <li>- Advocate for prioritization of IMAM beneficiaries who travel long distances to be attended to First in the health facilities</li> <li>- Conduct regular integrated outreach activities</li> <li>- Advocate for improved road networks to reduce transport cost</li> </ul>	- No. of integrated outreach activities conducted	down up to the facility In charges
Recommendation	Justification	Barrier/Evidence	Strategy/Purpose	Activity	Performance Indicator	Responsible
- Ensure IMAM program flexibility	IMAM program not flexible enough for the demand side (community)	<ul style="list-style-type: none"> <li>- Human wildlife conflict</li> <li>- Maternal workload</li> <li>- Career too ill to take child for revisit clinics</li> <li>- Program not flexible for school going children</li> <li>- Long waiting hours for IMAM services</li> </ul>	<p><b>Stakeholder involvement for improved uptake of IMAM services</b></p> <ul style="list-style-type: none"> <li>- To make the IMAM services available to the beneficiaries whenever they require them</li> <li>- To ensure continuity of treatment</li> <li>- To ensure adherence of</li> </ul>	<ul style="list-style-type: none"> <li>- To conduct health talks to caregivers of IMAM beneficiaries on the importance of adherence to IMAM protocols</li> <li>- Conduct support supervision visits to health facilities</li> <li>- S/CHMT to liaise with KWS to address issues of access to the health facilities</li> <li>- Health facilities to allow flexibility in IMAM service delivery for mothers who are engaged</li> <li>- Health facilities to allow beneficiaries to be brought by</li> </ul>	<ul style="list-style-type: none"> <li>- No. of health facilities reporting flexibility on IMAM service delivery</li> <li>- No. of supervision visits conducted</li> <li>- No. of Health talk sessions conducted</li> <li>- No. of cases brought by neighbors/relatives for follow up visits</li> <li>- Number of home visits and referrals conducted</li> </ul>	S/CHMT HCWs & Nutritionists CHEWs CHPs ECD Teachers





			IMAM treatment protocols	neighbors/relatives for IMAM services during follow up visits where caregiver is too ill <ul style="list-style-type: none"> <li>- Conduct community dialogues on how to address maternal workload issues</li> <li>- Enhance home visits by CHVs</li> <li>- Liaise with teachers for follow up visits by school going IMAM beneficiaries</li> </ul> <b>Management of flow of patients by;</b> <ul style="list-style-type: none"> <li>- Booking a particular number of patients in a day.</li> <li>- Increase the workforce</li> <li>- Increase space to accommodate ques.</li> <li>- Set aside a day for IMAM Programme only.</li> <li>- Separate IMAM clients from CWC clients</li> <li>- Design a service charter for IMAM clients.</li> <li>- Entertainment of clients in the waiting bay by installing a digital screen that can display nutrition information as a form of nutrition education.</li> </ul>		
Recommendation	Justification	Barrier/Evidence	Strategy/Purpose	Activity	Performance Indicator	Responsible
- Strengthen case identification, referral, enrollment and follow up	Irregular case finding by CHVs	Irregular case finding by CHVs <ul style="list-style-type: none"> <li>- Care giver not able to recall last contact with CHV</li> <li>- CHVs not having access to tools for screening</li> </ul>	<b>Improve CHVs conduct with the community</b> <ul style="list-style-type: none"> <li>- Early and timely detection of cases</li> <li>- Timely admission of all identified cases</li> </ul>	<ul style="list-style-type: none"> <li>- Mapping of all CHVs to identify the active and inactive ones</li> <li>- Conduct trainings or sensitizations of CHVs on IMAM</li> <li>- Regular monitoring of CHVs performance</li> <li>- Creation of more CUs and activate non-functional units</li> </ul>	<ul style="list-style-type: none"> <li>- Number of CHVs in each CU trained or sensitized on IMAM</li> <li>- Number of community units formed or functionalized</li> <li>- Number of support supervision done to CHVs</li> </ul>	CNC/SCNOs, CHAs, CHEWs, Key community leaders like Local chiefs, CHVs/CHVs



		<ul style="list-style-type: none"> <li>- CHVs recommended for training and refresher training</li> <li>- CHVs not having adequate resources to carry out their duties</li> <li>- Wrong referrals to the clinic, knowledge gap on admission &amp; discharge criteria</li> </ul>	<ul style="list-style-type: none"> <li>- Improve early treatment seeking</li> </ul>	<ul style="list-style-type: none"> <li>- Provide MUAC and referral tools to CHVs</li> <li>- Scale up CUs implementing the Family MUAC Approach</li> <li>- Facilitate adequate resources (transport, airtime, stipend) to carry out their duties</li> </ul>	<ul style="list-style-type: none"> <li>- Number of cases identified and referred to the health facility by CHVs</li> <li>- Number of MUAC tools issued to CHVs</li> <li>- Number of CHVs with referral tools</li> <li>- No. of CUs implementing Family MUAC Approach</li> </ul>	
<ul style="list-style-type: none"> <li>- Enhance CHPs/CHVs support to conduct community activities</li> </ul>	<p>CHVs demotivated to carry out community assessment activities</p>	<ul style="list-style-type: none"> <li>- Inaccessibility by CHVs in some gated communities</li> <li>- CHVs not having adequate resources (transport, airtime, stipend) to carry out their duties</li> <li>- CHVs facing hostility from host community thinking that CHVs are biased</li> <li>- CHVs not having referral slips</li> <li>- CHVs biasness towards programs with incentives</li> </ul>	<p><b>Improve CHVs capacity to carry out community activities</b></p> <ul style="list-style-type: none"> <li>- Creation of awareness to the community on the existence of CHVs and their work</li> <li>- Creating a rapport between the community and CHVs</li> <li>- Facilitate CHVs in their day to day activities</li> <li>- Improve availability of referral materials and timely referral</li> <li>- IMAM fully integrated with</li> </ul>	<ul style="list-style-type: none"> <li>- Engage and sensitize the key opinion leaders to support CHVs work in the community</li> <li>- Provide CHVs with identification tags when conducting their duties</li> <li>- Include CHVs and their work in public forums agenda</li> <li>- Sensitize key opinion leader on CHVs and their roles</li> <li>- Provision of a monthly stipend</li> <li>- Employ CHVs as casuals</li> <li>- Rewarding best performing CHVs</li> <li>- Mapping of the CUs with gaps in MOH 100 Referral slips</li> <li>- Hold meeting with stakeholders to mobilize finances of the referral materials</li> <li>- Procurement of MOH 100 Booklet for all the CUs without</li> <li>- Distribution of the MOH 100 Booklets in all the CUs with gap</li> </ul>	<ul style="list-style-type: none"> <li>- Number of sensitization sessions for key opinion leaders to support CHVs</li> <li>- Number of CHVs per unit who own badges</li> <li>- Number of CHVs who have been issued with badges/reflector jackets</li> <li>- Number of CHVs on a monthly stipend</li> <li>- Number of CHVs employed as casual workers</li> <li>- Number referred IMAM cases</li> <li>- Number of CU mapped with gaps</li> <li>- Number of sessions held with stakeholders</li> <li>- Number of MOH booklet procured or printed</li> </ul>	<p>CHAs, Chiefs, Key community figures, SCNOs, Implementing partners (NGOs)</p>





			<p>other CHVs/CHPs activities</p> <ul style="list-style-type: none"> <li>-</li> </ul>	<ul style="list-style-type: none"> <li>- Conduct sensitization/training sessions to the CHVs on IMAM with on integration with other services</li> <li>- Conduct CHVs spot checks to identify the level of integration with other services</li> </ul>	<ul style="list-style-type: none"> <li>- Total number booklets received by CUs with gaps</li> </ul>	
<ul style="list-style-type: none"> <li>- Strengthen linkage of IMAM with other program targeting under-fives (CWC, KEPI, TB/HIV)</li> </ul>	<p>IMAM not fully integrated with other programs</p>	<ul style="list-style-type: none"> <li>- CHVs biasness towards program with incentives</li> <li>- No regular meetings concerning IMAM</li> <li>- Little emphasis is given in IMAM program upon contact between CHVs and HCWs</li> <li>- Lack of IMAM program ownership by some HCWs</li> </ul>	<p><b>Strengthen program integration</b></p> <ul style="list-style-type: none"> <li>- Early detection of cases</li> <li>- To avoid missed opportunities</li> <li>- To increase opportunity for case identification and follow up</li> </ul>	<ul style="list-style-type: none"> <li>- Train or sensitize CHVs/CHPs on IMAM</li> <li>- Through S/CNTFs emphasize on the importance of IMAM program</li> <li>- Train or sensitize other program staff on IMAM and the importance of integration</li> <li>- Integrate IMAM services with the other child-focused health services (MCH, KEPI, CWC, Growth monitoring, VAS, deworming)</li> <li>- Conduct spot checks to assess integration of IMAM with other programs</li> </ul>	<ul style="list-style-type: none"> <li>- No. of sessions/forums where IMAM was an agenda</li> <li>- No. of staff for other cadres trained on IMAM</li> <li>- No. of cases referred from KEPI, CWC, Growth monitoring, VAS, deworming</li> <li>- No. of HCWs sensitization or training sessions conducted</li> <li>- No. of spot checks to identify integration of IMAM with other services</li> </ul>	<p>S/CHMT, HCWs, CHEWs, CHAs, CHVs/CHPs, Implementing partners</p>
<ul style="list-style-type: none"> <li>- Strengthen facility to facility and community linkage or communication</li> </ul>	<p>Poor facility-community linkage leading to low IMAM program coverage</p>	<ul style="list-style-type: none"> <li>- Care givers wanting incentives for attending mass screening, MtMSG</li> <li>- Migration especially in the nomadic community and movement to other towns</li> <li>- Cross boarder or common boarder challenges</li> </ul>	<p><b>Community and health facilities engagement</b></p> <ul style="list-style-type: none"> <li>- Improve community appreciation of IMAM program</li> <li>- To avoid double registration of beneficiaries</li> <li>- To improve case finding</li> </ul>	<ul style="list-style-type: none"> <li>- Sensitize the community on the importance of IMAM program</li> <li>- Involve key community leaders in IMAM issues</li> <li>- Share beneficiary names with CHVs and other nearby IMAM facilities to avoid double registration</li> <li>- Allow program flexibility</li> <li>- Establish a feedback mechanism that allows CHVs to provide input suggestions or report concerns to HCWs</li> <li>- Conduct regular HCWs &amp; CHVs review meetings to discuss IMAM issues</li> </ul>	<ul style="list-style-type: none"> <li>- No. of community dialogue conducted with IMAM as part of the agenda</li> <li>- No. of health facilities sharing beneficiary list for follow up</li> <li>- No. of health facilities with community feedback mechanisms</li> <li>- No. of facilities conducting regular review meetings</li> <li>- No. of review meetings conducted</li> </ul>	<p>Local leaders, CHAs, S/CHMT, HCWs &amp; Nutritionists, CHEWs, CHAs, CHVs/CHPs</p>



				<ul style="list-style-type: none"> <li>- Conduct supportive supervision to address imam issues that are beyond the scope of HCWs &amp; CHVs</li> </ul>	<ul style="list-style-type: none"> <li>- No. of support supervisions conducted</li> </ul>	
-		Non-existent or non-functional community health units	<p><b>Strengthen consistent health facility - community linkage</b></p> <ul style="list-style-type: none"> <li>- Establish new CUs or strengthen existing non-functional CUs</li> </ul>	<ul style="list-style-type: none"> <li>- Map out for CUs existence and functionality.</li> <li>- Mobilize resources for establishment and training of the CUs</li> <li>- Strengthen existing CUs</li> <li>- Establish new CUs.</li> <li>- Incentivize CHPs</li> </ul>	<ul style="list-style-type: none"> <li>- Reduced workload.</li> <li>- Increased IMAM coverage within the facility.</li> <li>- No. of functional CUs</li> <li>- No. of newly established CUs</li> </ul>	<ul style="list-style-type: none"> <li>-County Government.</li> <li>-Community strategy vocal person.</li> </ul>
Recommendation	Justification	Barrier/Evidence	Strategy/Purpose	Activity	Performance Indicator	Responsible
<ul style="list-style-type: none"> <li>- Strengthen the capacity of the health facility to offer quality IMAM services</li> </ul>	A number of issues (barriers) contributing to low coverage	<ul style="list-style-type: none"> <li>- Absenteeism of HCW due to Leave or in a training</li> <li>- Complaints of Understaffing of HCW</li> <li>- High workload for the available staff</li> <li>- Poor documentation</li> </ul>	<ul style="list-style-type: none"> <li>• Increase the number of Nutritionist in a facility.</li> </ul>	<p><b>Increase IMAM health care workforce</b></p> <ul style="list-style-type: none"> <li>- Conduct health workforce needs assessment</li> <li>- Hold advocacy sessions with the employment PSB for employment of more nutritionists</li> <li>- Motivate the existing nutrition volunteers through trainings and giving a stipend</li> <li>- Prioritize the available volunteers for employment whenever there are job openings.</li> </ul> <p><b>Improve capacity for IMAM service delivery</b></p> <ul style="list-style-type: none"> <li>- Map and identify facilities with issues.</li> <li>- Conduct IMAM package training for the HCWs</li> <li>- Consistent supportive supervision</li> <li>- Disciplinary actions to be taken against health care workers who routinely miss work without consent.</li> </ul>	<ul style="list-style-type: none"> <li>- No. of H/Fs identified with nutrition workforce capacity gap</li> <li>- No. of advocacy meetings held to discuss nutrition workforce</li> <li>- No of nutritionists employed.</li> </ul> <ul style="list-style-type: none"> <li>- No. of health facilities with gaps mapped</li> <li>- No of routine supervisions done</li> <li>- No of staffs upraised</li> <li>- No. of HCWs motivated</li> <li>- No of staffs employed.</li> <li>- Evidence of HCWs shifts</li> </ul>	<p>County Public Service Board, S/CHMT, CECs, implementing partners (WVK, UNICEF, WHH, KRCS)</p> <p>BEYOND ZERO campaigns.</p> <p>MED SUP</p>



				<ul style="list-style-type: none"> <li>- Reward HCPs who feel demotivated</li> <li>- Performance appraisal to well performing staffs</li> <li>- Conduct IMAM sensitization and training to HCPs</li> </ul> <p><b>Improve the quality of IMAM documentation</b></p> <ul style="list-style-type: none"> <li>- Conduct gap assessment to identify H/Fs in need</li> <li>- Allocate funding to support officers to conduct RDQAs, support supervision.</li> <li>- Provide and distribute reporting tools and registers at facility level.</li> <li>- Capacity build HCPs on reporting and proper documentation of IMAM registers</li> <li>- Conduct routine data quality audits</li> </ul>	<ul style="list-style-type: none"> <li>- No. of IMAM package trainings or sensitizations conducted.</li> </ul> <ul style="list-style-type: none"> <li>- No. of H/Fs identified with capacity need</li> <li>- No. of trainings/OJTs on documentation conducted</li> <li>- No. of RDQAs conducted</li> <li>- No. of supervision visits conducted per quarter</li> </ul>	
Strengthen the IMAM client retention strategy	Very high defaulter rates leading to poor program coverage	No defaulter tracing in the facility	<p><i>Improve IMAM client retention till cure</i></p> <ul style="list-style-type: none"> <li>- Establish a defaulter tracing system in all IMAM implementing Health Facilities</li> </ul>	<ul style="list-style-type: none"> <li>- Develop IMAM defaulters' list</li> <li>- Engage both the CHAs and CHVs in defaulter tracing by providing airtime, stipends for CHVs and defaulter tracing registers for follow up.</li> </ul>	<ul style="list-style-type: none"> <li>- No. of H/Fs with a structured defaulter tracing mechanism(s)</li> <li>- No. of H/Fs supporting CHAs/CHPs to conduct defaulter tracing</li> <li>- No. of H/Fs consistently reporting reduced default rate</li> </ul>	<ul style="list-style-type: none"> <li>-Med Sup.</li> <li>-Administrator</li> <li>-Nutritionist.</li> <li>-Health care</li> </ul>



### Annex 1: Kajiado County Seasonal Calendar

Common Diseases	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Diarrhea	↑	↑	↑	↑	↑	↑	→	↑	↑	→	→	→
URTI	↑	↑	↑	→	→	→	→	→	→	↑	↑	↑
LRTI	→	→	→	→	→	↓	↓	↓	→	→	↑	↑
Malnutrition	↑	↑	↑	↑	↑	→	→	→	↓	↓	↓	↓
Eye Infection	↓	↓	↓	↓	↑	↑	↑	↑	↑	↓	→	→
Common foods prices	↑	↓	→	→	→	→	↓	→	→	→	→	→
Planting & weeding	↓	↓	↑	↑	↑	↓	↓	↓	↑	↑	↓	↓
Harvesting	↑	↓	→	→	→	→	↓	→	→	→	→	→
In-Migration	↓	↑	↑	↓	↓	↓	↑	↑	↑	↑	↑	↑
Out-Migration	↑	↑	↑	↑	→	→	→	→	→	→	→	↓
Drought / famine	↑	↑	↑	↑	→	→	↑	↑	↓	↓	↓	↓

### Annex 2: Qualitative Data Source and Method - Team 1

Source	Method	Day 1	Day 2	Day 3
Health Program Manager (HPM)	KII			1
Health Care Provider (HCP)	KII	1	1	1
CHV - Community Based	KII	1	1	1
CHV - Facility Based	KII	1	1	
Carer - SAM Beneficiary - Individual	KII	1	1	1
Carer - SAM Beneficiary - Group	FGD	1	1	
Carer - MAM Beneficiary - Individual	KII	1	1	1
Carer - MAM Beneficiary - Group	FGD	1	1	
Carer - Cured SAM Beneficiary - Individual	KII	1		
Carer - Cured MAM Beneficiary - Individual	KII	1	2	
Carer - Defaulted SAM case - Individual	KII		1	
Carer - Defaulted MAM case - Individual	KII			
Carer - Non-Respondent SAM Case - Individual	KII			1
Carer - Non-Respondent MAM Case - Individual	KII		1	
Carer of any Under-five - Individual	KII	1	2	1
Lay person - mother/father/Retired Teacher or police	KII	1	2	1
Traditional Healing Practitioner or Birth Attendant (THP/TBA)	KII	1		
Religious Leader	KII	1		1
Shop Attendant	KII	1	1	
Chemist Attendant	KII		1	1

### Annex 3: Qualitative Data Source and Method - Team 2

Source	Method	Day 1	Day 2	Day 3
Health Program Manager (HPM)	KII	1	1	
Health Care Provider (HCP)	KII	1	2	1
CHV - Community Based	KII	1	2	1
CHV - Facility Based	KII	1	2	1
Carer - SAM Beneficiary - Individual	KII		1	1
Carer - SAM Beneficiary - Group	FGD		1	1
Carer - MAM Beneficiary - Individual	KII		1	1



Carer - MAM Beneficiary - Group	FGD		1	1
Carer - Cured SAM Beneficiary - Individual	KII		2	1
Carer - Cured MAM Beneficiary - Individual	KII	1	2	1
Carer - Defaulted SAM case - Individual	KII			1
Carer - Defaulted MAM case - Individual	KII	1	1	1
Carer - Non-Respondent SAM Case - Individual	KII			
Carer - Non-Respondent MAM Case - Individual	KII			1
Carer of any Under-five - Individual	KII	1	2	1
Lay person - mother/father/Retired Teacher or police	KII	1	2	1
Traditional Healing Practitioner or Birth Attendant (THP/TBA)		1		1
Community leaders		1	2	1
Chemist			1	

#### Annex 4: Qualitative Data Source and Method - Team 3

Source	Method	Day 1	Day 2	Day 3
Health Program Manager (HPM)	KII	2		
Health Care Provider (HCP)	KII	2	1	1
CHV - Community Based	KII	1	1	1
CHV - Facility Based	KII	2	1	1
Carer - SAM Beneficiary - Individual	KII	1		1
Carer - SAM Beneficiary - Group	FGD	1		
Carer - MAM Beneficiary - Individual	KII	1	1	1
Carer - MAM Beneficiary - Group	FGD		1	
Carer - Cured SAM Beneficiary - Individual	KII	2	1	1
Carer - Cured MAM Beneficiary - Individual	KII	1	1	1
Carer - Defaulted SAM case - Individual	KII	1		1
Carer - Defaulted MAM case - Individual	KII		1	1
Carer - Non-Respondent SAM Case - Individual	KII		1	
Carer - Non-Respondent MAM Case - Individual	KII			1
Carer of any Under-five - Individual	KII	1	1	1
Lay person - mother/father/Retired Teacher or police	KII	3	1	1
Traditional Healing Practitioner or Birth Attendant (THP/TBA)		1	1	1
Mother to mother support group	FGD			1

#### Annex 5: Qualitative Data Source and Method - Team 4

Source	Method	Day 1	Day 2	Day 3
Health Program Manager (HPM)	KII	1		1
Health Care Provider (HCP)	KII	3	2	1
CHV - Community Based	KII	2	1	1
CHV - Facility Based	KII	1	2	1
Carer - SAM Beneficiary - Individual	KII		1	1
Carer - SAM Beneficiary - Group	FGD		1	
Carer - MAM Beneficiary - Individual	KII		1	1
Carer - MAM Beneficiary - Group	FGD		1	



Carer - Cured SAM Beneficiary - Individual	KII			1
Carer - Cured MAM Beneficiary - Individual	KII	1	1	1
Carer - Defaulted SAM case - Individual	KII			1
Carer - Defaulted MAM case - Individual	KII	1	1	1
Carer - Non-Respondent SAM Case - Individual	KII			
Carer - Non-Respondent MAM Case - Individual	KII			1
Carer of any Under-five - Individual	KII	2	2	1
Lay person - mother/father/Retired Teacher or police	KII	1	1	
Traditional Healing Practitioner or Birth Attendant (THP/TBA)	KII	2	1	
Ward Admin	KII	1	1	1

#### Annex 6: Qualitative Data Source and Method - Team 5

Source	Method	Day 1	Day 2	Day 3
Health Program Manager (HPM)	KII			1
Health Care Provider (HCP)	KII	1	1	2
CHV - Community Based	KII	1		2
CHV - Facility Based	KII			
Carer - SAM Beneficiary - Individual	KII	1	1	1
Carer - SAM Beneficiary - Group	FGD			
Carer - MAM Beneficiary - Individual	KII	1	1	
Carer - MAM Beneficiary - Group	FGD		1	1
Carer - Cured SAM Beneficiary - Individual	KII			1
Carer - Cured MAM Beneficiary - Individual	KII	1	1	
Carer - Defaulted SAM case - Individual	KII			1
Carer - Defaulted MAM case - Individual	KII	1	1	1
Carer - Non-Respondent SAM Case - Individual	KII	1		
Carer - Non-Respondent MAM Case - Individual	KII	1	1	
Carer of any Under-five - Individual	KII			1
Lay person - mother/father/Retired Teacher or police	KII	1	1	2
Traditional Healing Practitioner or Birth Attendant (THP/TBA)	KII	1	1	1
Ward Admin	KII	1		2
Chemist Attendant	KII	1	1	

#### Annex 7: Qualitative Data Source and Method - Team 6

Source	Method	Day 1	Day 2	Day 3
Health Program Manager (HPM)	KII	1		
Health Care Provider (HCP)	KII		2	1
CHV - Community Based	KII	1	1	
CHV - Facility Based	KII	1	2	1
Carer - SAM Beneficiary - Individual	KII	1		3
Carer - SAM Beneficiary - Group	FGD			
Carer - MAM Beneficiary - Individual	KII	2	2	1
Carer - MAM Beneficiary - Group	FGD			
Carer - Cured SAM Beneficiary - Individual	KII	1		2
Carer - Cured MAM Beneficiary - Individual	KII		2	2



Carer - Defaulted SAM case - Individual	KII		1	
Carer - Defaulted MAM case - Individual	KII		1	
Carer - Non-Respondent SAM Case - Individual	KII	1		1
Carer - Non-Respondent MAM Case - Individual	KII			
Carer of any Under-five - Individual	KII			
Lay person - mother/father/Retired Teacher or police	KII	1	2	
Traditional Healing Practitioner or Birth Attendant (THP/TBA)	KII	1	1	1
TBAs	FGD		1	
Village leaders	SSI	1	2	
Support group	FGD		1	
Religious leaders	KII		1	

### Annex 8: Qualitative Data Source and Method - Team 7

Source	Method	Day 1	Day 2	Day 3
Health Program Manager (HPM)	KII	1	1	1
Health Care Provider (HCP)	KII	1	1	2
CHV - Community Based	KII		1	
CHV - Facility Based	KII	1	1	
Carer - SAM Beneficiary - Individual	KII		1	
Carer - SAM Beneficiary - Group	FGD			
Carer - MAM Beneficiary - Individual	KII	1	1	
Carer - MAM Beneficiary - Group	FGD		1	1
Carer - Cured SAM Beneficiary - Individual	KII			
Carer - Cured MAM Beneficiary - Individual	KII	1		1
Carer - Defaulted SAM case - Individual	KII		1	
Carer - Defaulted MAM case - Individual	KII	1		
Carer - Non-Respondent SAM Case - Individual	KII			
Carer - Non-Respondent MAM Case - Individual	KII			
Carer of any Under-five - Individual	KII	1		1
Lay person - mother/father/Retired Teacher or police	KII	2	2	1
Traditional Healing Practitioner or Birth Attendant (THP/TBA)			1	
Church Leader	KII	1	1	
MCA				1

### Annex 9: Qualitative Data Source and Method - Team 8

Source	Method	Day 1	Day 2	Day 3
Health Program Manager (HPM)	KII	1	2	
Health Care Provider (HCP)	KII	1	1	1
CHV - Community Based	KII			
CHV - Facility Based /Community	KII	1	4	1
Carer - SAM Beneficiary - Individual	KII	1		
Carer - SAM Beneficiary - Group	FGD		3	
Carer - MAM Beneficiary - Individual	KII			
Carer - MAM Beneficiary - Group	FGD	1	2	
Carer - Cured SAM Beneficiary - Individual	KII			



Carer - Cured MAM Beneficiary - Individual	KII			
Carer - Defaulted SAM case - Individual	KII		2	
Carer - Defaulted MAM case - Individual	KII			
Carer - Non-Respondent SAM Case - Individual	KII			
Carer - Non-Respondent MAM Case - Individual	KII			
Carer of any Under-five - Individual	KII	1		1
Lay person - mother/father/Retired Teacher or police	KII	1	3	1
Traditional Healing Practitioner or Birth Attendant (THP/TBA)	KII	1	2	1
Religious leader	KII	1	1	
Ass chief/nyumba kumi	KII	1	1	1

### Annex 10: Qualitative Data Source and Method - Team 9

Source	Method	Day 1	Day 2	Day 3
Health Program Manager (HPM)	KII			1
Health Care Provider (HCP)	KII		1	1
CHV - Community Based	KII		1	1
CHV - Facility Based	KII	1		1
Carer - SAM Beneficiary - Individual	KII		1	
Carer - SAM Beneficiary - Group	FGD		1	
Carer - MAM Beneficiary - Individual	KII	1	1	
Carer - MAM Beneficiary - Group	FGD	1	1	1
Carer - Cured SAM Beneficiary - Individual	KII	1	1	1
Carer - Cured MAM Beneficiary - Individual	KII	1	1	
Carer - Defaulted SAM case - Individual	KII	1		1
Carer - Defaulted MAM case - Individual	KII			
Carer - Non-Respondent SAM Case - Individual	KII			
Carer - Non-Respondent MAM Case - Individual	KII			
Carer of any Under-five - Individual	KII	2		
Lay person - mother/father/Retired Teacher or police	KII	1		1
Traditional Healing Practitioner or Birth Attendant (THP/TBA)			1	
Community leaders	SSI	1		
Chemist	KII	1		

### Annex 11: Community Assessment Implementation Roadmap

FIELD ACTIVITIES - SQUEAC SURVEY IMPLEMENTATION											
TASK	No. of Days	9 <sup>th</sup> Aug 2023	9 <sup>th</sup> - 11 <sup>th</sup> Aug	11 <sup>th</sup> to 16 <sup>th</sup> Aug	20 <sup>th</sup> Aug	21 <sup>st</sup> & 24 <sup>th</sup> Aug	25 <sup>th</sup> & 26 <sup>th</sup> Aug	27 <sup>th</sup> & 29 <sup>th</sup> Aug	30 <sup>th</sup> Aug - 2 <sup>nd</sup> Sept	2 <sup>nd</sup> - 15 <sup>th</sup> Sept	Status
Resource Mobilization in the counties for funding and capacity Gap	Month of July										
Presentation of the ROAD MAP (Methodology) to the National SQUEAC Taskforce for Review & Approval	1	First week Aug									





<b>Mobilization of the Survey Team -Training Participants</b> •County Staff (6 MOH Staff per County) •Partner Organization Staff in each county	6																			
<b>Classroom training:</b> Training on Quantitative Data tools	1																			
Field Data Collection: Quantitative Data collection	4																			
<b>Classroom training:</b> Training on Community Assessment & Detailed work plan; Distribution of tasks to the assessment team; Local terminology and seasonal calendar	2																			
<b>Field Data Collection: Field data collection (Qualitative Data Collection)</b>	3																			
Boosters & Barrier Analysis Seasonal Calendar Analysis	3																			
•Development of Concept/Mind maps																				
Presentation of Results and submission of summary report Writing of final report	7																			
Presentation of the findings to the county	1																			
Incorporation of feedback into final report	2																			
<b>TOTAL NO. OF DAYS</b>	<b>30</b>																			

### Annex 12: Community Assessment Enumerator Training Schedule

[Kajiado County, Kenya] Day 1: 20 <sup>th</sup> August 2023 Agenda			
8.30	Opening	Introductions Overview of agenda Questions and clarifications Participants' Expectations	All participants
	Welcome Remarks	Opening remarks from the County Gov't	Office of Director County Dept. of Health & Office of CNC
9.00	Introduction to Coverage Assessment	What is Coverage Assessment? What are the various methods for Coverage Assessment?	NITWG Support
9.30	Coverage Assessment Methodology	What Method of Coverage Assessment is being implemented in Kajiado? What are the Stages and Steps involved?	CNC
10.30	<b>TEA BREAK</b>		
10.50	Cont. Coverage Assessment Methodology	Stages and Steps in Community Assessment in Kajiado Community Assessment Timeline	CNC
11.30	Stage 1: Quantitative Data Collection	Data Collection Procedure Service Delivery point Tools to Interact - Registers vs Reports	Plenary
12.00	Stage 1: Quantitative Data Collection	Quantitative Data Collection Tools and Database	NITWG Support
13.00	<b>LUNCH BREAK</b>		
14.00	Stage 1: Quantitative Data Collection	Quantitative Data Collection Tools and Database	NITWG Support



15.00	Stage 1: Quantitative Data Collection	Practical filling up of the Quantitative Tools with Health Facility Registers - In-Patient, OTP & SFP	Group work & Plenary Discussions
17.00	Wrap up	Printing & Distribution of Tools Review of Day & Closure	All participants
17.30	<b>TEA BREAK</b>		
<b>Day 2: 25<sup>th</sup> August 2023 Agenda</b>			
8.30	Opening	Prayers Introductions Overview of agenda	All participants
	Quantitative Data Field Experience	Review of Quantitative Data collection experience Finalization of Quantitative Data Entry	All participants
10.25	<b>TEA BREAK</b>		
10.45	Introduction to IMAM program	What are components of IMAM programme? What are admission and discharge criteria? What is treatment for OTP and TSFP?	SCNO
	Cont. Introduction to IMAM Program	How does community outreach strategy operate?  How is the Referral mechanism in the county? (CHS)	SCNO
11.30	Community Assessment	Introduction Local Terminology Seasonal Calendar (in groups)	SQUEAC TOT All Participants
13.00	<b>LUNCH BREAK</b>		
14.00	Community Assessment	Key principles for Qualitative data collection	SQUEAC TOT
	Community Assessment	Qualitative data collection tools or Interview guides review	SQUEAC TOT
17.00	Wrap up	Review of Day & Closure	All participants
17.00	<b>TEA BREAK</b>		
<b>Day 3: 26<sup>th</sup> August 2023 Agenda</b>			
08.00	<b>RECAP</b>	Review of previous day's work	All participants
08.30	Community Assessment: Interview skills review	Review and role play with interview and data collection guides Plenary discussion	All participants
10.30	<b>TEA BREAK</b>		
10.30	Community Assessment: Interview skills review	Review and role play with interview and data collection guides Plenary discussion	All participants
13.00	<b>LUNCH</b>		
14.00	Qualitative data collection: challenges and questions	Group discussions about concerns and common challenges during qualitative data collection	All participants
14.30	Qualitative data collection: challenges and questions	Feedback from group discussions	All participants



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15.00	Qualitative Data collection	Development of the Qualitative sampling framework	All participants
15.30	Logistics and planning	Allocation of teams, planning for data collection, distribution of materials	All participants
17.00	Wrap up	Review of Day & Closure	All participants
17.00	TEA BREAK		



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