Final Report: CMAM Capacity Assessment Results and Action Plan

Dollo and Afdear Zones, Somali Region, Ethiopia

November 2017

Tech-RRT

Report by Michele Goergen, CMAM/IYCF Advisor, Tech RRT

Technical Rapid Response Team

USAID
DU PEUPLE AMERICAIN

Acknowledgements

The Technical Rapid Response team (Tech RRT) would like to extend thanks to all the people who helped realize this assessment in Afdear and Dollo Zones. Particularly:

- NGO partners who helped with the assessment: Action Against Hunger, Islamic Relief, Save the Children International and GOAL
- Concern Worldwide for hosting the Tech RRT Adviser
- The ENCU/Nutrition Cluster, UNICEF, WHO and WFP for providing guidance and support
- The Regional Health Bureau and DPPB in Somali Region
- Health Center/Post staff and community members for participating in the assessment

This report is made possible, in part, by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of the Tech RRT and do not necessarily reflect the views of USAID or the United States Government.

1. Introduction

The Somali region in Ethiopia is facing an acute food security and nutrition crisis, with its third year of poor rains. The severe acute malnutrition (SAM) caseload for 2017 is already double the region's projected estimate for the year. According to the Somali Nutrition Sector update on October 6, 2017, Dollo and Afdear zones are among the top three zones with the highest rates of SAM in the Somali Region. The population in the region is overwhelmingly pastoralist and is sparsely dispersed, often living in remote, not easily accessible areas, making access and coverage challenging. The lack of potable water and weak infrastructure remain a challenge in the response operation. A recent extensive Acute Watery Diarrhea (AWD) outbreak has used many of the available health resources and aggravated rising malnutrition rates.

A number of measures have been taken by the Regional Health Bureau (RHB) to help reach the increasing case load and improve coverage and quality of Community-based Management of Acute Malnutrition (CMAM) services in the Somali Region. The RHB, with support from UNCIEF and partners, has scaled up the number of static health facilities with CMAM services from 520 Outpatient Therapeutic Feeding Programs (OTP) to 1176, and 38 Stabilization Centers (SC) to 142 from September 2016-2017.

Thirty-five Mobile Health and Nutrition Teams (MHNT) have been developed by the RHB and UNICEF to increase coverage in hard to reach areas and standardize services provided (essential emergency health for all, IMNCI for U5 with EPI, SAM-MAM, WASH and WTC provision and maternal care). WHO is committed to improving quality of care in 33 referral SCs in the Somali Region.

UNICEF scaled up to 18 the number of CMAM monitors supporting 9 zones most affected by the drought in 2017. CMAM Monitors (UNICEF) along with SC mentors (WHO) are working in all zones to improve quality of services. In addition, a number of cascaded CMAM trainings have been undertaken at the zonal level. There are also a range of tools available including the National CMAM Monitoring Scorecard/TFP scorecard, supervision checklists and lists of trainers and trainees, but there is a lack of clarity on effectiveness, how these are collated, analyzed and used to assess and improve quality or identify gaps.

Quality of care in CMAM services is crucial to ensuring proper treatment of children under 59 months with acute malnutrition. This Capacity Assessment is the first step in a larger initiative to improve capacity building efforts in the Somali Region. The capacity assessment serves to identify strengths, gaps and gather information on underlying causes and solutions to address these gaps. The second step will focus on the development of an action plan to address gaps and improve CMAM services by showing where to focus coaching and training efforts. This report provides detail on the capacity assessment and recommendations and a way forward as developed by the RHB and partners in a workshop at regional level in Jijiga. Following finalization of the action plan, a coaching package will be developed to train coaches and mentors in each zone.

Part I: Capacity Assessment Methodology and Results

2. Assessment Objectives

Goal of the Capacity Assessment:

To assess the capacity of health staff implementing CMAM services and understand the community perspective of these programs to identify priority needs and improve quality of CMAM services from community to zonal level.

Assessment Objectives

- Determine baseline capacity of health workers in SCs, OTPs and TSFPs
- Identify gaps in service delivery, knowledge, reporting and environment of health facilities
- Understand the CMAM services from the community perspective in terms of program awareness/effectiveness and to improve social mobilization challenges
- Understand priority needs for training, coaching, etc.
- Use the results to develop an action plan to improve CMAM services that can be replicated in all zones in the Somali Region.

3.Evaluation Sites

Sites for the assessment were chosen in coordination with the Regional Health Bureau (RHB) and implementing partners and based on accessibility. As requested by the RHB, a mix of Government and NGO supported sites were selected. In total, the capacity assessment was conducted in 15 sites:

Afdear

- Chorati (SC, OTP, TSFP)
- Daraye (SC, OTP)
- Harder (OTP)
- Masago Badan (OTP)
- Masala Adun (OTP)

Dollo

- Kurtunie (SC)
- Daratole (SC)
- Isgoyska (OTP)
- Jinole (OTP)
- Lahelow (OTP)
- Mire (OTP)
- Wafdahug (OTP)
- Dila Ano (OTP)

4. Methodology

Two types of assessments were conducted

1. **Technical questionnaire**
   - Administered to health workers/nurses implementing SC, OTP, TSFP services
2. **Discussion groups**
   - Facility level: Discussion groups with health workers/nurses to gather more detailed information about program challenges
   - Community level: Discussion groups with caregivers of children 0-59 months
   - Woreda Level: Two discussion groups were conducted with nutrition focal points at Woreda level

- **Participants:**
  - Health workers present at the health center/post upon arrival
  - Caregivers of children 0-59 months present at the time of assessment at community level

5. Questionnaires (See Annex 2)

The capacity assessment is a questionnaire consisting of 37 (SC) and 43 (OTP/TSFP) technical questions directly from the Guidelines for Management of Acute Malnutrition in Ethiopia. Questions were divided into the following topics:

1. Detection and awareness (OTP/TSFP) Admission Criteria (SC)
2. Nutrition and Medical Protocol (SC)
3. Nutrition and Medical Protocol (OTP)
4. Nutrition and Medical Protocol (TSFP)
5. Registers and Reporting
6. Food Item Availability and Stock Management
7. IYCF activities
8. Hygiene

Each assessment leader had an answer sheet with key scoring indicators. Depending on answer completeness, assessment leaders assigned a score to each answer. Scoring criteria was noted on the questionnaire as follows:

☹	Requires significant improvement
😐	Good, but needs some improvement
☺	Perfect, no improvement needed

Discussion groups allowed participants to talk about what is working well and the main challenges in running CMAM services in their respective areas.

After completing the questionnaire and discussion groups at Health Center and Health Post level, assessment leaders went to a community at least 8km away from the nearest health

facility to interview community members about their knowledge and perception of CMAM services in their communities.

Assessment supervisors conducted a discussion group with nutrition focal points in two woredas.

Following completion of the assessment, information was entered into an excel database and analyzed. All discussion group question answers were recorded and analyzed.

6. Materials

- Questionnaires and answer sheet
- Discussion group questionnaires
- Pen
- Folder

7. Timeline

A 2-day training for 16 assessment leaders and two assessment supervisors was conducted on October 30-31, 2017. Assessment leaders were from NGO partners and supervisors were from the RHB and DPPB. Health Centers/Posts were appointed to assessment leaders and supervisors on the last day of the training. Assessment leaders collected data from November 1-3. Data was analyzed and preliminary results were presented at the RHB to partners on November 7 in Jijiga and to FMOH and partners in Addis on November 8, 2017.

8.Limitations

- Rainy season created accessibility issues and some facilities were not reachable.
- Vastness of area made it difficult to reach far facilities within the time frame of the assessment.
- TSFP services were difficult to assess for a number of reasons. Only six facilities visited provided TSFP services. Documents to review were limited and the assessment results are based mostly on staff knowledge and not observation.
- Though mobile health and nutrition teams provide CMAM services, assessing these services were beyond the scope of this capacity assessment and therefore were not included.

9. Results SC

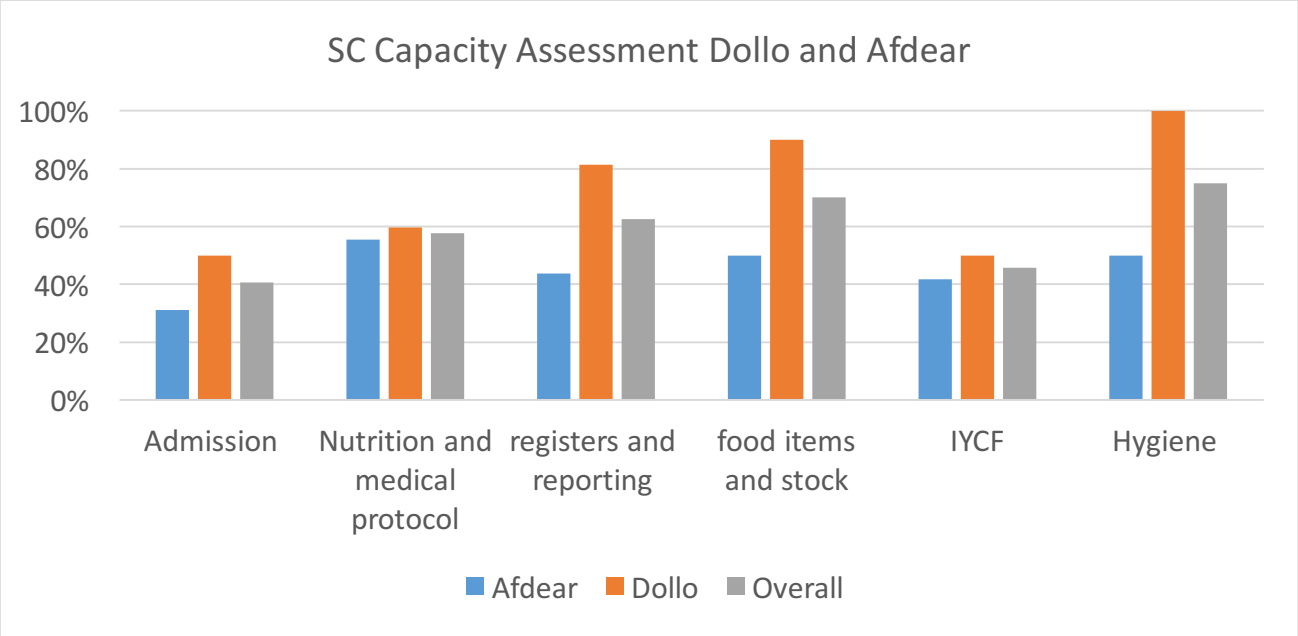
Overall four SC sites were assessed. Eight staff members participated in the questionnaires and discussion groups at Health Center level. 75% of facilities (3 facilities and 8 staff members) reported receiving training in SC services since June of 2017 and supervision or monitoring visits since August.

Figure 1: SC Assessment Statistics

Question	Daraye	Chorati	Kurtunie	Daratole	TOTAL
Staff participating in assessment	2	3	2	1	8
Staff trained in CMAM	0	3	2	3	8
Date of last training	0	Aug-17	Aug-17	Aug-17	3
Date of last supervision visit	0	Sep-17	Oct-17	Nov-17	3
Date of last monitoring visit	0	Oct-17	n/a	Oct-17	3

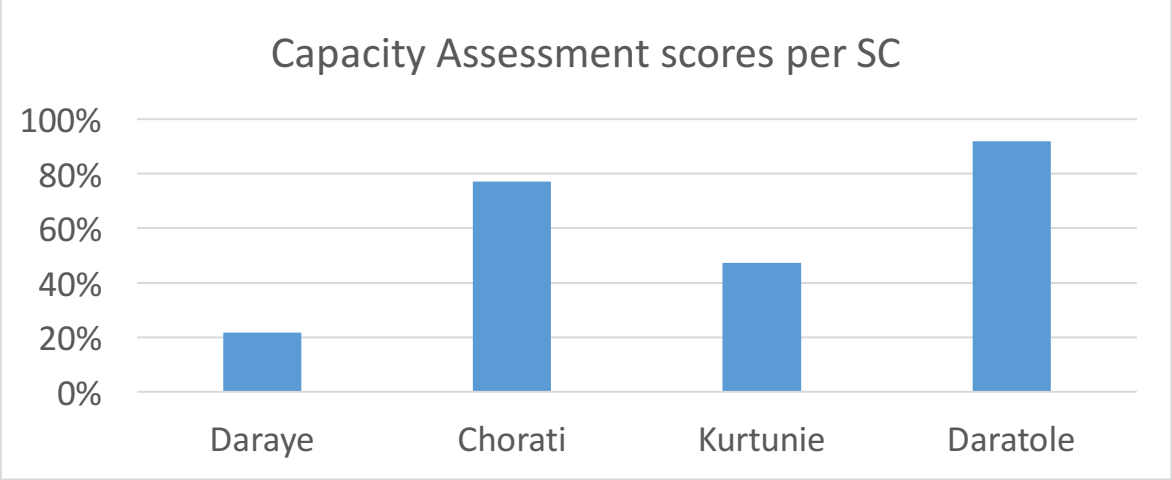
The four SCs included in the assessment received a total score of 58% (171/296 points). See figure 2 for scores in each topic.

Figure 2: SC Capacity Assessment Results in Dollo and Afdear Zones



As noted in the above table, Dollo has higher scores in all categories when compared to Afdear. This is most likely due to long term NGO support that has been scaled up with attention from partners (UNICEF, WHO, MSFH, GOAL and AAH) on SC quality.

Figure 3: Results per Stabilization Center



Capacity per SC varied as per the above graph. Some facilities showed high results, while others were lower. This is due to a number of factors such as length of time the facility has been operating, the number of staff trained at the facility and the level of NGO support in each facility. Action plans at the end of this report will outline best practices and recommendations that can be replicated to improve quality of treatment.

The capacity assessment revealed underlying issues regarding gaps and challenges related to quality treatment in SC's. To explain better the scoring, the main strengths have been listed below followed by a more detailed discussion of the gaps. Gaps are organized into two categories. Overall gaps identify systematic and staffing challenges and technical gaps identify deficiencies on the implementation of the national nutrition protocol.

Strengths

- Staff availability and willingness to participate in the assessment
- Three quarters of the facilities scored above 50% on understanding anthropometric admission and discharge criteria
- 75% of SC's visited had received training and supervision or monitoring visits since August 2017
- 3 out of 4 facilities had proper stock storage systems and reported receiving therapeutic milks on time
- 3 out of 4 facilities had handwashing points with soap
- 100% had proper latrine facilities
- All facilities had a copy of the national protocol available

Overall Gaps

- Though 50% of SC's visited provided transport support for caregivers and 75% provided food or money to purchase food while admitted, all facilities reported challenges in getting caregivers to stay for the duration of treatment
- Limited SC hardware available like milk preparation materials, mattresses, etc.

- Poor SC set up: Disorganized, beds not set up, poor utilization of existing space, not welcoming environment for caretakers/children, not divided into phases
- Staff:
  - Insufficient man power/high workload
  - 24-hour care: several facilities reported not receiving overnight duty entitlement
  - Some SC's have NGO paid staff working alongside government paid staff and reported tension regarding different levels of pay between staff members
- Low number of total staff trained on SC protocols. No SC visited reported more than 3 staff members had received training

Technical Gaps

- 2 of 4 health facilities visited did not recognize oedema, lack of appetite and medical complications as admission criteria
- 3 of 4 facilities showed poor techniques in taking anthropometric measurement: MUAC: don't find midpoint, take upside-down; weigh children with clothes on, trouble finding WFH using WFH chart
- 3 of 4 facilities lacked understanding of SC treatment for infants <6 months:
  - Couldn't explain admission criteria for infants <6 months
  - No use of Supplementary Suckling Technique
  - No discussion of relactation and breastfeeding while consuming therapeutic milks
  - One nurse stated: 'Complications make child unable to breastfeed'
- 0 facilities knew the symptoms of dehydration in a malnourished patient vs. a well-nourished patient and only 1 facility had a solid understanding of how to treat dehydration in malnourished children
- 3 out of 4 facilities prescribed paracetamol to treat fever in malnourished patients and couldn't explain treating fever with cooling techniques
- All facilities could name at least one symptom of AWD but only one SC visited received training on AWD and SAM

10.Results OTP

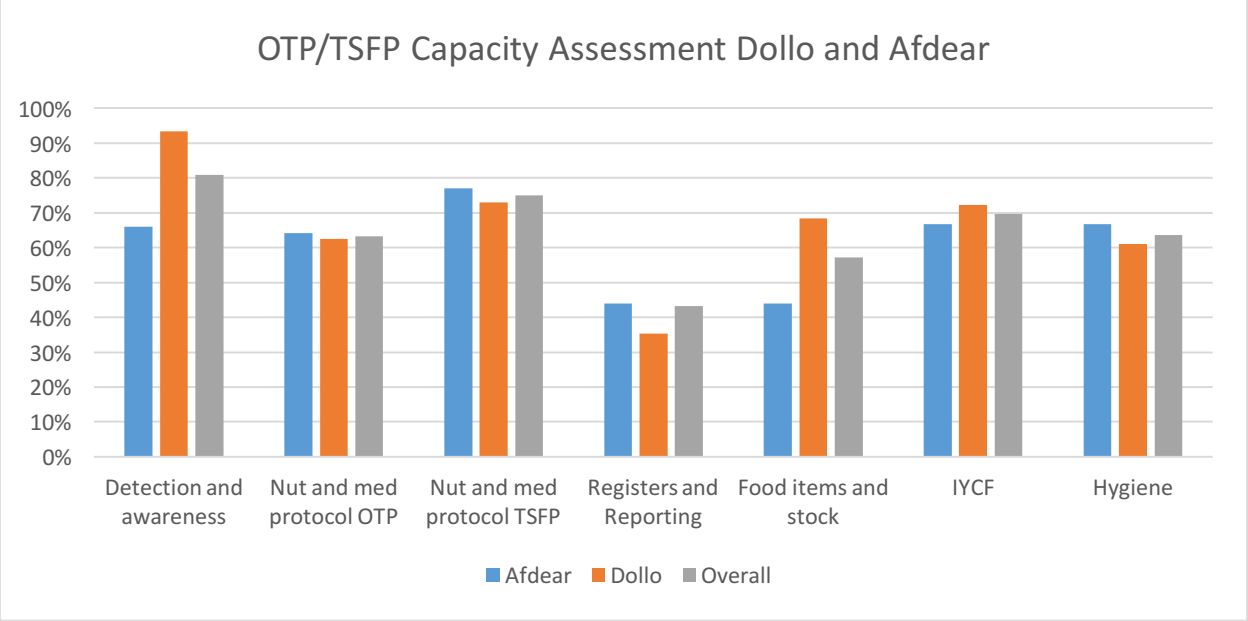
Overall 11 OTP sites were assessed. Fourteen staff members participated in the questionnaires and discussion groups at Health Center/Health Post level. 73% of facilities (8 facilities and 11 staff members) reported receiving training in CMAM services since June of 2017 and 82% of facilities (9) reported receiving supervision or monitoring visits since August.

Figure 4: Assessment statistics OTPs

question	Daraye	Harder	Masago Badan	Masala Adun	Chorati	Isgoyska HP	Jinole HP	Lahelow	Mire HP	Wafdahug HP	Dila Ano HP	TOTAL
Staff participating in assessment	2	1	1	2	2	1	1	1	1	1	1	14
Staff trained in CMAM	0	0	1	2	2	0	1	1	1	2	1	11
Date of last training	n/a	n/a	Aug-17	Sep-17	Aug-17	n/a	Jan-17	Jun-17	Aug-17	Aug-17	Aug-17	
Number of Active Case Finders	0	n/a	n/a	2	4	8	2	4	3	8	1	32
Date of last supervision visit	0	Oct-17	n/a	Sep-17	Oct-17	Oct-17	Aug-17	Aug-17	Oct-17	Oct-17	Sep-17	
Date of last monitoring visit	0	0	n/a	Oct-17	none	none	Aug-17	Aug-17	n/a	Oct-17	n/a	

The 11 OTP facilities included in the assessment received an overall score of 59% (518/880 points). See figure 5 for scores in each topic of the questionnaire.

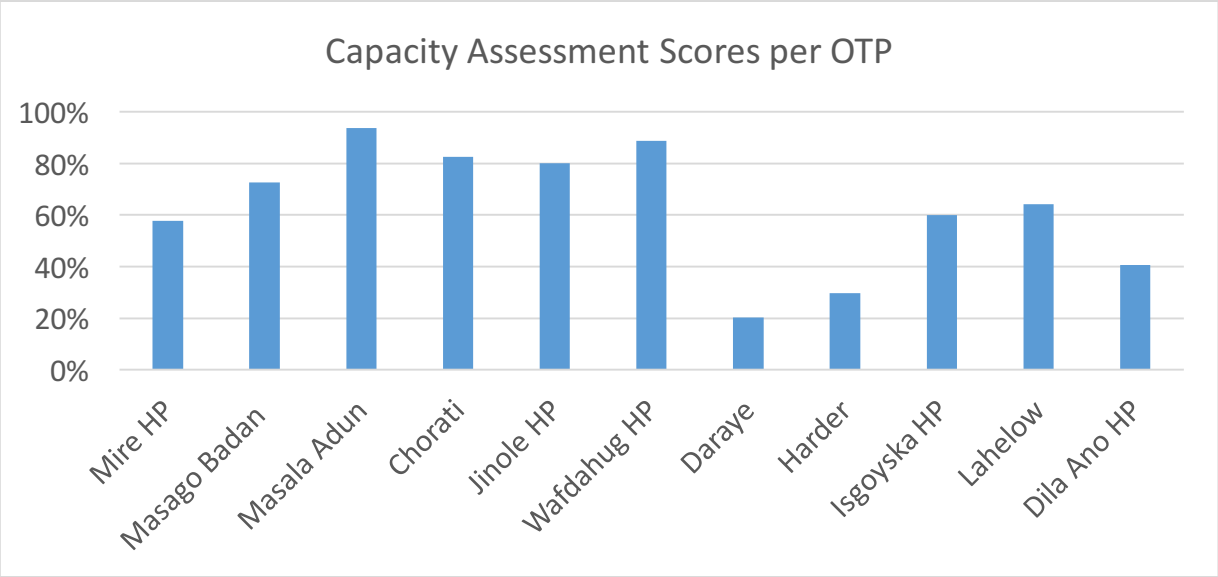
Figure 5: OTP Capacity Assessment results Afdear, Dollo and Overall



As noted in the above table, highest scores were seen in detection and awareness. This is most likely due to an emphasis on active case finding in Dollo Zone. Dollo Zone reported 26 active case finders compared to just six in Afdear zone. Though there is a high demand for CMAM

services at community level, there is a limited understanding of inclusion and discharge criteria by community members. Most community members want to participate in nutrition programs and are unclear on why certain people are selected for programs and others are not. Scores on the Nutrition and Medical Protocol showed that health workers interviewed had received some training and had knowledge of nutrition and medical protocols. All health facility workers reported positive experiences with supervision and monitoring and stated that receiving these visits was motivating.

Figure 6: Scores per OTP



Some of the facilities participating in the capacity assessment showed very high results. Masala Adun, for example, had staff that had been running CMAM services for eight years and was well versed in National CMAM protocols. Other Facilities were newly added during the recent scale up and have received less support and training (Daraye and Harder).

Strengths

- Staff availability and willingness to participate in the assessment
- 73% of facilities had received training since June 2017
- 82% of facilities received supervision or mentoring visits since August
- 9 out of 11 facilities conduct active case finding in the community
- 10 out of 11 facilities have OTP registration books
- 8 out of 11 facilities reported receiving RUTF on time

Overall Gaps

- Risk practices observed: All OTP staff interviewed reported sharing of RUTF among Family members as a reason for stagnant weight and slow evolution of children in the program
- Pastoral community movement resulting in defaulters

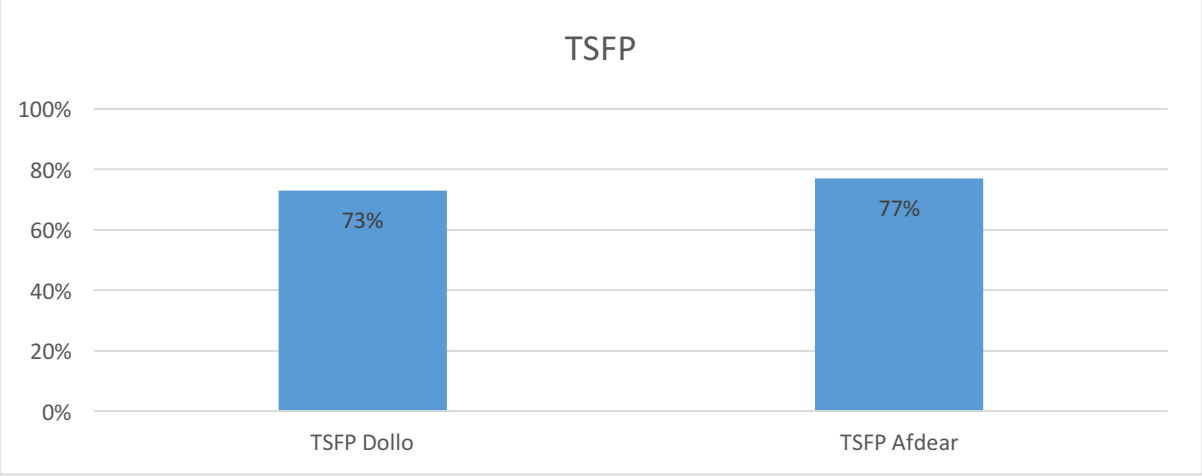
- All facilities reported that HEW have too high of a workload
- All health facilities noted that social mobilization can be improved at community level and linkages between the community and health center/posts should be strengthened

Technical Gaps

- 8/11 facilities showed limited understanding of discharge criteria. Additionally, OTP individual cards showed MANY children with recorded MUACs >11 for multiple weeks while waiting to reach target weight. This may be due to improper taking of anthropometric measurements, but should be taken into consideration that children with a MUAC >11 frequently remain in the program
- 72% of facilities demonstrated poor techniques in taking anthropometric measurements: MUAC: don't find midpoint, take upside-down; weigh children with clothes on
- Reporting:
  - 8 facilities lacked monthly report forms and discrepancies were seen when comparing registers and monthly report data
- Stock shortages were reported in 3 facilities and 7 facilities were not clear on how to estimate caseload when making stock requests
- 8 facilities had some IYCF counselling materials, but only 4/11 facilities could list three key IYCF messages to communicate to caregivers

11.Results TSFP

Questions on the TSFP were included as a section of the OTP questionnaire. The below results have been extrapolated from the from the questionnaire to show TSFP services. These results were based on knowledge and not verified by observation.



Strengths

- 5 out of 6 facilities understood the admission criteria
- 5 out of 6 facilities provided education to caregivers on the proper administration of plumpy sup and CSB++ (only for malnourished, not for infants <6 months, wash hands before preparing/administering)

Overall Gaps

- Risk Practices Observed: All health workers interviewed reported that CSB++ is shared with the whole family and that it's not seen as curative
- 100% of caregivers interviewed mentioned that more children should be included in the program and the program should be longer in duration. This demonstrates lack of understanding of TSFP program criteria at community level and acute food shortages in the home
- All health workers administering the TSFP program reported community pressure to admit all children into the program and stated that mothers don't want to go through admission process as they are afraid they won't qualify
- All health workers reported that on distribution days all community members show up wanting ration, making their work challenging and chaotic
- All health facilities reported problems with supply chain (late arrival, frequent stock shortages)

Technical Challenges:

- TSFP cards were not available for review
- Lack of clarity on discharge criteria
- Poor linkages with OTP programs
- Limited understanding of CSB++ preparation (measurements, consumption recommendations)

12. Active Case Finding

Active case finding is a crucial component of CMAM services that helps ensure coverage of catchment areas to detect and refer all children suffering from SAM or MAM to health facilities. The context in the Somali region is particularly challenging due to the vastness of the area and the unpredictable movement of the pastoralist communities. 73% of facilities visited reported having active case finders. Active case finders include HEW and community volunteers. As seen above active case finding was stronger in Dollo in part, because there are more HEW and Health Development Army (HAD), and/or NGO trained Community Volunteers (CV) trained to conduct active case finding. Discussion groups illuminated many challenges to active case finding and some suggestions on how to address these challenges.

Challenges

- Limited link between community and facility
- Oedema is seen as a different disease
- Limited linkages between Health Facilities and Health Centers
- No social mobilization or linking with community leaders

- Limited coordination with distributions and campaigns
- HDA/CVs trained but not motivated or incentivized (no certificates, badges, t-shirts, etc.)
- HDA/CV's are managed by HEW who are overburdened
- Distance is hard to cover even with HDA/CVs and make it hard to follow up on referrals
- Situation makes things really challenging (food shortages, lack of transport, distance, insecurity, mobile communities etc.)

Feedback from Discussion Groups:

- For community awareness, include training for woman's affairs groups and youth groups
- Should take better advantage of campaigns for awareness and screening
- Better integrate HF with community leaders
- Better establish community volunteers-train, increase number, motivate them
- Better coordinate with community leaders and religious leaders-link to health centers and health posts
- Motorcycles or some mode of transport would help reach distant areas (motorcycles)

13. Pastoralist Communities

Reaching Pastoralist communities is a noted challenge due to unpredictable movements. Discussion groups reflected that pastoralist groups move based on rain and grazing opportunity. Often those who are sick, elderly or getting education stay behind. This can include children receiving CMAM services, but not always. It was also noted that husbands/men decide when and where to move. To better target pastoralists many solutions were identified during the discussion groups. These include:

- Train HDA in pastoralist communities
- Coordinate with pastoralist leaders
- They have cell phones for communication and can use these for passing information
- HDA in stagnant communities can communicate with pastoralists and connect them to CMAM services or local HDA once they are settled in their new communities

14. Infant and Young Child Feeding (IYCF)

Ensuring proper IYCF practices serves a critical role in the prevention of SAM and MAM, especially in emergency situations where poor IYCF practices abound. The main challenges identified in community level discussion groups on IYCF practices are as follows:

1. Lack of exclusive breastfeeding
2. No awareness about importance of breastmilk think it's not enough
3. Mothers have lots of household duties
4. IYCF Practices for infants <6 months:
    a. Give boiled sugar water at birth as tradition to give energy to the child
    b. Give animal milk (cow, camel and goat) to grow the child, stop hunger and stop crying; if no animal milk is available some give formula milk

5. Women say they don't have enough milk due to maternal hunger, sickness and pregnancy
6. Some use bottles others say they are too expensive

Caregivers would like more information on:

1. How to feed a sick child
2. How to feed children with diarrhea
3. How to deal with increasing food prices

15. The Community Perspective

Understanding community perception of CMAM services can improve understanding of and participation in CMAM services. For this assessment discussion groups were held in 14 communities.

- **179 caregivers of children 0-59 months were interviewed in Dollo and Afdear**
  - 5 were pastoralist communities
  - 2 IDP sites
  - 6 permanent communities
  - 1 mixed

- **62% reported participating in a nutrition program**
  - Those who didn't participate: 82% had heard about nutrition programs

- **59% reported receiving a home visit where MUAC was taken**
  - Messages given during screening:
  - Child is 'ok'
  - Child is malnourished,
  - 'Go to health center and get drugs and medicine'
  - Hygiene and nutrition messages
  - Nothing at all

- **Impact of nutrition programs**:
  - child 'get back normal life'
  - get healthy
  - gain weight
  - grow child
  - increase blood
  - better health
  - more energy

Part II: Prioritization of key gaps and action points

The Capacity Assessment results were presented and validated at a workshop on November 7, 2017 at the Regional Health Bureau attended by the RHB, Nutrition Cluster, NGO and UN partners. The second part of this report will detail the gap analysis that was conducted during the workshop and the action plan that was developed to address these gaps.

16. Key Gaps and Action Points

After validation and discussion of the results, participants in the workshop identified and prioritized the following gaps:

1. Supply and stock management
2. Staffing
3. Active Case Finding and social mobilization/Pastoralist Communities
4. Supervision and Monitoring
5. Application of minimum standards
6. Reporting and Data Collection
7. Coordination

Participants were then divided into four groups to identify challenges and causes behind the gaps and develop solutions and action points to address gaps. These were presented and will be discussed and validated during the second half of the Tech RRT ToR in Somali Region. Actions were organized into short, medium and long-term goals thereby allowing completion of simple low-cost actions to take priority over actions that require more time, planning and financial support. **Please Refer to Annex 1 for the Action Plan.**

It was determined during the workshop that the best way forward to improve CMAM capacity is to support existing SC, OTP and TSFP's to offer high quality CMAM services, ensure adequate coverage of existing catchment areas and develop a sustainable system for community outreach, alert raising and referral. The massive scale up from September 2016-2017 brought challenges of ensuring quality and coverage across this vast region given that infrastructure and basic services for transport, water and electricity remains fragile in remote areas.

The surge in MHNT providing services in hard to reach communities has been an effective stop gap to reach roaming pastoralist populations and cover the vast area. However, the long-term feasibility of mobile clinics to reach those living beyond CMAM service catchment areas is unrealistic and solutions must be sought. Distance, access and insecurity create significant barriers to reaching some of the most vulnerable. Though some solutions have been identified in the action plan, further discussions should be held at regional and national level to determine a way forward.

Ensuring trained medical and nursing staff implementing CMAM services remains a challenge as caseloads increase and services scale up. Qualified HEW are difficult to find in remote areas.

Improving quality of supervision and monitoring is critical in ensuring CMAM services are performing at acceptable levels.

17.Discussion

The overall score for CMAM services included in this assessment reflect many strengths including dedication at all levels to increase coverage, quality and reach the most vulnerable. Feedback from those implementing CMAM services at health center and health post level show that supervision and monitoring visits are valued and motivating. In the Somali Region, supervision and monitoring are parallel services conducted by different bodies with multiple checklists. Making coaching/mentoring and staff capacity review more systematic and including effective on the job coaching techniques, would go a long way in having a cohesive approach to improve capacity in CMAM services.

- Needs were expressed to streamline supervision checklists among all partners, to develop agreed upon minimum standards and ensure they are included in checklists
- Health workers wish supervisors would stay longer during supervision visits and provide more on the job coaching.
- It was also discovered that lack of motivation or commitment from staff does not always require salary increases. Other forms of motivation include performance based promotions, recognition in the form of certificates, coaching and trainings
- Improvement of coaching skills for supervisors is seen as crucial to overcoming many of the technical challenges highlighted in this assessment including closing gaps with reporting and supply management.
- Strengthening coordination, specifically at zonal level is also seen as crucial to the improvement of CMAM service quality, supply chain management and reporting processes.
- Strong efforts should be applied through coaching and training to improve taking of anthropometric measurements and provide clarity of admission and discharge criteria

Overall, supervision with effective coaching techniques coupled with updated training curricula would help address many of the technical gaps along with communication of and adherence to minimum standards for CMAM services.

18.Recommendations and Way Forward

In addition to the action points and recommendations outlined in the above sections, the below steps outline a few additional recommendations and a way forward.

1. Review and validate actions for each of the identified gaps and development of a plan to implement agreed upon actions (RHB, Cluster, Tech RRT)
2. Provide on-the-job-coaching training, cascade training down to woreda level and create coaching plan (Tech RRT, Cluster, RHB)
3. Identification of existing minimum standards and facilities currently meeting minimum standards as example for other facilities to emulate (RHB, Partners, Cluster)

4. Better understanding during nutrition education and awareness raising to determine the stigma associated with Oedema (Partners, W/HDA, HEW)
5. Strengthening of Zonal Nutrition Task force by increasing human resources to include technical, logistical and reporting specific roles (RHB, Partners)
6. Improve training in stabilization centers for the treatment of infants <6months (RHB, WHO, Partners)

Annex 1: Action Plan (to be validated with RHB Somali)

Goal	Action	Responsible	Due Date
Short term			
Improve Supervision and Monitoring	Develop annual integrated supervision plan		
	Appoint focal person to monitor and follow up on supervision plan		
	Review, adaption and use of common supervision tools and checklists		
	Conduct regular monitoring and supervision with feedback from health center/post staff		
	Train existing supervisors in coaching techniques		
Draw up and implement agreed set of Minimum Standards	Avail pre-determined standards/indicators		
	Leadership/coordination for implementation of minimum standards at facility level		
	Effective training/capacity building on minimum standards (coaching)		
	Create and provide relevant guidelines, updated job aides at facility level		
	Include minimum standards in supervision checklists		
Increase coverage and effectiveness of Active Case Finding/social mobilization/Pastoralist Communities	Provide escorts and regular security briefing updates		
	Use MHNT to target hard to reach areas		
	Development of strong concise messaging on CMAM services to improve community level understanding		
	Train for woman's affairs groups and youth groups on CMAM program awareness		
	Coordinate with campaigns for awareness and screening		
	Better integrate HF with community leaders		
	Train more H/WDA to conduct screening (including within pastoralist communities)		
	Develop/implement performance based incentives (certificates, scratch cards) for HDA		

	Motorcycles or some mode of transport to reach distant areas		
	Allow Pastoralist community members to take OTP Individual cards and receive treatment at any health facility		
Medium			
Motivate staff and reduce turnover	Provide On-job mentorship using coaching techniques during supervision visits		
	Regular Supportive supervision and with feedback from HF teams		
	Creation of a database of those trained in CMAM services and contact information		
	Develop/implement regular rewards/ motivation scheme for those implementing CMAM		
	Train all staff members on CMAM services so all can rotate in as required		
	Develop clear roles and responsibilities for each staff working in CMAM services		
	Provide job aids and wall charts with key messages on CMAM treatment		
Improved Coordination between regional, zonal and woreda levels	Strengthen linkage between zonal and regional level cluster platforms		
	Strengthening zonal level cluster meeting		
	Establishment of woreda nutrition clusters		
	Triangulation of the action points follow up from regional to zonal level		
	Output tracking sheet establishment to measure the trained staff and supervision outputs		
	Complete 4W matrix every month		
Long Term			
Effective and timely Supply and stock management system	Establishment of hub structure at zonal level		
	Include stock management in coaching and supervision visits		
	Stock preposition		
	Hire dedicated technical staff trained on stock management and systems		
	Hire logistician at woreda level		
	Staff training at facility level on supply inventory management		
	Provide vehicle for transportation of supplies		
	Develop a minimum reporting package		

Improve accuracy and timeliness of Reporting and Data Collection	Establishment of call center at regional level and pre-paid card cost allocation for the service providers		
	Staff motivation mechanism establishment		
	Providing streamlined reporting tools at all levels (tally sheets, registration book, cards, monthly statistic reports)		
	Regular supportive supervision and coaching		
	Documented monitoring system		
	Establishment of focal persons at all levels to triangulate the data		

Annex 2: Questionnaire

Name of assessment Leaders:		**Date:**		
Name of Health Center or Post:		**Zone:**		**Woreda:**
Number of staff trained in OTP/SFP?:		**Number of staff participating in assessment:**		
Date of Last OTP/SFP training?:		**Date of last Supervision visit:**		
Number of people who do active case finding for this center/post?:		**Date of last monitoring visit:**		
	Use the following Scoring for Each question	☹	Requires significant improvement	
		😐	Good, but needs some improvement	
		☺	Perfect, no improvement needed	

ASSESSMENT OTP/SFP

No	Topics	No	Yes		
I	***Detection, Referral and program awareness***	☹	😐	☺	**Comments**
1	*Is active case finding conducted in the community?*				
2	*How often is active case finding conducted in the community?(weekly, monthly, every 6 months)*				
3	*What tools do the Health Extension workers use to conduct the screening?*				
4	*What activities are done to ensure the community is aware of the CMAM program?*				
5	*Do you crosscheck MUAC and Oedema when referrals arrive from the community? Is it correct?*				
II	***Nutritional and medical Protocol (OTP)***	☹	😐	☺	**Comments**
6	*What is the admission criteria for OTP?*				
7	*What are the main medical complications for severe acute malnourished children?*				
8	*When do you refer children to the Stabilization center?*				
9	*How do you conduct appetite test?*				
10	*How do you determine the amount of plumpy nut (RUTF) to give to a child ?Observe*				

11	*Can you demonstrate how to take MUAC, weight and Oedema?*				
12	*What do you do if a child's weight is stagnant for 2 consecutive weeks?*				
13	*Do you fill the OTP card properly? Verify.*				
14	*What is the OTP discharge criteria?*				
15	*What counselling to you give the caregiver at discharge?*				
16	*Do you have a TSFP you refer to at discharge?*				
17	*Is a copy of the National Protocol/quick reference available? (Observe)*				
III	***Nutritional and Medical Protocol (TSFP)***	☹	😐	☺	**Comments**
18	*What is the admission criteria for SFP?*				
19	*Do they properly fill out the SFP treatment card? (verify)*				
20	*How do you ensure caregivers know how to prepare and give the CSB++ and PlumpySup?*				
21	*What health/nutrition education messages do you give caregivers?*				
22	*What is the Discharge Criteria for the TSFP?*				
23	*How do you request the CSB++ and plumpy sup? (verify)*				
24	*What is the referral process from the community to the SFP?*				
25	*How do you ensure linkages to the OTP?*				
IV	***Registers and reporting***	☹	😐	☺	**Comments**
26	*Do you have the OTP Registration book (confirm)? Is it filled correctly?*				
27	*Do you have Monthly report forms (confirm)?*				
28	*Do you fill the Monthly report form accurately and timely (confirm)?*				
29	*Do you have the OTP individual card (confirm sufficient supply and that they are filled and stored properly upon discharge)*				
V	***Food item availability and Stock Management***	☹	😐	☺	**Comments**

30	*How do you request your RUTF and routine medications?*				
31	*Where do you store your stock? (verify that storeroom is in proper condition)*				
32	*Usually do you receive your supply on time? If no, why not?*				
33	*How do you estimate the caseload when requesting new RUTF?*				
34	*Are you filling a stock report to follow the consumption of medicine and therapeutic food? (verify)*				
VI	***IYCF and Nutrition Education***	☹	😐	☺	**Comments**
35	*Do you provide IYCF Counselling to caregivers?*				
36	*Are IYCF counselling materials available in the health facility (verify)*				
37	*What are 3 key IYCF messages you communicate to caregivers of infants <24 months?*				
VII	***Hygiene and facility set up***	☹	😐	☺	**Comments**
38	*Hand washing points are available and with soap? (observe)*				
39	*Is safe drinking water available for the appetite test? (observe)*				
40	*Is there a proper latrine system? (observe)*				
					General Comments:
	Overall Scoring	☹	😐	☺	
	Total up how many times each box was ticked:				

Name of assessment Leaders:		**Date:**		
Name of Facility:		**Zone:**	**Woreda**	
Number of staff trained in CMAM?:		**Number of staff participating in assessment:**		
Date of Last CMAM training?:		**Date of last Supervision visit:**		
Number of Health Extension workers for this facility?:		**Date of last monitoring visit:**		
	Use the following Scoring for Each question	☹	Requires significant improvement	
		😐	Good, but needs some improvement	
		☺	Perfect, no improvement needed	

ASSESSMENT SC

No	Topics	No	Yes		
I	***Admission Criteria***	☹	😐	☺	**Comments**
1	*What is the admission criteria?*				
2	*What is the admission criteria for infants <6 months?*				
3	*Can you show me how you take anthropometric measurements (observe MUAC, WT, HT and Oedma)*				
4	*How do you determine the Weight for Height? Can you show me?*				
II	***Nutritional and medical Protocol (SC)***	☹	😐	☺	**Comments**
5	*What are the 2 Phases of Treatment in the SC?*				
6	*What is the therapeutic food to give in each phase?*				
7	*How do you calculate the dosage? Can you show me?*				
8	*How do you monitor the amount of milk each patient receives per feed? (Check the multichart to ensure it is filled with this information)*				
9	*What recommendations do you make to mothers who are breastfeeding while their child is receiving therapeutic milk?*				

10	*How do you administer therapeutic milk to an infant <6 months?*				
11	*What are the signs of dehydration in a malnourished child?*				
12	*How do you treat dehydration in a malnourished child?*				
13	*What are the symptoms of AWD?*				
14	*Have you been trained in management of AWD with SAM?*				
15	*How do you treat a fever in a malnourished child?*				
16	*What is the discharge criteria to go from SC to OTP? Can you explain?*				
17	*Do you give to the patient ta transfer form to the OTP? Observe transfer form.*				
18	*What are the discharge procedures?*				
19	*What counselling do you give to the caretaker upon discharge?*				
20	*Is food provided for the caregivers? If so, how many meals per day? (verify that it's consumed in a separate area)*				
21	*Is transport provided for caregivers requiring assistance with transport?*				
22	*Is a copy of the National Protocol available? (Observe)*				
III	***Registers and reporting***	☹	😐	☺	**Comments**
23	*Do you have the TFP registration book (confirm)? Is it filled correctly?*				
24	*Do you have Monthly report forms (confirm)?*				
25	*Do you fill the Monthly report form accurately and timely (confirm)?*				
26	*Do you have the Multichart card (confirm sufficient supply and that they are filled properly)*				
IV	***Food item availability and Stock Management***	☹	😐	☺	**Comments**
27	*How do you request your Therapeutic milks and medications? (observe form)*				

28	*Where do you store your stock? (verify that storeroom is in proper condition)*				
29	*Usually do you receive your supply on time? If no, why not?*				
30	*How do you estimate the caseload when requesting new therapeutic milk?*				
31	*Are you filling a stock report to follow the consumption of medicine and therapeutic Milk? (verify)*				
V	***IYCF and Nutrition Education***	☹	😐	☺	**Comments**
32	*Do you provide IYCF Counselling to caregivers?*				
33	*Are IYCF counselling materials available in the health facility (verify)*				
34	*What are 3 key IYCF messages you communicate to caregivers of infants <24 months?*				
VI	***Hygiene and facility set up***	☹	😐	☺	**Comments**
35	*Hand washing points are available and with soap? (observe)*				
36	*Is safe drinking water available for patients and caretakers? (observe)*				
37	*Is there a proper latrine system? (observe)*				
					General Comments:
	Overall Scoring	☹	😐	☺	
	Total up how many times each box was ticked:				