



Community Assessment of the Kwale Integrated Management of Acute Malnutrition (IMAM)

6th – 19th August 2023



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Acronyms

BFCI	Baby Friedly Community Initiative
CA	Community Assessment
CHMT	County Health Management Team
CHP	Community Health Promoter
CU	County Health Management Team
IGA	Income Generating Activity
IMAM	Integrated Management of Acute Malnutrition
IYCN-E	Infant and Young Child Nutrition - Emergency
KRCS	Kenya Red Cross Society
KEMSA	Kenya Medical Supplies Agency
KII	Key Informant Interviews
MAM	Moderate Acute Malnutrition
MOH	Ministry of Health
MTMSGs	Mother to Mother Support Groups

MUAC	Mid Upper Arm Circumference
NGO	Non-Governmental Organization
OJT	On the Job Training
OTP	Outpatient Therapeutic Program
RUST	Ready to Use Supplementary Feeds
RUTF	Ready to Use Therapeutic Feeds
SAM	Severe Acute Malnutrition
SCHMT	Sub-county Health Management Team
SFP	Supplementary Feeding Program
SMART	Standardized Monitoring and Assessment of Relief and Transitions
SQUEAC	Semi-Quantitative Evaluation of Access and Coverage
TBA	Traditional Birth Attendant
TCA	To come again
UNICEF	United Nation Children Fund
WHZ	Weight for Height Z-score

Executive Summary

Kwale County is situated in the south coast of the country, bordering the Republic of Tanzania to the South West, and the following Counties; Taita Taveta to the West, Kilifi to the North, Mombasa to the North East and Indian ocean to the East and South East. The County has an estimated total population of 969,359 *and* 145745 *of* <5s (projected populations 2022) and covers an area of 8,267.1km² (KNBS 2019). The county is divided into five sub counties namely Kinango, Matuga, Msambweni, Lungalunga and Samburu. The main economic activity is agriculture which includes fishing, livestock and mixed farming

The county has 130 health facilities (May 2023) offering integrated management of acute malnutrition (IMAM) services that include seven stabilization centers i.e. Msambweni county referral hospital, Kwale hospital, Kinango, Lungalunga, Samburu sub county hospitals, Tiwi HC and Kinondo Kwetu. In response to drought and to improve access the County has mapped 115 outreach sites of this 65 are supported by World Vision.

A community assessment (CA) was conducted in the county to provide information about the bottlenecks to CMAM program and come up with appropriate action plan. Being the first Community Assessment, the survey was to act as a baseline.

The overall objective of the Community assessment was to provide information about the bottlenecks to CMAM program as well as to come up with appropriate action plan. The specific objectives were:

- 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

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

Barrier	Recommendations	Actions
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1. Long distance covered to reach IMAM sites/facilities	Intensify bimonthly integrated outreaches to villages which are more than 5 kms from the health facility	Identification and Selection of outreach sites
2. Poor health seeking behaviours	Conduct community dialogues on behavior change for the community and giving continuous feedback on health outcomes to the community leaders	Organize community dialogues. Involve community leaders in the dialogues
3. Lack of enough communication and coordination between HCWs, CHPs and the community	Regular monthly meetings with CHPs and Healthcare workers to discuss IMAM activities Forming a health facility committee with representation from the Subcounty Nutrition Coordinator, health facility, CHPs, community leaders and religious leaders. Ensuring HCWs and CHPs have adequate tools for communication and coordination.	Conduct monthly HW-CHPs meetings. Formation of a health facility committee. Provide CHPs and HW with tools
4. Low motivation among CHPs	Link community units with income generating activities Plan for refresher courses on IMAM Performance appraisal Ensure consistency of the monthly stipend Providing working materials e.g Identification badges, Bags, Uniform/T-shirts, CHPs kits. Provide bicycles to ease their movement. Review their transport and subsistence allowance. Support supervision and OJT	Link CUs with social service department. CHPs training on IMAM Conduct performance appraisal. Lobby for consistent monthly stipend and working materials. Conduct monthly support supervision.
5. Heavy workload due to insufficient staffing	Lobby for more health workers. Have specific nutrition clinic days.	Lobby for more nutritionists and nurses to be employed so as to reduce workload Identifying specific days for nutrition

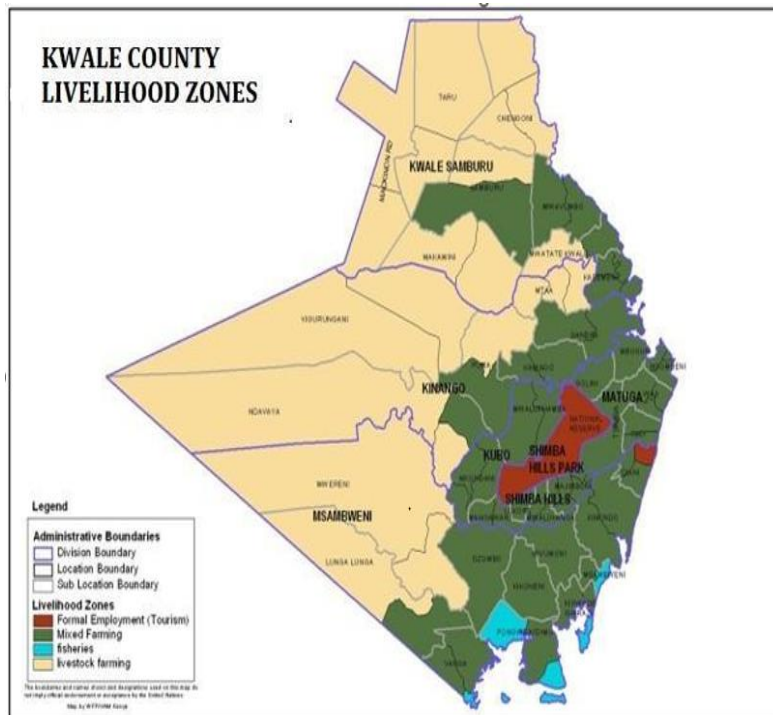
<p>6. High defaulter rate</p>	<p>Develop a proper defaulter tracing mechanism e.g tickler box in tracking of defaulters.</p>	<p>Line listing of bi weekly miss appointment and sharing with CHPs every Friday Use of tickler box effectively Support CHPs to follow up of miss appointment. Use of miss opportunity diary</p>
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1.0 Introduction

1.1 Background Information

Overview of Kwale county

Kwale County is situated in the south coast of the country, bordering the Republic of Tanzania to the South West, and the following Counties; Taita Taveta to the West, Kilifi to the North, Mombasa



to the North East and Indian ocean to the East and South East. The County has an estimated total population of 969,359 and 145,745 of <5s (projected populations 2022) and covers an area of 8,267.1km² (KNBS 2019). The county is divided into five sub counties namely Kinango, Matuga, Msambweni, Lungalunga and Samburu. The main economic activity is agriculture which includes fishing, livestock and mixed farming

Figure 1: Map of Kwale County

Nutrition Situation

According to NDMA EW bulletin (May 2023), the County drought status is at recovery and the trend is stable across all livelihood zones. A SMART survey conducted in July 2022 in the County revealed a global acute malnutrition (GAM) prevalence by WHZ at 6.3% while severe acute malnutrition (SAM) prevalence was at 1.8%. Integrated phase classification for acute malnutrition classified the County in Alert Phase (IPC AMN phase 2). GAM and SAM by MUAC is 1.7% & 0.5% respectively (Integrated SMART survey of July 2022)

The county has 130 health facilities (May 2023) offering integrated management of acute malnutrition (IMAM) services that include seven stabilization centers i.e. Msambweni county referral hospital, Kwale hospital, Kinango, Lungalunga, Samburu sub county hospitals, Tiwi HC and Kinondo Kwetu. In response to drought and to improve access the County has mapped 115 outreach sites and of this, 65 are supported by World Vision.

Over the years Kwale has received partner support from USAID, World Vision, UNICEF, WFP, Stawisha, Kenya Red Cross and Hellen Keller. The support has helped in training Health workers in but not limited to, 125 in IMAM, 60 in BFCI, 50 IMAM Surge and 60 in IYCN-E, conducting integrated outreaches in more than 65 sites across all the sub counties and about 500 CHVs in BFCI however, no community health volunteers who have been trained on CMAM.

1.2 Justification for the community assessment Survey

Being a Semi-arid county, Kwale 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 CMAM 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 6.1 to 7.3 in 2022. levels increased across the survey zones.

A community assessment (CA) was conducted in the county to provide information about the bottlenecks to CMAM program and come up with appropriate action plan. Being the first Community Assessment, the survey was to act as a baseline.

1.3 Objectives of the Survey

The overall objective of the Community assessment was to provide information about the bottlenecks to CMAM program as well as to come up with appropriate action plan. The specific objectives were:

- 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

2.0 Methodology

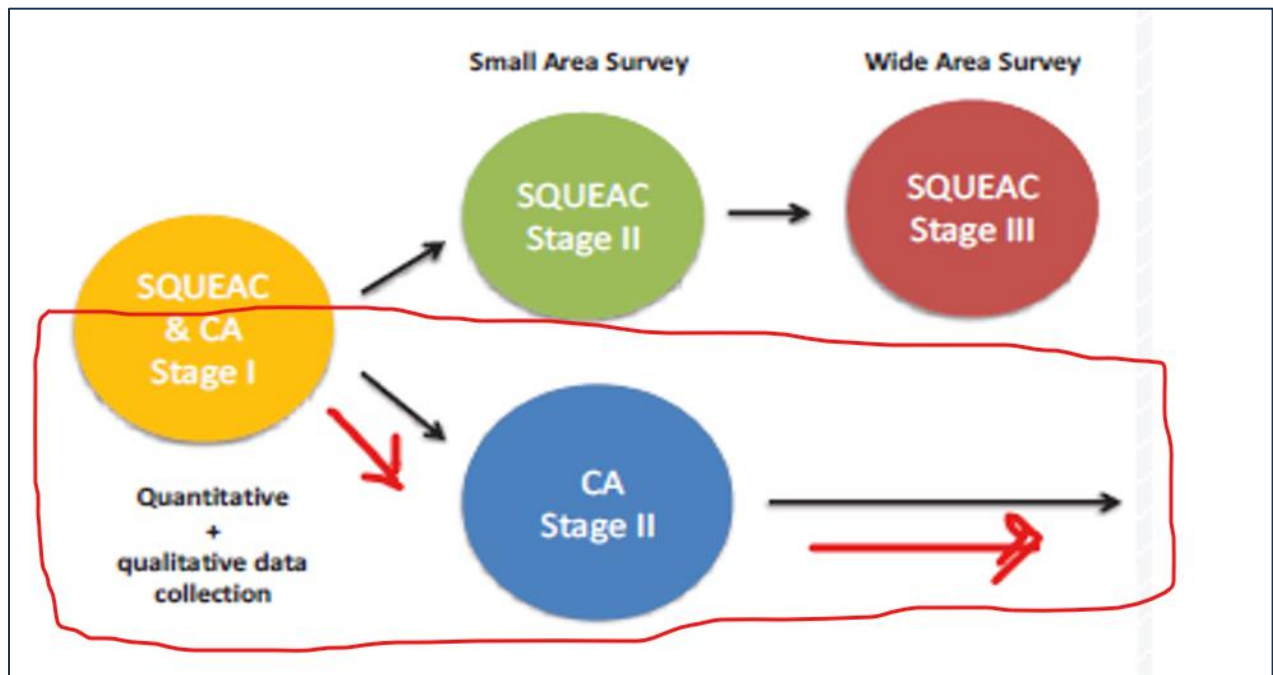


Figure 2: Decision tree

The Community Assessment involved a seven-steps process namely;

Step 1: Training of enumerators and identification of stakeholders

Step 2: Quantitative data collection.

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

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

3.0 Results of the Community Assessment Survey

3.1 COMMUNITY ASSESSMENT STAGE 1

3.1.1 Quantitative data

This data was obtained from OTP registers, SFP beneficiaries registers and monthly stock summary for the last 12 months (August 2022 – July 2023) to include data overtime, MUAC, Z-scores and oedema at admissions and exit indicators; cure, defaulter, non-response and death rates. Admissions and exit graphs were plotted against the seasonal calendar for the five Sub-counties and the entire county to compare the trend of the program data.

3.1.2 INPATIENT MANAGEMENT OF ACUTE MALNUTRITION

98% of admissions to IP were direct an indication that no deterioration of cases while in outpatient management (OTP or SFP). Deaths were reported in majority of the months apart from Jan 2023 and March 2023 which may be attributed to late admission to program and poor health seeking behavior. Majority of clients successively stabilized and discharged to OTP as shown in figure 3 below.

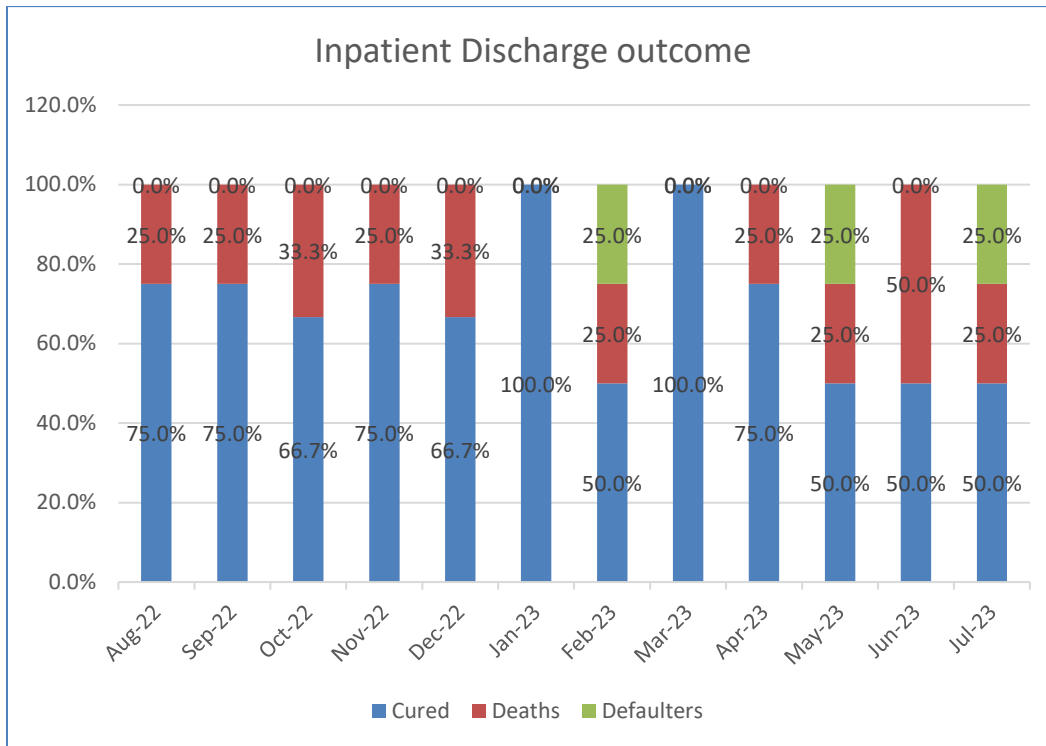


Figure 3: Inpatient Discharge outcome

3.1.3 Out-Patient Therapeutic Program (OTP)

OTP Admissions Overtime

There was a notable increase in admissions into OTP program in the month of October 2022 which may be attributed to increased integrated outreach activities. Low admissions in December 2022 followed after heightened screening and case finding in the month of October leading to fewer cases being admitted.

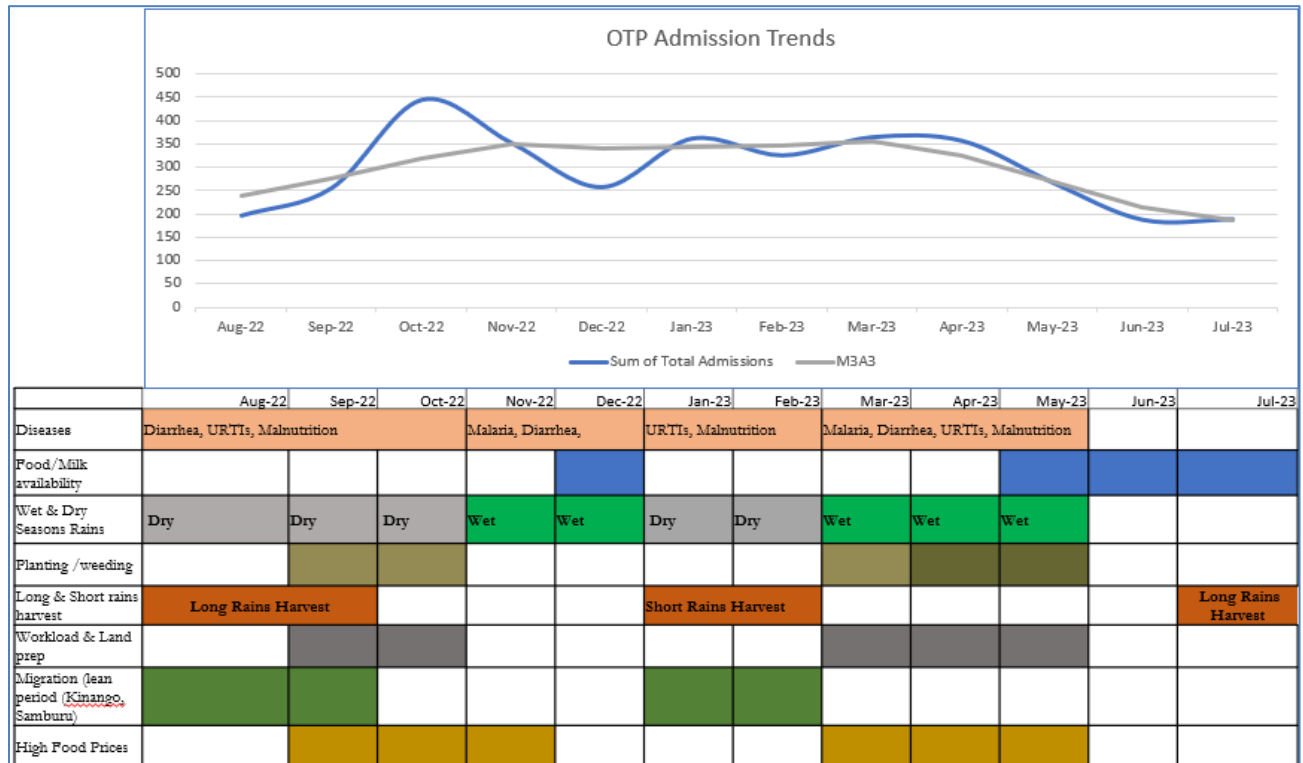


Figure 4: OTP Admissions Over time

OTP Admissions by MUAC

This was assessed for clients who were admitted by MUAC as the criteria for admission. Median MUAC was 11.2cm, indicating Early Admissions into the OTP program. While majority of the MUAC admissions were early MUAC admissions, there were still many admissions made with low MUAC indicating late critical admission some as low as <9.0cm. There were many cases of wrong admission (221 cases with MUAC \geq 11.5cm) into OTP owing to a mix up of the criteria. Both late admissions and wrong admissions criteria negatively impact on the OTP program coverage

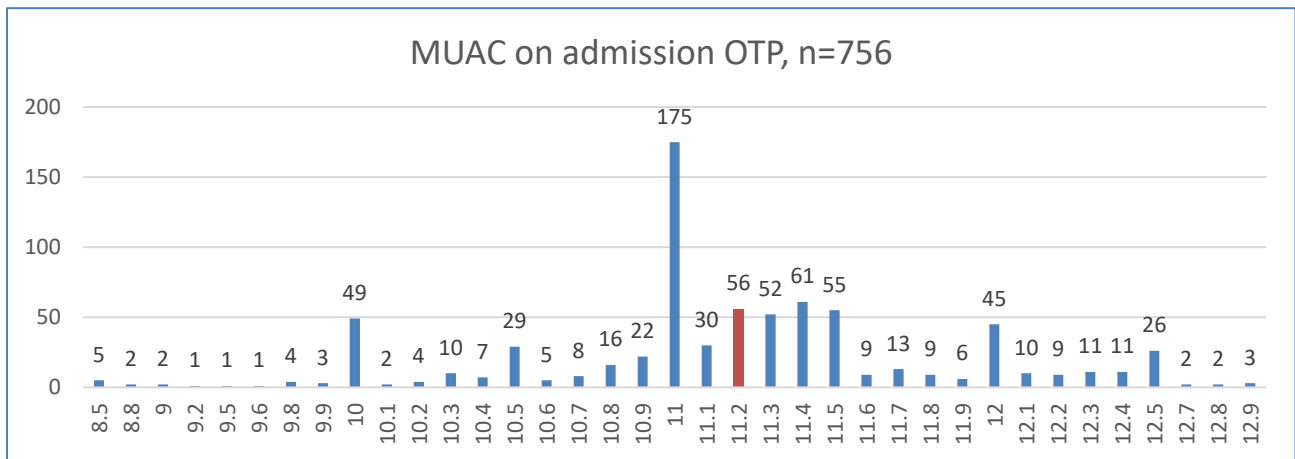


Figure 5: OTP Admissions by MUAC

OTP Admissions by Z-Score and Oedema

WHZ score was the main admission criteria in the county. Majority (87.8%) were admitted with < -3 SD an indication of early admission. Few cases (3.5%) were admitted with <-2SD indicating wrong criteria. A few cases were admitted with <-4sd indicating very late admission. A small number (44) of children were admitted with bilateral pitting oedema.

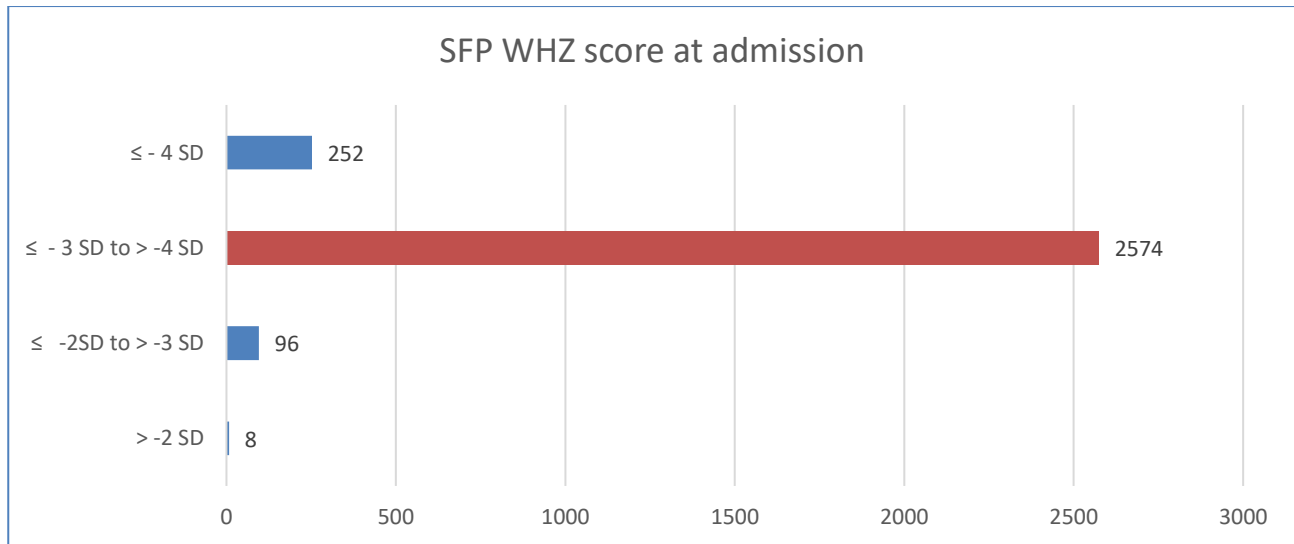


Figure 6: OTP Admission by Z-score

OTP Exits Over time (Performance Indicators) at County level

The source documents indicated poor performance of OTP Program in the past 12 months with above threshold cure rate being reported only in June and July 2023. High Defaulter rate in OTP program is recorded throughout the assessment period apart from June and July 2023.

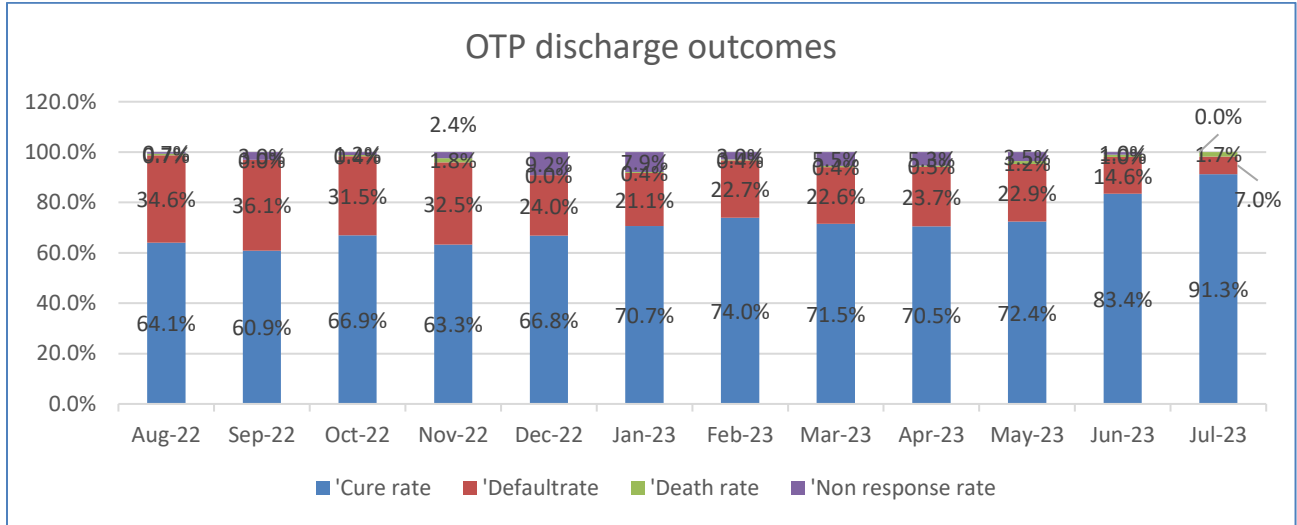


Figure 7: OTP Discharge Outcomes

OTP Exits Over time (Performance Indicators) at Sub-County level

At sub-county level, the source documents indicated poor performance of OTP Program in the past 12 months with above threshold cure rate being reported only in Kinango and Samburu sub-counties. Msambweni had the highest default rate with almost 2 out of 3 beneficiaries defaulting. At county level, cure rate was 71.6% while default rate was 24.0% both performing below threshold as shown in Figure 8 below

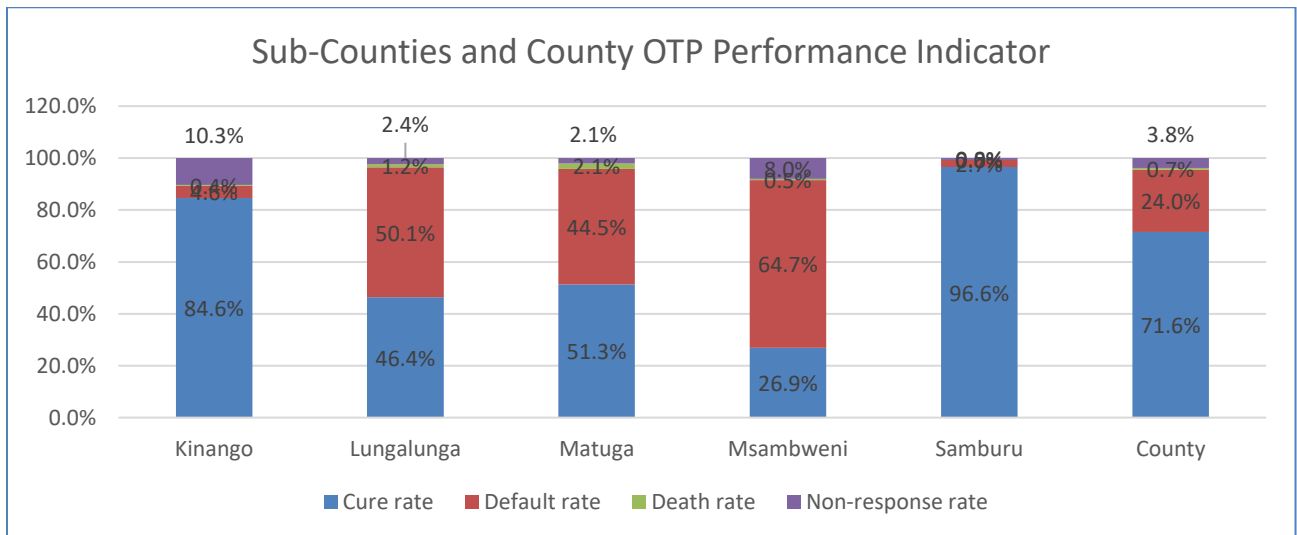


Figure 8: OTP Performance Indicator by Sub-Counties

OTP Length of stay for cured

Median LOS was 10 weeks which implies long stay beyond recommended 8 weeks. IMAM protocol adherence is a challenge observed from the late and early discharges. Reports of CHPs managing the IMAM program also contributes to the late and early discharges

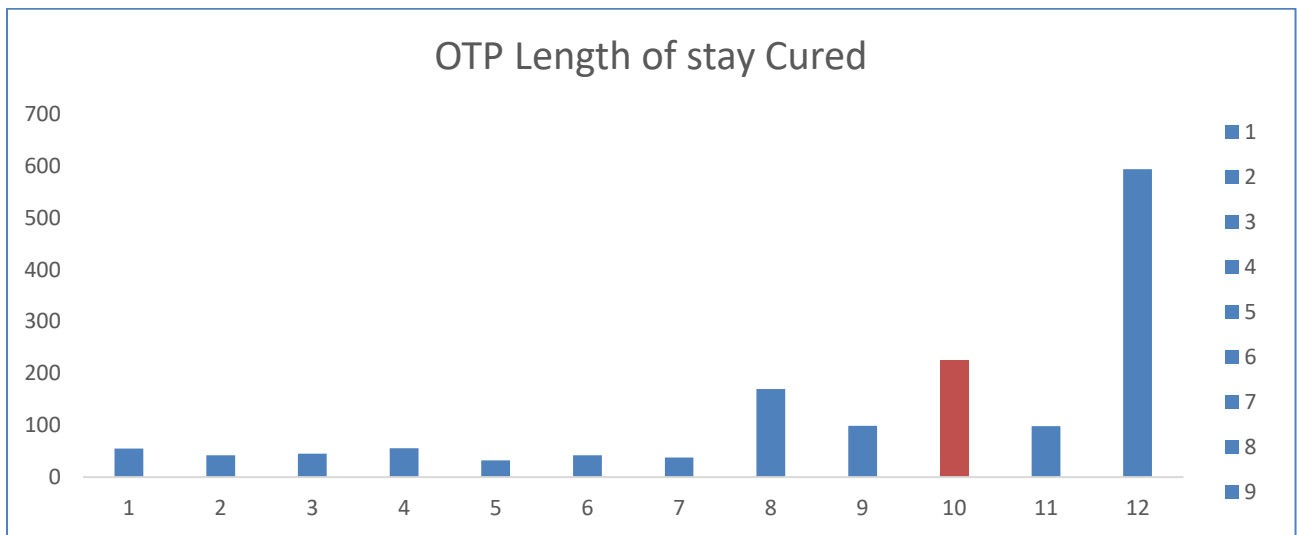


Figure 9: Length of stay for cured OTP MUAC admissions

OTP MUAC at discharged Cured

Median MUAC was 12.4 indicating a long stay in the program before being discharged to SFP. However, some beneficiaries were exited as cured without having attained the required MUAC suggesting poor documentation or wrong discharge

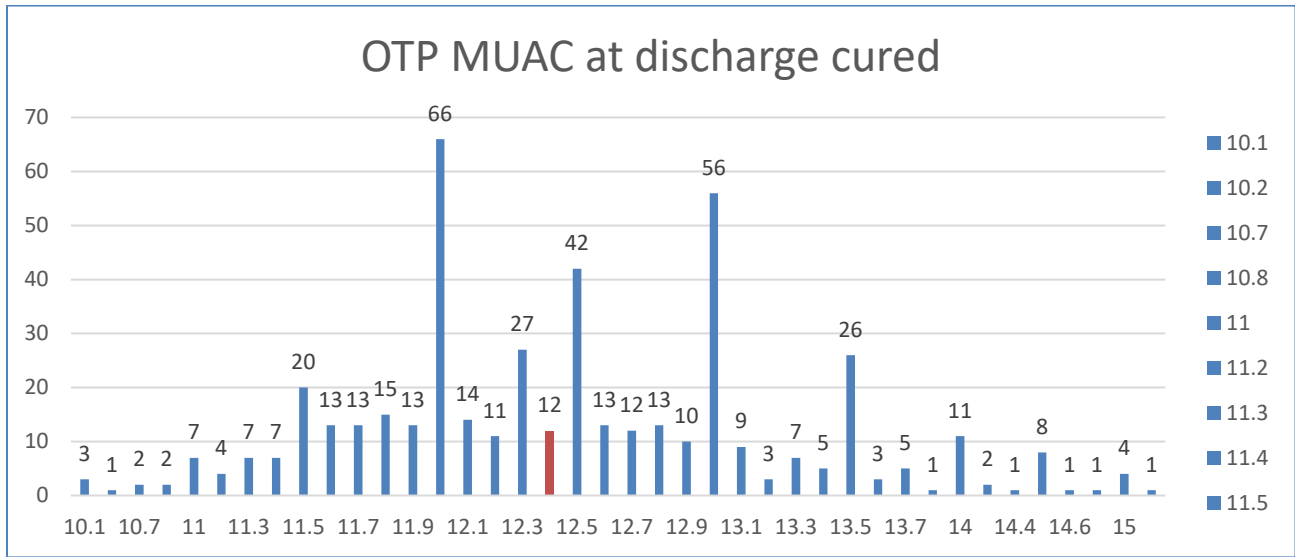


Figure 10: OTP MUAC at discharge Cured

3.1.4 SUPPLEMENTARY FEEDING PROGRAM (SFP)

Admission over Time

There were increased admissions into SFP program recorded in October 2022 attributed to increased integrated outreach activities. Low admissions in December 2022 followed after heightened screening in the month of October 2022 leading to fewer cases being admitted.

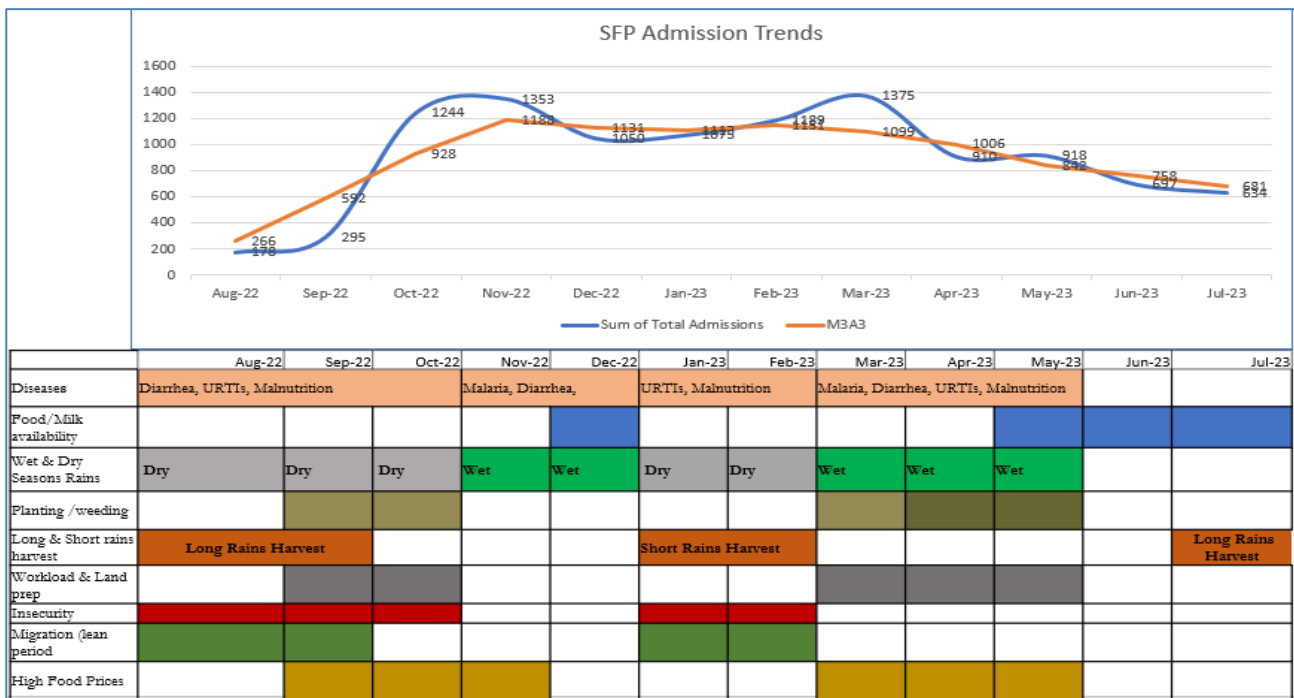


Figure 11: SFP Admissions

SFP Admissions Based on MUAC

Median MUAC is 12.0cm, indicating Early Admissions into SFP program. While still 50% of the MUAC admissions are early, there are still many admissions made with low MUAC indicating late critical admission some as low as <11.0cm. There were many cases of wrong admission (161 cases with MUAC \geq 12.5cm and 158 cases with MUAC <11.5cm) into SFP. Both late and wrong admission negatively impact SFP program coverage

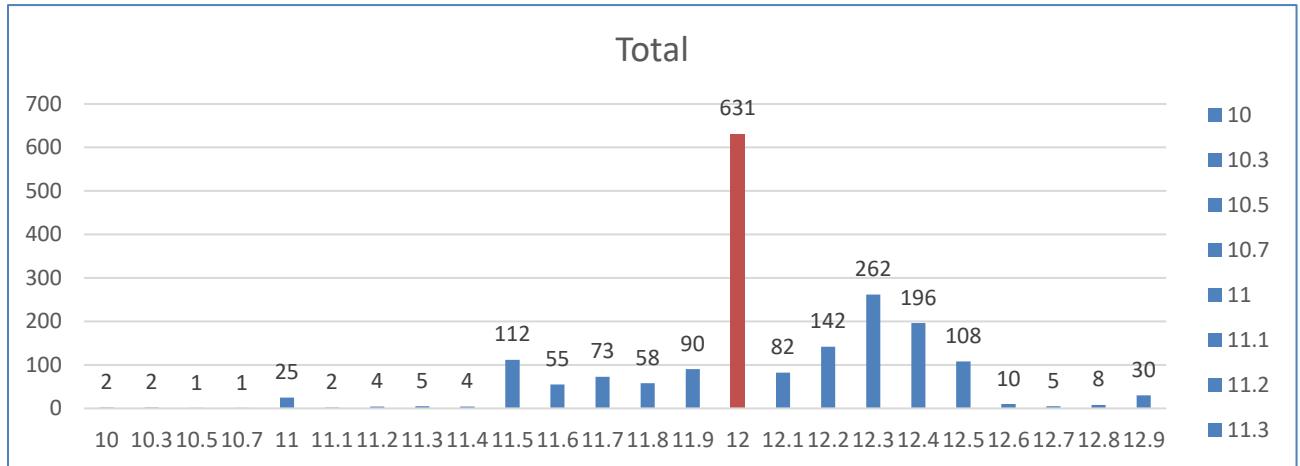


Figure 12: SFP Admissions by MUAC

SFP WHZ score at admission

Most children were admitted early at $\leq -2z$ - $\geq -3sd$ (n=6888). A few cases admitted with $< -4sd$ indicating very late admission. Cases of wrong admission were also observed in the SFP program ($< -3sd$ - $\geq -4sd$)

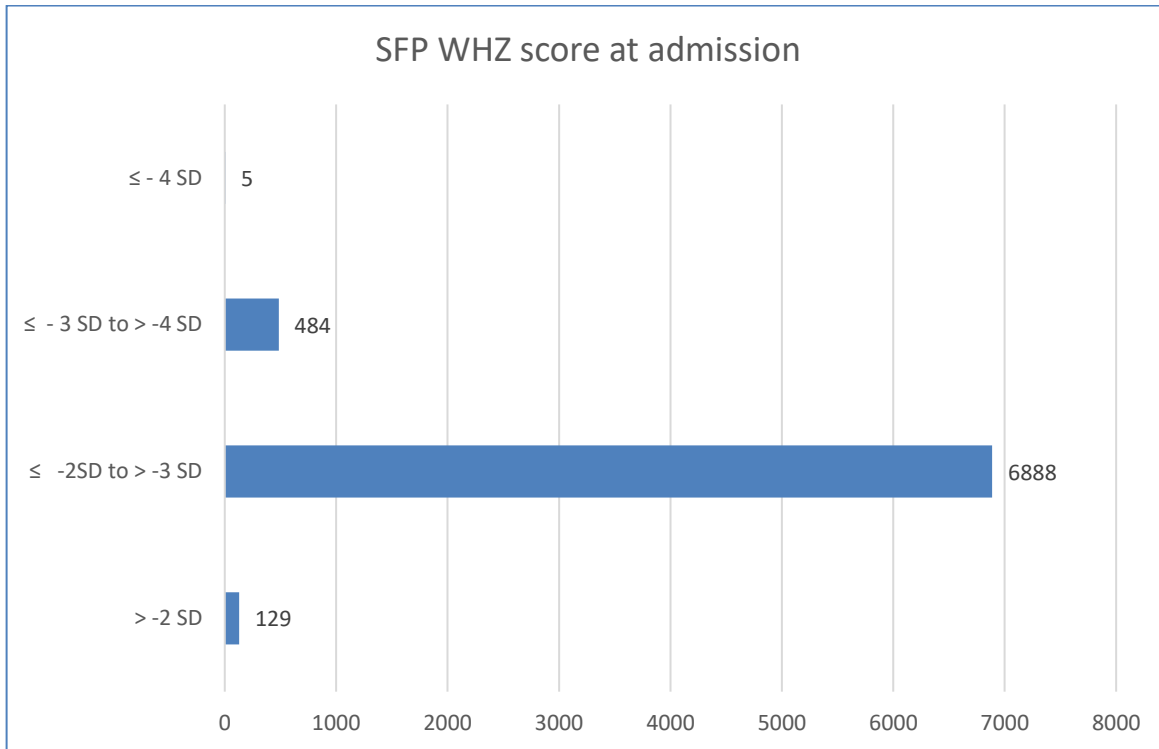


Figure 13: SFP WHZ at Admission

SFP Discharge outcome- County

The cure rate and defaulter rate were below the sphere standard of 75% and 15% across the periods.

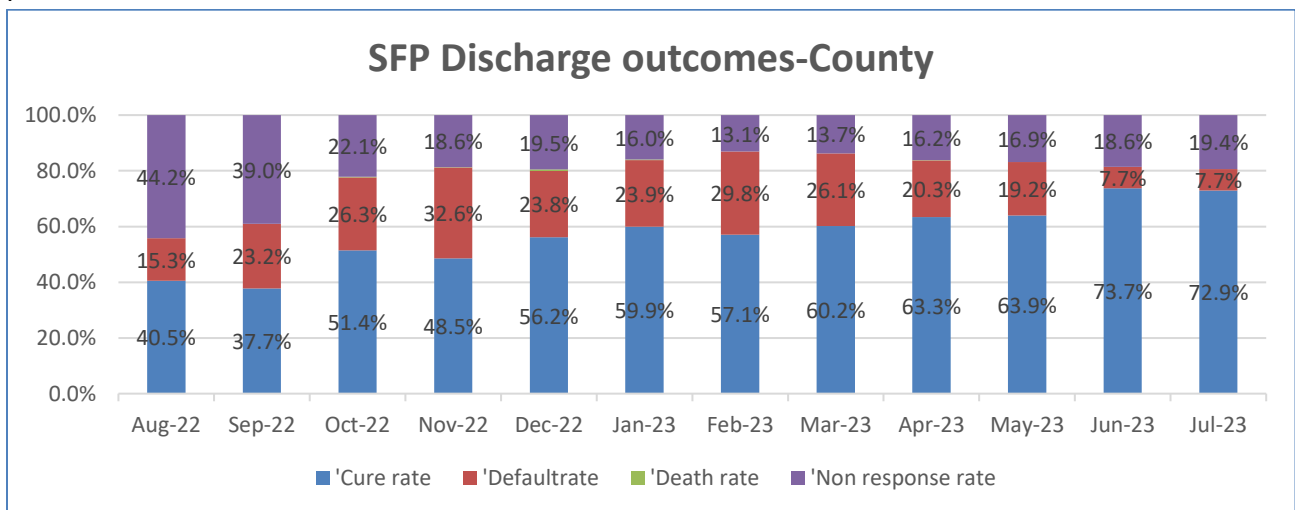


Figure 14: SFP Discharge outcomes

SFP Discharge outcome at Sub-County level

At sub-county level, the source documents indicated poor performance of SFP Program in the past 12 months with above threshold cure rate being reported in Kinango and Samburu sub-counties.

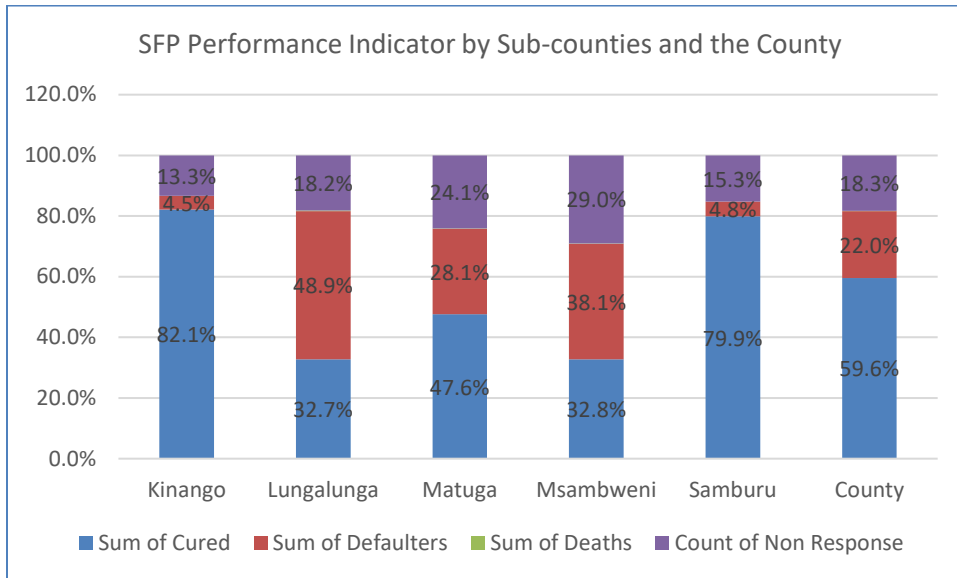


Figure 15: SFP Discharge outcomes by Sub-Counties

SFP MUAC at discharge Cured

Timely discharge for cured was observed with most cases being discharged with MUAC ≥ 12.5 cm. Median MUAC at discharge was 13.0cm. Few cases of early discharge before the recommended exit criteria was observed and this may be attributed to poor documentation.

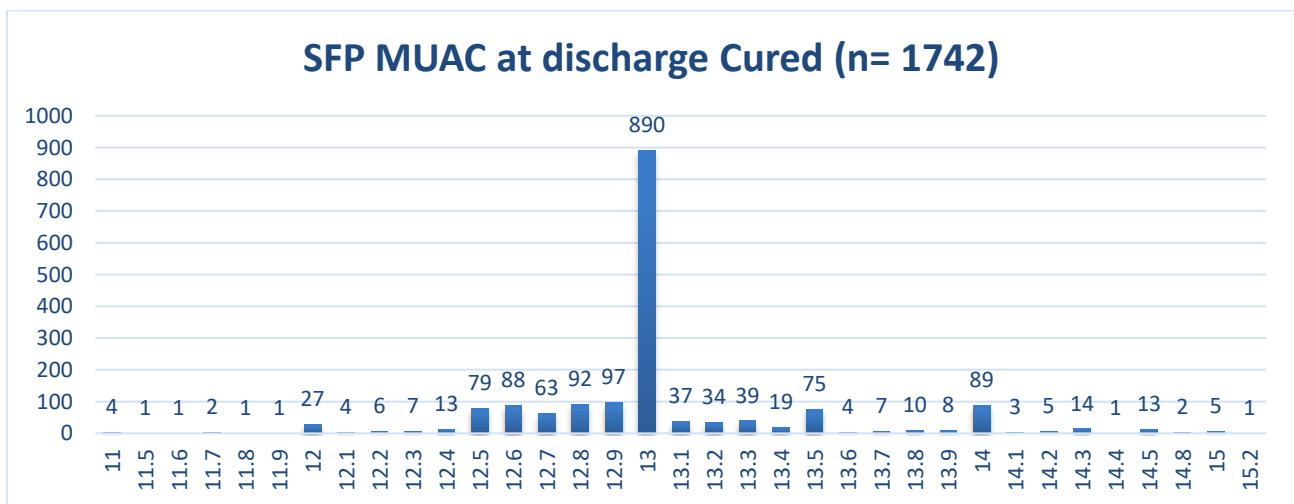


Figure 16: SFP MUAC at discharge cured

SFP WHZ score at discharge Cured

Discharge as cured observed to be done within the recommended discharge criteria (> -2 SD). However, early discharges, when the children are not yet cured, were also observed which may be

attributed to poor documentation and mix up of the discharge criteria. This is poor case mismanagement which impacts negatively on the program.

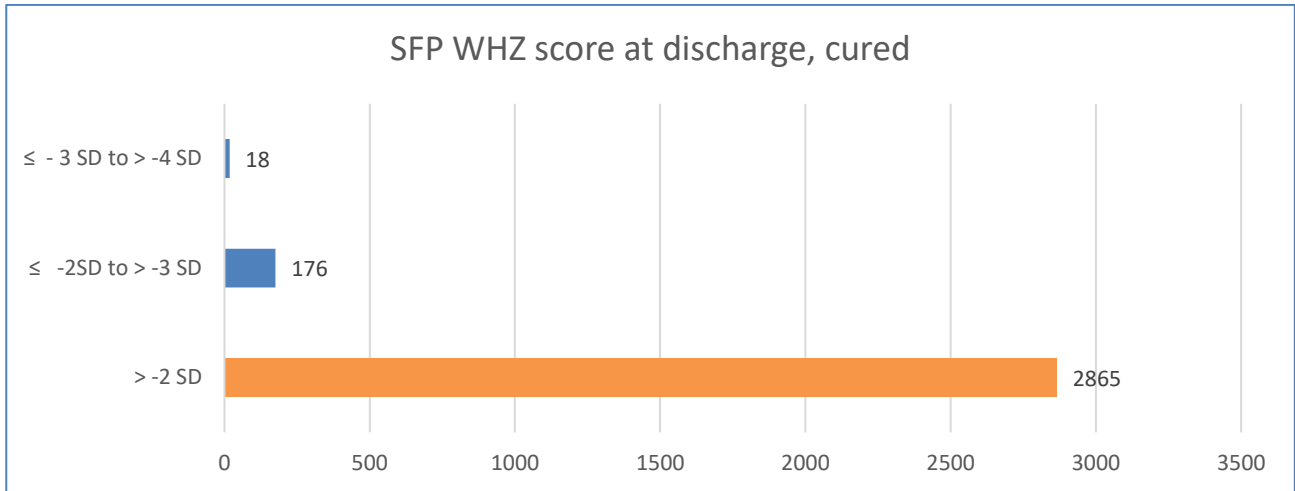


Figure 17: SFP WHZ at discharge, cured

SFP Cured Length of stay

Median LOS at discharge was 10 weeks, but early and late discharges were observed. Too Early and late discharges are attributed to a lack of following the IMAM Protocol by some program managers & also CHPs being left to manage the program.

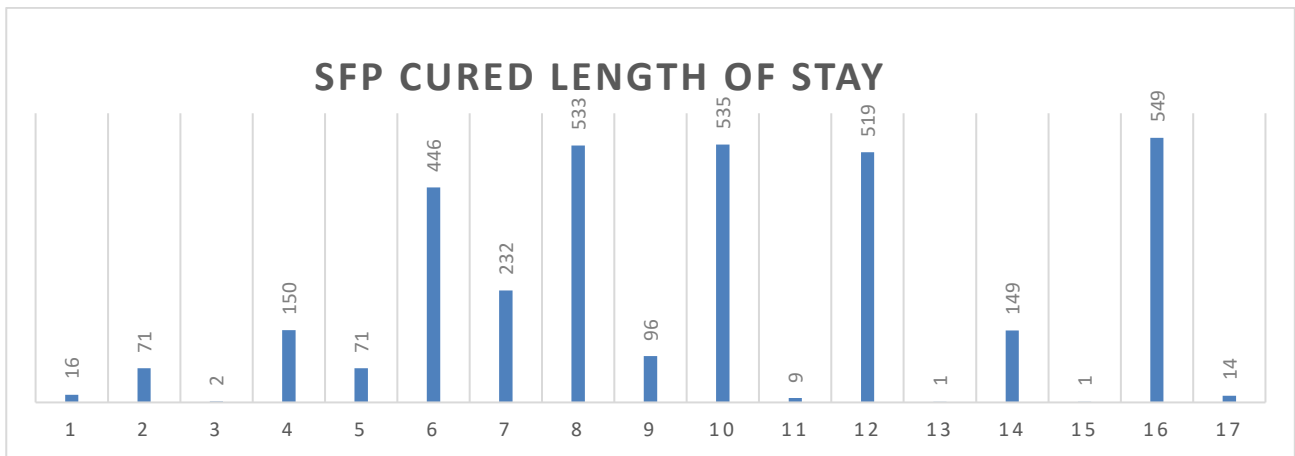


Figure 18: SFP cured length of stay

3.1.5 Program Defaulting

The default rate is one of the four core performance indicators of IMAM programs. It represents the proportion of children discharged from the program who were absent for two consecutive follow-ups. Defaulting is a major barrier to both therapeutic and supplementary feeding programs.

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 labor demand. Therefore, the graph of the defaulters should be compared to the seasonal calendar of the region.

When the program has a high number of defaulters it will be important to know when the beneficiaries defaulted from the program. When many children default early (1 to 2 weeks), they are likely to be current SAM/MAM cases. When they default late (6 to 8 weeks) they are likely to be recovering cases.

Defaulting Trends (Outpatient Therapeutic Program)

OTP average default rate for the County was 24.0% an indication of poor program performance. The most affected Sub Counties were Msambweni, Lungalunga and Matuga where default rate was 64.7%, 50.1% and 44.5% respectively. High defaulting cases in October maybe attributed to scaling up of outreaches without proper integration of outreach data and HFs data as some beneficiaries exited as defaulters instead of transfers. Lack of clear defaulter tracing mechanism could also be attributed to defaulting. Children discharged after 1 week could be as a result of poor documentation or knowledge gap on admission criteria.

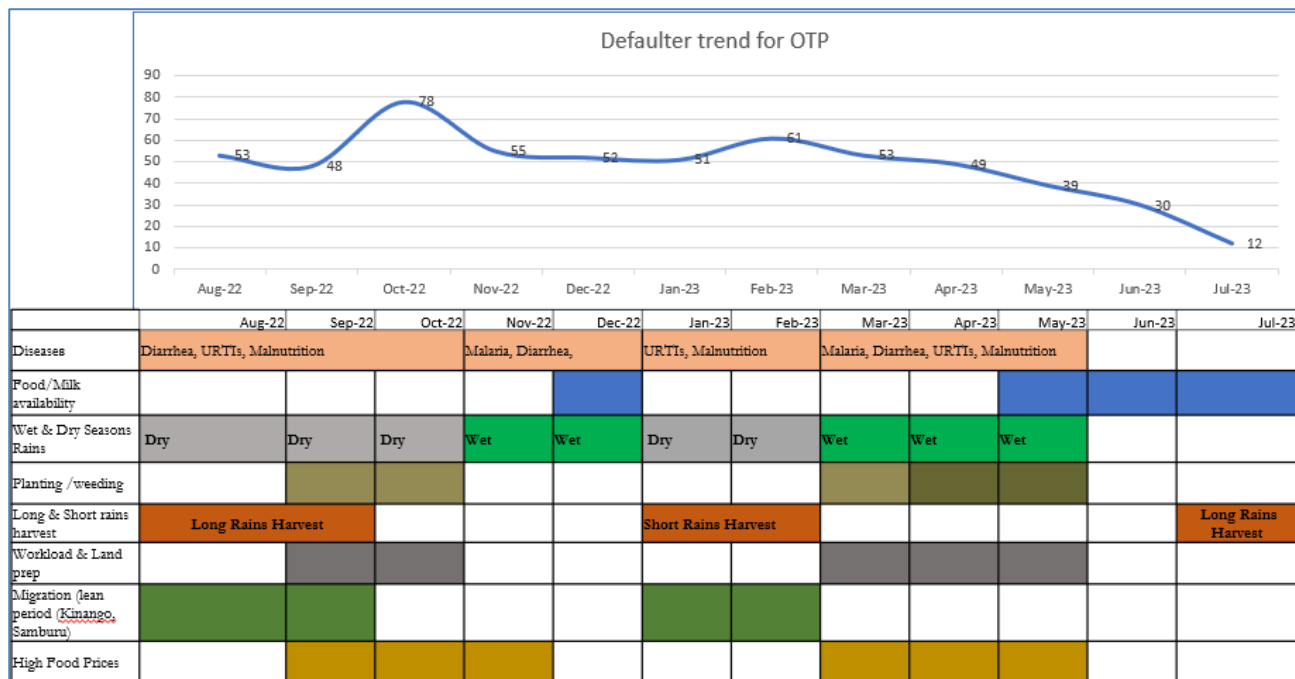


Figure 19: OTP defaulting trends in comparison with seasonal calendar

Median MUAC at default was 12.0cm indicating most defaulted after recovering before final proof of cure visit. However, 30.0% of the beneficiaries defaulted before the discharge criteria.

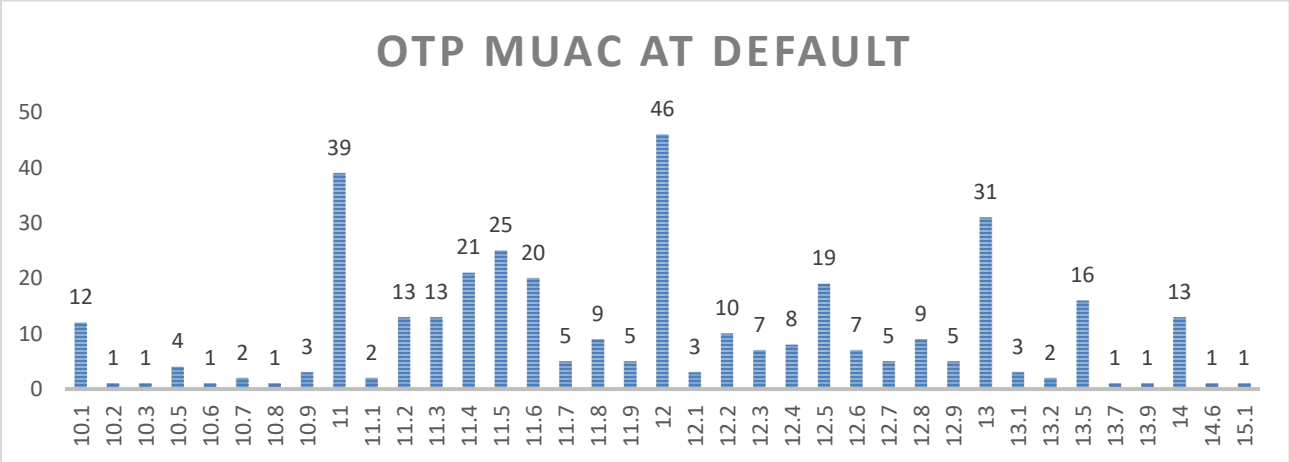


Figure 20: MUAC on discharge for defaulters

Defaulting Trends (Supplementary Feeding Program)

SFP average defaulting in the County was 22.0% with a non-response rate of 18.3% an indication of poor program performance. Lungalunga, Msambweni and Matuga sub-counties were more affected by defaulting with 48.9%, 38.1% and 28.1% default rate respectively. This could majorly be attributed to poor documentation, lack of integration of outreach data and HFs data and weak defaulter tracing mechanism.

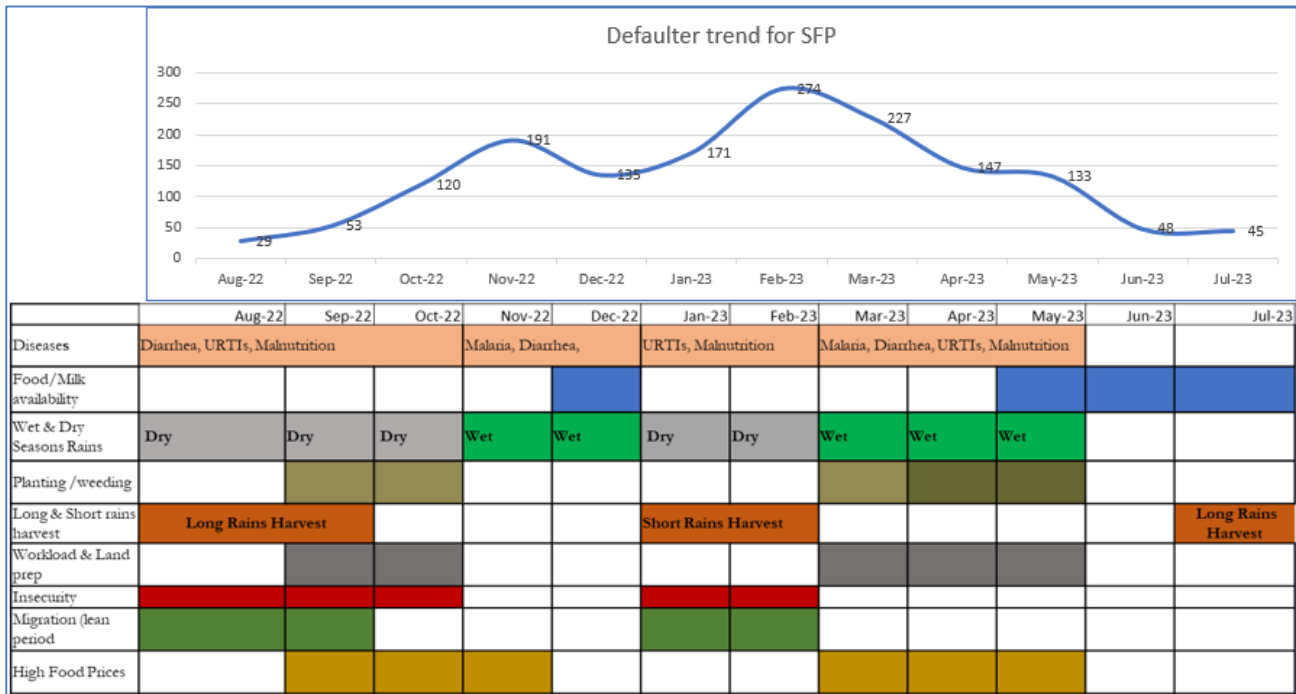


Figure 21: SFP defaulting trends in comparison with seasonal calendar

Median MUAC at default was 12.4cm an indication of early default before criteria for discharge whilst still MAM. A significant proportion of beneficiaries defaulted with MUAC ≥ 12.5 cm, while recovering before final proof of cure visit. Poor adherence to IMAM protocol was observed where there was a mix-up of the discharge criteria. Some cases were found to be cases of wrong admissions that were later dropped.

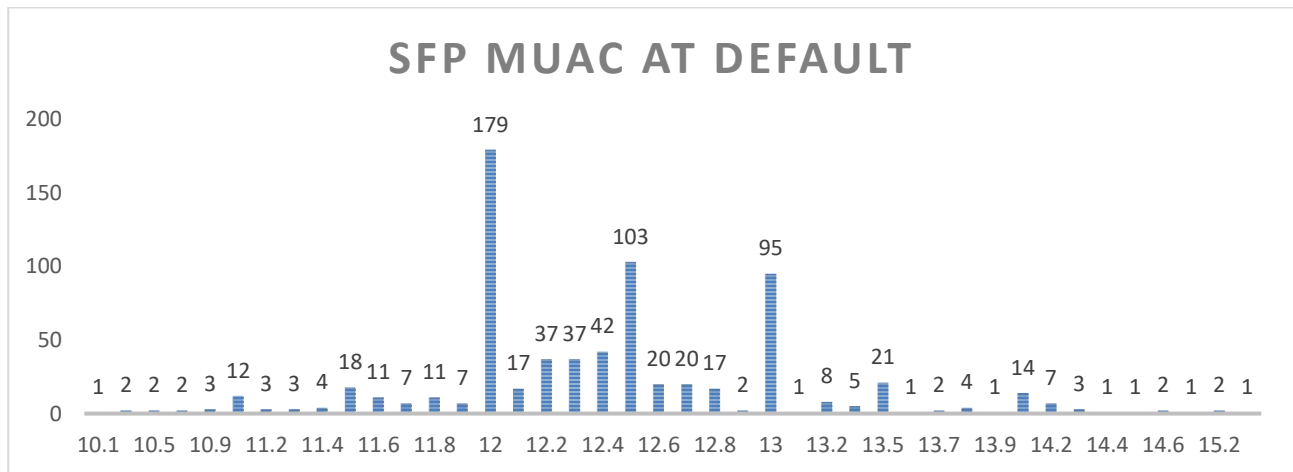


Figure 22: SFP MUAC at default

3.1.1.4 Documentation

Documentation and reporting are essential aspects in process monitoring of IMAM program. According to both quantitative and qualitative data, it was revealed that there were huge gaps in filling of OTP/SFP registers. Major issues included: missing follow up detail, missing discharge criteria and exit details, lack of referral slips as well as lack of ration cards. Some health facilities had no details of CHPs activity records. After further investigation, it was established that on the job trainings, joint support supervision as well as routine data reviews were conducted but with little adherence.

3.2 COMMUNITY ASSESSMENT STAGE 2

3.1.2.1: Qualitative Data: Triangulation by source and method

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

Table 2: Triangulation by Source and Method

Source	Symbol	Method	Symbol
Carers of beneficiaries	A	Semi structured interviews (SSI)	1
Carers of defaulting cases	B	Key informant Interviews (KIIs)	2
Community lay people	C	Informal group discussion/FGDs	3
Community Health Promoters (CHPs)	D	Observation	4
Health worker	E	Document review	5
Community leaders	F		
TBAs/THP/Herbalist	G		
NGO representative /Program staff	H		
Observation	I		
OTP/SFP Registers	J		

3.2.1 OTP and SFP Boosters and Barriers

Table 2: Key boosters to OTP/SFP Programs

	Boosters	Short Summary	Source	Methods
1	Presence of Integrated outreaches	<ul style="list-style-type: none"> Some of the health care workers talked of monthly integrated outreach services including IMAM services serving villages that are more than 8km away from the link facility. CHPs and HW said that they receive lunch allowance during outreaches and this motivates them. County nutritionist said the county currently has about 130 integrated outreach sites the new OTP /SFP clients are those from the routine growth monitoring and intergrated outreaches 	Nurse, RCO, nutritionist, CNC, CHP	SSI, KII
2	Good health seeking behaviors by the caregivers	<ul style="list-style-type: none"> Communities reported that they seek health interventions whenever the children became sick with the help of the CHPs who visit them in their households 	CHP, Community lay people, Community leaders	SSI, KII
3	RUTF/RUSF	<ul style="list-style-type: none"> RUTF and RUSF Commodities is always available and not shared because it is perceived as medicine The Nutrition commodities are stored in the same store as the other medication in the IMAM integrated facilities and bin cards updated “Chakula cha Watoto” 	Sub-county nutritionist, nurses, CHPs, data collection team, Nutritionist	Observation, KII,
4	Good linkage between health care workers and CHPs.	<ul style="list-style-type: none"> CHP and Health care workers referrals - CHPs screen children at HH level during routine home visits and refer all identified malnourished children to the health facility for management and also the HW after prescription /management they refer back to the CHPs for follow up for support Health workers said that they receive clients with a note from the CHPs for nutrition review and also use phones to do follow up on the clients to reduce defaulters They hold monthly feedback meeting where they discuss all indicator 	CHP and Health care worker	SSI, KII

5	Good perception of IMAM program by community	<ul style="list-style-type: none"> • CHV said that the community likes IMAM program as it helps improve the nutrition status of children and mothers. • Caregiver of beneficiary encourages others whose children look malnourished to visit the health facility CHPs and care givers have positive attitude towards IMAM services. • It is a good program that helps children who are underweight become healthier again through proper management and follow up (TBA Samburu) 	Caregivers CHPs,	FGD, KII
6	Quality of IMAM services	<ul style="list-style-type: none"> • Free IMAM services at facility and integrated outreach site, • Willingness of caregivers to accept and adhere to IMAM services • Good treatment outcome of malnourished children (cure rate). 	Caregivers, HCWs, CHPs	SII, KII, FGD
7	Availability of screening and reporting tools	<ul style="list-style-type: none"> • Anthropometric equipment are available though not adequate especially the weighing scales • IMAM registers and reporting tools MOH 713.MOH 733, MOH734 in most of the IMAM sites 	Healthcare workers, CHPs	SSI, KII
8	Screening at health facility	<ul style="list-style-type: none"> • Health workers said most of the new clients are those identified during outpatient medical treatment and are referred for nutrition review and admission according to criteria. • Caregivers of defaulters said that she knew her child was malnourished during a visit to the health facility for medical treatment where a health worker screened the child and explained that the child was malnourished and would be admitted into IMAM Program • Some Caregiver of beneficiary got to know about their children being malnourished during clinic visit where the child was screened for weight ,height and MUAC, 	Caregivers Health care wokers	KII, FDG, SSI
9	Some Knowledge /awareness on malnutrition	<ul style="list-style-type: none"> • - Village elder, nyumba kumi said they some are aware of plumpynut/nutrition commoditie - “<i>chakula ya watoto</i>” and said it is given to children with low weight . 	Village elders, nyumba kumi,	KII, SSI

10	No stigmatization	<ul style="list-style-type: none"> Majority of the Caregivers said that they were not stigmatized in the usage of IMAM commodities which has motivated the beneficiaries to take their children without fear Caregivers did not hide their children who are malnourished 	Caregivers	FDG, SSI
11	Some Collaboration between the health workers CHPs and the community on nutrition matters	<ul style="list-style-type: none"> The health workers said they work together with the CHPs on nutrition programming but due to staff shortage they allow the CHPs to assist manage IMAM program under the health workers watch and offering support where needed. Nurses said that they hold debrief sessions with CHPs at the facility after any nutrition related training or their monthly in-charges meetings. Village elder said that the nutrition work is mainly for CHPs and nurses 	CHP, Nurse, Village elders	IDI, KII
12	CHPs recognition and motivation	<ul style="list-style-type: none"> Communities are aware of the CHPs and their roles, they talked of screening, deworming, home visits vitamin A supplementation They get some monthly stipend, lunch allowances, “Jamii wanatambua kazi tunazozifanya na wanashukuru uwepo wetu”- CHP kizibe dispensary 	Caregivers Community leaders CHPs	SSI, FGD
13	Presence of Nutrition Officers	<ul style="list-style-type: none"> The health workers said, “The nutritionist conduct mentorship and OJT to health workers, ensure no nutrition commodity stockouts” this is an important attribution as it ensure smooth running of the IMAM services 	Nutritionist, Nurse	IDI, KIII

Table 3: Key barriers to OTP/SFP Programs

No	Barriers	Short summary	Sources	Method
1	Long distance covered to reach IMAM	Most beneficiaries had to walk long distances (about 13 Km) to reach the IMAM sites resulting to missing of clinics and eventually increased defaulter rate.	Carers of beneficiaries, Carer of defaulter,	Semi-structured interview (SSI), FGD

	sites/facilities	A carer of a defaulter in Tanganyika in Matuga Sub-county reported that she was unable to finish the treatment because the distance to reach the IMAM site was more than 8 km	community lay people	
2	Poor health seeking behaviour	Herbal therapy was also common among beneficiaries in rural areas. Most of them sought this treatment as they associated malnutrition with superstition and believed that traditional treatment is superior than conventional medicine and nutrition therapy. It was reported that, the head of the household is the only person to decide whether a child will be taken to clinic or not. 'mwenyewe' amekataa so the child will not be taken to hospital irrespective of child's health status, this delays treatment and sometimes may cause mortality	Community lay people, CHPs, carers of beneficiaries	FGD, SSI
3	Inadequate knowledge on malnutrition	TBAs and community lay people had very little knowledge on what malnutrition is as they relate it with infidelity, curses 'chirwa' thus delaying referral and management.	Community leaders, TBAs, traditional healers, community lay people	KII, SSI, FGD
4	Community unaware of presence of CHVs and their roles	Some were not aware of CHVs working in their locality and their roles. 'Sisi hatujawahi pata huduma za madaktari wa nyanjani tykiwa nyumbani'. Hatujui kazi yao ni gani, Waa dispensary, Matuga subcounty.	Carers of beneficiaries,	FGD,
5	Negative perception and stigma on IMAM services	A defaulter in Mwabila stated that the community perceives IMAM commodities are for HIV/TB clients hence hard for them to consume the products as they fear being associated with HIV. A few carers of beneficiaries associated the commodities with diarrheal related conditions	Carer of beneficiaries, care of defaulters, community lay people, community leaders, traditional healers/TBAs	SSI, FGD, KII

6	Communication and coordination between HCWs, CHVs and the community	It was reported that community leaders are not given feedback on imam outcome.		Week barrier
7	Low motivation among CHVs	<p>Most of the CHVs reported that Inconsistency of stipend given to CHVs by the county government and irregular capacity building sessions demotivates the them.</p> <p>Some of the CHVs have to walk long distance to their link health facilities and cover a vast area to visit their households which pause a challenge in early identification of malnutrition and proper referral and follow up.</p> <p>Lack of CHVs identification tags demotivates them as they claim that they are not recognized and their work is not felt in the community</p>	CHPs, Healthcare workers	KII, SSI
8	Poor quality of IMAM services due to heavy workload	Lack of comprehensive nutrition counselling to the beneficiaries due to heavy workload, attitude, knowledge gap among healthcare workers especially in outreaches leads to poor outcome nonresponse such as defaulters and non-respondents	Healthcare workers, CHPs	KII, SSI
9	Heavy workload	<p>Most facilities are understaffed as they manned by one or two technical officers serving a population of more than 3000 people. This in turn translates to ineffective services as officers delegate nutrition roles to non-technical staff</p> <p>The officers also report that the IMAM registers and summaries are too many to handle as sometimes it become difficult to record initial and follow-up visits leading to defaulters and they wish to be reduced to one register one summary.</p>	Healthcare workers, CHPs	KII,SSI

10	Caregiver refusal on IMAM services	It was note that there were incidences that partners or husbands denied permission for their spouses or their malnourished children to seek IMAM services commonly referred as the 'Mwenye syndrome'. This eventually increases defaulting rates	Carers of defaulters, carers of beneficiaries	SSI
11	Inconsistency of outreaches	Outreaches should be done on a monthly basis but due to inadequate resources to conduct it, it is rarely done thus leading to poor case finding among beneficiaries and high default rate among clients already in the system.	Healthcare workers, CHPs, community leaders, carer of defaulters	KII, SSI
12	Caregiver's competing tasks at home	This included household chores, attending burial services and other ceremonies such as weddings as well as income generating activities among other activities. This minimizes clinic attendance or follow-up visits especially when it collides with clinic days. One of the beneficiaries stated that 'Attending burial is important since if you don't attend you are isolated by the community and you will be left out in every activity held in the village'. The caregiver ultimately prioritizes burial services over the honoring the appointment date at the clinic.	Carers of beneficiaries, CHPs	SSI, FGD
13	Transportation cost	High poverty levels in the community contribute poor attendance to the facility especially when the client come from far which means the client has to pay for transport to access the facility creating unnecessary financial burden to the client and this may lead to client defaulting from the programme. As much as the IMAM services are free, transport should be considered and paid for.	Carers of defaulters	SSI
14	Awareness of IMAM services	At the community, men are not very much aware of the IMAM services since children are taken care of by their mothers most of the time. The lack of awareness leads to men denying their wives/partners permission to go to the facility hence causing the clients be defaulters	Community lay people, Community leaders	FGD

15	Sharing of RUTF	Sharing of RUTF is common among households who are food-insecure and this leads to underdosage of RUTF and eventually the clients fail to recover in time (non-respondents)	Carers of beneficiaries, CHPs, healthcare worker, community lay people	KII,SSI,FGD
16	RUTF perceived as food	The taste of RUTF is sweet and since the ingredients involve peanuts, chocolate sauce its commonly referred to as ground nuts/peanuts/chocolate or biscuits. It is ready to eat and given freely at the facility hence viewed as food other than treatment product thus may lead to failure to respond to treatment.	Carers of beneficiaries, community lay people, community leaders	SSI, KII,FGD
17	Missed appointments/Non-committal towards TCAs	Most beneficiaries fail to honor date for next visits hence leading to non-adherence and non-respondent	Healthcare workers	SSI

OTP/SFP BOOSTERS WEIGHTING				
	Boosters	Source	Method	Weight
1	Distance to IMAM facility	A(2)	1(1), 3(1)	1
2	Good health seeking behaviour	C(6), A(4), F(1)	3(7), 1(3), 2(1)	3
3.	Knowledge on malnutrition	A(15), B(4), E(12), H(2), C(12), D(12), F(8), G(5)	1(31), 3(19), 2(20)	2
4.	Community aware of presence of CHVs and their roles.	A(16), F(5), D(4), H(2), C(17), B(2), E(8), G(1)	3(20), 1(20), 2(15)	5
5.	Good perception on IMAM services	C(14), F(6), B(3), E(8), A(16), G(3), D(8), H(2)	3(24), 2(17), 1(19)	3
6.	Good communication and coordination between HWs, CHVs and the community	E(11), G(1), A(2), D(20), F(2)	3(1), 2(14), 1(21)	4
7.	CHV motivation and recognition as community doctors	D(13)	1(13)	2
8.	No Stigma towards IMAM treatment	A(20), B(2), C(4), E(8), F(6), G(1), H(2), D(1)	3(14), 2(12), 1(18)	5

9.	Quality of IMAM service leading to good outcome.	A(24), I(2), C(12), F(2), D(3), E(6)	3(20), 2(8), 1(13), 4(2)	1
11	Willingness of caregivers to accept and adhere to IMAM services	A(19)	1(10), 3(9)	5
12	Presence of outreaches	A(8)	2(8)	5
14	Free IMAM services	A(20)	1(20)	5
15	Awareness of IMAM services	G(7), D(8), A(14), E(8), B(5), F(6), C(12), H(2)	2(21), 1(21), 3(20)	4
16	No sharing of RUTF	A(12)	3(6), 1(6)	4
17	RUTF perceived as medication	A(13), H(2), D(9), C(3), E(10), F(1)	3(9), 1(14), 2(15)	4
18	Proper documentation	I(17)	4(17)	4
19	HWs trained on IMAM	E(14)	2(14)	3
20	Presence of a Nutrition Officer	I(14)	4(14)	5
21	Treatment outcome of malnutrition	A(8), G(3), C(5), F(1)	3(9), 2(3), 1(5)	4
22	CHVs and HW Referral	D(20),E(20), A(6), H(2)	1(23), 2(22), 3(3)	4
23	Good linkage between traditional healer/TBA, CHVs and healthcare workers	G(3)	1(3)	3
24	Health Worker positive attitude towards IMAM services	E(4)	2(4)	2
25	Availability of tools i.e Anthropometric tools and registers at the Health facility	I(6)	4(6)	3
26	Availability of tools for CHVs	D(17)	1(17)	2

OTP/SFP BARRIERS WEIGHTING			
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	Barriers	Source	Method	Weight
1.	Long distance to IMAM facility	A(4), B(4), C(1)	1(7), 3(2),	5
2.	Poor health seeking behaviour	C(3), D(1), A(3)	3(4), 1(3)	4
3.	Inadequate knowledge on malnutrition	F(1), G(5), C(3)	1(4), 2(2), 3(3)	4
4.	Community unaware of presence of CHVs and their roles.	A(2)	3(2)	1
5.	Negative perception on IMAM services	G(1), A(4), C(2), F(1), B(2)	2(4), 3(4), 1(2)	2
6.	Communication and coordination between HWs, CHVs and the community	G(1), F(6), E(4)	2(11)	1
7.	Inadequate CHV motivation	D(7), E(4),	1(7), 2(4)	4
8.	Stigma towards IMAM treatment	B(2), C(3),	1(2), 3(3)	1
9.	Poor quality of IMAM service	E(2), D(1),	2(2), 1(1)	4
10.	Heavy workload (Health Worker), many IMAM registers	E(19), I(10)	2(19), 4(10)	5
11.	Caregiver refusal on IMAM services	B(1), A(1),	1(2),	1
12.	Inconsistency of outreaches	E(4), D(6), F(1), B(1)	2(5), 1(7),	4
13.	Caregiver Competing tasks at home	D(2), A(2)	1(3), 3(1)	2
14.	Transportation cost to IMAM site	B(1),	1(1)	3
15.	Awareness of IMAM services	F(2), C(3), G(2),	2(3), 3(3),1(1)	3
16.	Sharing of RUTF	A(8), C(9), E(1), D(1)	1(4), 2(1), 3(14)	3
17.	RUTF perceived as food	A(4), C(5), F(3)	3(7), 1(2), 2(3)	3
18.	Poor documentation	I(14)	4(14)	4
19.	HW not trained on IMAM	E(8)	2(8)	4
20.	No Nutrition Officer	I(121)	4(121)	5
21.	Commodity stockouts (RUTF)			1
22.	Inadequate anthropometric equipment	I(130)	4(130)	3

4.0 Conclusion

Kinango and Samburu reported good performance indicators compared to the rest of the sub-counties. This can be attributed to; good partner support from USAID, UNICEF, WFP, WVK and Kenya Red-cross, heightened capacity building with training being done on both CHPs and health workers, Active case finding and bi-weekly outreaches, Early linkages of beneficiaries and CHPs, regular review meeting between SCHMT and HWs and regular review meetings between CHAs and CHPs with nutrition being among their main agendas.

On the other hand Matuga and Msambweni reported very poor outcome indicators over the period with the following issues being raised as challenges; Despite the sub-counties being small many beneficiaries complain of long distance to the facilities hence high defaulter rate, there were also issues of wrong admission and discharge criteria hence affecting the whole outcome of the program, poor documentation was noted with a number of facilities using other modes of documentation instead of the recommended nutrition registers, also noticed the possibility of calculation errors in calculating cure rates where most cured beneficiaries were discharged as transferred to SFP and not as cured yet they are cured according the program guidelines, most personnel are not trained on IMAM and lastly they lack support from partners since are concentrated either in Kinango, Samburu or Lungalunga. Other issues raised were: some beneficiaries preferred flour i.e CSB or FBF than RUTF, poor linkage between CHPs and beneficiaries and the need of having support to conduct regular outreaches.

In conclusion, the barriers to IMAM services identified in the County can be attributed to the weak community mobilization component. Little or no motivation of the CHPs to conduct early screening for case finding, beneficiaries' follow up and minimal defaulter tracing mechanisms in the health facilities. Majority of the health workers had not been trained on IMAM services and this was compounded further by frequent transfers of already trained staffs on IMAM within the county.

5.0 Recommendations

Below are some of the recommendations based on the identified boosters and barriers.

Table 4: Cross cutting Barriers to Both OTP and SFP and the corresponding Recommendations

	BARRIERS IDENTIFIED	RECOMMENDATIONS
1	Long distance covered to reach IMAM sites/facilities	<p>Intensify bimonthly integrated outreaches to villages which are more than 5 kms from the health facility</p> <p>Increase the number of health facilities offering IMAM services.</p> <p>Use Primary care Network (PCN) to ensure IMAM services are offered intensively.</p>
2	Poor health seeking behaviours	<p>Conduct community dialogues on behavior change for the community and giving continuous feedback on health outcomes to the community leaders</p> <p>Involve champions (beneficiaries) and share success stories in community health talks</p> <p>Nutrition awareness campaigns that have eye catching key messages through SBCC (social behavior communication and change) approach</p> <p>Male involvement in health care practices</p> <p>Conduct frequent health talks for behavior change</p>
3	Inadequate knowledge on malnutrition	<p>Conduct community advocacy on malnutrition.</p> <p>Capacity build Community Health Promoters (CHPs) and Healthcare workers on IMAM through trainings and sensitization meetings.</p> <p>Conduct community nutrition days.</p> <p>Conduct community baraza on malnutrition.</p> <p>Use of existing multi-disciplinary teams such as DHC (Dispensary Health Committees), PCN (Primary Care Networks) and similar platforms in addressing the barriers and bottle-necks identified</p> <p>Target and sensitize public administrators on matters nutrition during the ‘Afya na Utawala’ sessions where nutrition is usually overlooked during RAMNCAH discussions</p> <p>Sensitize health care workers on community strategy</p> <p>More nutrition refresher courses</p>

4	Community unaware of presence of CHPs and their roles	<p>Conduct community barazas to inform the public on presence of CHPs and their roles.</p> <p>Regular meetings with CHPs to stress on availing themselves to their allocated households.</p> <p>CHPs to conduct targeted home visits.</p> <p>Conduct refresher trainings for CHPs on their responsibilities.</p> <p>CHPs to conduct dialogues within their catchment areas.</p> <p>Regular health talks by CHPs at the health facility.</p> <p>Use of media (radio talks) to convey and enhance key nutrition messages</p>
5	Negative perception and stigma on IMAM services	<p>Conduct community nutrition days, advocacy on malnutrition and community baraza on malnutrition.</p> <p>Conduct comprehensive nutrition education and counselling in CWCs and nutrition clinics.</p> <p>Strengthen childcare education activities at the facility and community.</p> <p>Bring on board male champions whose children benefited from IMAM program</p>
6	Low communication and coordination between HCWs, CHPs and the community	<p>Regular monthly meetings with CHPs and Healthcare workers to discuss IMAM activities</p> <p>Forming a health facility committee with representation from the Subcounty Nutrition Coordinator, health facility, CHPs, community leaders and religious leaders.</p> <p>Ensuring HCWs and CHPs have adequate tools for communication and coordination.</p> <p>Have appropriate feedback mechanism in place</p>
7	Low motivation among CHPs	<p>Link community units with income generating activities</p> <p>Plan for refresher courses on IMAM</p> <p>Conducting performance appraisal</p> <p>Follow-up on consistency of the monthly stipend</p> <p>Providing working materials e.g Identification badges, Bags, Uniform/T-shirts, CHPs kits.</p> <p>Provide bicycles to ease their movement.</p> <p>Review their transport and subsistence allowance.</p> <p>Conduct support supervision and OJT.</p>

		<p>Recognize CHPs who performed best and recognize the little effort provided by the CHPs such as accepting, prioritizing and considering the referral forms submitted by the CHPs</p> <p>The CHPs should work with CBOs</p> <p>Appraisal (for those who are active)</p>
8	Poor quality of IMAM services	<p>Regular mentorship and OJT</p> <p>Conduct regular support supervision and RDQA</p> <p>Training healthcare workers and CHPs on IMAM.</p> <p>Ensure availability of IMAM tools and equipment.</p> <p>Conduct data review meetings.</p> <p>Lobby for more Nutrition Officers/technicians.</p> <p>Promote ownership of the IMAM program as part of essential health services through integration.</p> <p>Reward best performers and benchmark from best performing or most improved sub-counties</p>
9	Heavy workload	<p>Lobby for more health workers.</p> <p>Have specific nutrition clinic days.</p> <p>Motivate healthcare workers</p> <p>Organize debriefing sessions on mental health to health workers to curb burnouts and depression</p>
10.	Inconsistency of Integrated outreaches	<p>Support bimonthly integrated outreaches to villages which are more than 5 kms from the health facility.</p>
11	Poor childcare practice due to caregiver's competing tasks at home	<p>Community dialogues</p> <p>Mother to mother support groups to sensitize caregivers on proper childcare practice.</p> <p>Family MUAC for screening at home and early detection of malnutrition.</p> <p>Help the caregivers to adjust their schedules and be flexible</p>
12	Transportation cost	<p>Support bimonthly integrated outreaches to villages which are more than 5 kms from the health facility.</p>

		Engage other family members when issues of transport, distance and the like arise
13	Awareness of IMAM services	Involve key community leaders in IMAM activities to support community sensitization, mobilization and defaulter tracing. Strengthen DHC committees and bridge the gap by ensuring sub-county nutritionists are members of the committees Involve religious leaders in community health projects
14	Stockout of RUSF, RUTF and CSB	Strengthen commodity pipeline. Encourage partners to support all programs (OTP and SFP) as one. Encourage health workers to report and order on time. Train health workers on LMIS Proper forecasting and quantification of commodities Avail more IMAM registers
15	RUTF perceived as food leading to sharing	Educate and sensitize communities on IMAM services Provide protection ration, cash transfers and relief food to households with malnourished children.
16	High defaulter rate	Develop a proper defaulter tracing mechanism e.g tickler box in tracking of defaulters. Facility incharge to share the list of defaulters to CHAs and task CHPs for tracing and follow up

5.0 Recommendations and Action Points

Table 5: County Action plans for the Proposed Recommendations

Barrier	Source	Recommendations	Action points	Achievement Indicators	Means of Verification	Persons Responsible
Long distance covered to reach IMAM sites/facilities	Carers of beneficiaries, Carer of defaulter, community lay people	Intensify bimonthly integrated outreaches to villages which are more than 5 kms from the health facility	Identification and Selection of outreach sites Increase IMAM sites Lobby for outreach support from partners	Number of sites selected per link facility.	List of selected sites to be shared with partners. Outreach reports, photos	Health care workers, CHPs, the community, MOH and Partners
Poor health seeking behaviours	Community lay people, CHPs, carers of beneficiaries	Conduct community dialogues on behavior change for the community and giving continuous feedback on health outcomes to the community leaders	Organize community dialogues. Involve community leaders in the dialogues Identification and training of community champions Include SBCC on matters nutrition to improve behavior change in households Include CHPs on gender issues	Number community dialogue days. Number of community champions identified and trained	Dialogue report, Photos, List of attendees	Health care worker, CHPs, Community and Community leaders.
Community unaware of presence of CHPs and their roles	Carers of beneficiaries	Conduct community baraza to inform the public on presence of CHPs and their roles. Regular meetings with CHPs to stress on availing themselves to their allocated households. CHPs to conduct targeted home visits.	Daily Nutrition talks at the health facility. Involving CHPs in community dialogues, CHPs training on community strategy basic module.	Number of Nutrition talks done per week. Number of Barazas. Number of trainings done	Nutrition talk schedule Training report Community Baraza report	Community leaders, CHPs, Nutrition Officer, CHAs

		Conduct refresher trainings for CHPs on their responsibilities. CHPs to conduct dialogues within their catchment areas. Regular health talks by CHPs at the health facility.	Include CHPs session in community Barazas			
Negative perception and stigma on IMAM services	Carer of beneficiaries, care of defaulters, community lay people, community leaders, traditional healers/TB As	Conduct community nutrition days, advocacy on malnutrition. Community baraza on malnutrition. Conduct comprehensive nutrition education and counselling in CWCs and nutrition clinics. Strengthen childcare education activities at the facility and community.	Plan for monthly nutrition days and community barazas. Exit interviews for IMAM beneficiaries. Formation of M2M support groups (Implementation of BFCI)	Number of Nutrition days conducted. Number of beneficiaries reached. Number of M2MSG formed.	Nutrition days report M2MSG meeting reports. Exit interview report	Nutrition Officer, CHPs, Community, Partners
Low communication and coordination between HCWs, CHPs and the community	CHPs, Health care workers	Regular monthly meetings with CHPs and Healthcare workers to discuss IMAM activities Forming a health facility committee with representation from the Subcounty Nutrition Coordinator, health facility, CHPs, community leaders and religious leaders. Ensuring HCWs and CHPs have adequate tools for communication and coordination.	Conduct monthly HW-CHPs meetings. Formation of a health facility committee. Provide CHPs and HW with tools	Number of HW-CHPs meetings. Number of active Health facility committees Number of Health workers and CHPs with adequate tools	Minutes for HW-CHPs meetings and Committee meetings. Checklist of tools	CHPs, Health care workers, community, CNC, SCNC, Religious leaders, Partners

Barrier	Source	Recommendations	Actions	Achievement Indicators	Means of Verification	Persons Responsible
Low motivation among CHPs	CHPs, Healthcare workers	<p>Link community units with income generating activities</p> <p>Plan for refresher courses on IMAM</p> <p>Performance appraisal</p> <p>Follow-up consistency of the monthly stipend</p> <p>Providing working materials e.g Identification badges, Bags, Uniform/T-shirts, CHPs kits.</p> <p>Provide bicycles to ease their movement.</p> <p>Review their transport and subsistence allowance.</p> <p>Support supervision and OJT</p> <p>Recognize CHPs who performed best</p> <p>Recognize the little effort provided by the CHPs such as accepting, prioritizing and considering the referral forms submitted by the CHPs</p>	<p>Link CUs with social service department.</p> <p>CHPs training on IMAM</p> <p>Conduct performance appraisal.</p> <p>Lobby for consistent monthly stipend and working materials.</p> <p>Conduct monthly support supervision.</p> <p>Review the CHPs performance and reward the best performer</p>	<p>Number of community members linked to social service department.</p> <p>Number of CHPs monthly report.(MOH 515)</p> <p>Availability of monthly stipend and working materials.</p>	<p>Functionality assessment report.</p> <p>CU Registration certificate.</p> <p>Distribution list</p>	<p>CHPs,</p> <p>Community strategy focal person</p> <p>CHAs, Partners</p>
Stockout of RUSF, RUTF and CSB	Healthcare workers, carers of beneficiaries, CHPs	<p>Strengthen commodity pipeline.</p> <p>Encourage partners to support all programs(OTP and SFP) as one.</p> <p>Encourage health workers to report and order on time.</p> <p>Train health workers on LMIS</p>	<p>To conduct LMIS Training to health workers</p> <p>Timely reporting at all levels</p> <p>Review imam program policy</p>	<p>Number of health care workers trained</p> <p>Number of LMIS/DHIS timely reported</p> <p>SFP/OTP implemented together (unicef and wfp)</p>	<p>Training reports</p> <p>Uploaded LMIS reports</p> <p>Availability of RUSF and RUTF.</p> <p>DHIS MOH 713 & MOH 734</p>	<p>CNC/SCNC/HCW /PATNER</p>

RUTF perceived as food leading to sharing	Carers of beneficiaries, community lay people, community leaders	Educate and sensitize communities on IMAM services Provide protection ration, cash transfers and relief food to households with malnourished children.	Continuous community sensitization by the CHPs, during household visits Conduct nutrition health talks at the health facility Provision of protection ration for the food in secured household to avoid sharing	number of health talks conducted improved community awareness on the importance of adherence	Health talk book/register with topics on imam	HCW/CHPS/PARTINERS SCNC/CNC
High defaulter rate	Healthcare workers, CHPs	Develop a proper defaulter tracing mechanism e.g tickler box in tracking of defaulters.	Line listing of bi weekly missed appointment and sharing with CHPs every Friday Use of tickler box effectively Support CHPs to follow up of miss appointment. Use of miss opportunity diary	Updated list of missed appointments Number of children brought back to care	Reports Reduced number of defaulters SFP/OTP registers	HCW/CHPS
Poor childcare practice due to caregiver's competing tasks at home	Carers of defaulters, carers of beneficiaries	Community dialogues geared towards advocating for male involvement so as to reduce caregiver's workload Mother to mother support groups to sensitize caregivers on proper childcare practice. Family MUAC for screening at home and early detection of malnutrition Help the caregivers to adjust their schedules and be flexible	Conducting community dialogues Formation of M2MSG Sensitization on Family MUAC Establishing PD hearth sites Conduct more health education sessions whenever they attend nutrition clinics and	Number of community dialogues Number of M2MSG formed Number of sensitizations done Number of PD hearth sites established Number of health talks conducted	Report on community dialogues done Monthly M2MSG reports Sensitization reports done on family MUAC. List of PD hearth sites Session photos	Community, Health care workers, CNC, SCNC, Partners

			emphasize the need of follow-up visits			
Transportation cost	Carers of defaulters, carers of beneficiaries	Support bimonthly integrated outreaches to villages which are more than 5 kms from the health facility	Identification and selection of outreach sites	Number of sites selected per link facility.	List of selected sites to be shared with partners. Outreach reports, photos	Health care workers, CHPs, the community, MOH and Partners
Heavy workload due to insufficient staffing	Healthcare workers, CHPs	Lobby for more health workers. Have specific nutrition clinic days. Motivate healthcare workers Organize debriefing sessions of mental health to health workers to curb burnouts and depression	Identifying specific days for nutrition Organize for mental health welfare program	No. of nurses and nutritionists employed	County strategic plan report	Health care workers, CHPs, the community, MOH and Partners
Inadequate knowledge on malnutrition	Community leaders, TBAs, traditional healers, community lay people	Conduct community advocacy on malnutrition. Capacity build Community Health Promoters (CHPs) and Healthcare workers on IMAM through trainings and sensitization meetings. Conduct community nutrition days. Conduct community baraza on malnutrition. Use of existing multi-disciplinary teams such as DHC (Dispensary Health Committees), PCN (Primary Care Networks) and similar platforms in addressing the	Conduct community dialogues days and baraza on malnutrition. Conduct regular nutrition talks Training of CHPs and health care workers on malnutrition and PD hearth Conduct OJTs, mentorship and support supervision. Continuous Medical education Address the barriers in DHC and PNC committees	Number of OJTs, Mentorship and supervision conducted. Number of trainings and CMEs. Number of nutrition talks done per week. Number of community dialogues. Number of PD hearth groups formed. Number of administrators sensitized on IMAM	Training reports CMEs minutes Support supervision reports Community dialogue reports. PDHearth monthly reports. Pictures.	CNC, Health care workers, Community leaders, community, CHPs, Partners

		<p>barriers and bottle-necks identified</p> <p>Target and sensitize public administrators on matters Nutrition during the ‘Afya na Utawala’ sessions where nutrition is usually overlooked during RAMNCAH discussions</p> <p>Sensitize Health care workers on community strategy</p> <p>More Nutrition refresher courses</p>	<p>Sensitize public administrators on IMAM</p> <p>Train healthcare workers on community strategy</p>	<p>Number of healthcare workers trained on community strategy</p>		
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6.0 Appendices

Annex 1: Community Assessment Team

Enumerators

No.	NAME	No.	Name
1	Ali Hoyo Masoudi	11.	Mariam Mjeni
2	Omar Mwatita	12.	Faith Neema Detche
3	Saidi Jumapili Mwanyae	13.	Samuel Makupe
4	Magdaline Mupa	14.	Binti Khamis
5	Diana Mjimba	15.	Zuwa Ngome
6	Halima Hassan Dzirumu	16.	Mapenzi Kidubo
7	Ruth Kadzo Karisa	17.	Mwanyama Meri Lugwe
8	Halima Azizi	18.	Julius Thuku
9	Salome Chinyavu Thoya		
10	Aisha Mwasahani		

Lists of Supervisors (Team leads)

No.	NAME
1	Mchemudzo Kombo
2	Mariam Ngao
3	Mwanamisi Beja
4	Kamanza M. Ngedzo
5	Asmaa Koja
6	Burhaan Bakari
7	Abdalla Salim
8	Mbesa Kimeu
9	Fatuma Chidzugah
10	Mwanasiti Gwama
11	Terezia Mzungu
12	Mwanatumu Kassim

Overall supervision

NO	NAME	Designation
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1	Joseph Njuguna	NITWG Support
2	Rachel Kahindi	CNC

Annex 2: Community Assessment Work plan

FIELD ACTIVITIES - COMMUNITY ASSESSMENT IMPLEMENTATION																				
TASK	No. of Days	Jul-23	Jul-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Status
Resource Mobilization in the counties for funding and capacity Gap																				
Roadmap Drafting and sensitization at the County level	2nd week July																			completed
CNC Shares the ROAD MAP (Methodology) to the National Coverage Assessment Taskforce for Review & Approval	3rd week July																			completed
Mobilization of the Survey Team - Training Participants •County /Sub County MOH Supervisors (12 Staff) •Partner Organization Staff in each •MOH Enumerators (20 Staff)	4th week July																			completed
Stage One																				completed
Step 1: Classroom training: Training on Quantitative data collection tools	2																			completed
- Introductions and schedules																				completed
- Training on Community Assessment																				completed
- Local terminology and calendar																				completed
Detailed work plan; Distribution of tasks to the assessment team																				completed
Step 2: Quantitative Data Collection in all IMAM facilities	4																			completed
•Complementary quantitative data collection																				completed
Step 3: Quantitative data synthesis, interpretation and analysis																				completed
•Seasonal calendar Analysis																				completed
Stage two																				completed
Step 4: Qualitative information collection:	5																			completed
Training enumerators on Qualitative data collection tools																				completed
•OTP and SFP qualitative data collection																				completed
Step 5: Contextual data analysis (qualitative) and Triangulation	2																			completed
Step 6: Identification of potential Barriers and Boosters of coverage																				completed
•Histogram, BBQ weighted/unweighted, concept development of action plan	2																			completed
Recommendations and Summary report																				completed
Presentation of Results and submission of summary report																				completed
Writing of final report																				completed
Incorporation of feedback into final report																				completed
TOTAL NO. OF DAYS	15																			

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