COVERAGE MONITORING NETWORK

WRAP UP WORKSHOP REPORT KENYA

8TH and 9TH FEBRUARY 2016

VENUE: MONARCH HOTEL, NAIROBI

COVERAGE MONITORING NETWORK

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1. BACKGROUND INFORMATION

The Coverage Monitoring Network (CMN) is an inter-agency initiative implemented by ACF-UK and its partners Concern Worldwide, Helen Keller International and International Medical Corps, with other members including: International Rescue Committee, Save the children, Goal, valid international and World Vision. The first phase of the CMN was launched in July 2012, with the support of the European Commission Directorate-General for Humanitarian Aid and Civil Protection (ECHO) and USAID's Office of Foreign Disaster Assistance (OFDA). The project aimed to improve nutrition programs through the promotion of quality coverage assessment tools, capacity building and information sharing in 9 priority countries in Africa and Asia (including South Sudan, Kenya, Ethiopia, Niger, Burkina Faso, Mali, Chad, DRC and Pakistan). The main objective of the CMN is to contribute to a reduction in malnutrition-related mortality and morbidity through improved capacity of selected nutrition programs to develop and implement actions to increase access and coverage of services. In order to achieve this, the CMN has focused on 3 main areas;

- Improved integration of coverage assessment tools by nutrition programs
- Increased availability of actionable recommendations for improving coverage of nutrition programs
- Increased availability and utilization of lessons learned, best practices and information to improving program coverage

See Annex I for further details on these activities.

2. WORKSHOP OBJECTIVES

Principle objective:
To improve access to and uptake of SAM and MAM treatment programs in Kenya

Specific objectives:

- To share the findings and recommendations coming from coverage assessments in Kenya over recent years.
- To share and document examples of how the evidence and data generated by recent coverage assessments (including SQUEAC assessments and partners of the BNA pilot study) are being used by programs,
- To share and document activities being undertaken in different contexts to overcome barriers to access and to identify best practices in key contexts.
- To discuss and agree the next steps needed to improve programming in order to improve access and uptake of services to treat SAM and MAM.

DAY 1		
TIME	**TOPIC**	**LEAD**
Morning	- Introductions and outline of agenda - Update on the finalisation of the national coverage guidelines - Presentation of country profile: including mapping of coverage assessments, overview of trends in programme data and community profile	- CMN - NITWG - NITWG members
Afternoon	- Transforming coverage results into action: experiences, challenges and best practices. - Group work to identify and document other best practices	- NITWG members and CMN
DAY 2		
TIME	**TOPIC**	**LEAD**
Morning	- National Priorities for scaling up access and coverage of services. - Group work to discuss and identify next steps to improve access and uptake of IMAM programmes	- CMN - NITWG partners and CMN
Afternoon	- Presentation of group work and further discussion and allocation of responsibilities - Next steps and new developments in coverage methodologies	- CMN and partners

3. SUMMARY OF DISCUSSIONS

As the focal point for all matters related to nutrition data in country, the Kenya Nutrition Information Technical Working Group (NITWG) was responsible for the facilitation of the workshop. More specifically, the specific Coverage TWG[1] was at the forefront of conversations. Accordingly, in collaboration with the MoH, this TWG has been working on the development of a National Coverage Guideline for IMAM programmes, due for release by June 2016.

The NITWG, in collaboration with CMN, presented a country profile with an updated mapping of coverage assessments and trends of program data. In Kenya, more than 35 coverage assessment have been carried out that the CMN have a record of. However, it is important to recognise that the CMN does not have a record of all assessments carried out. The NITWG is encouraged to share all results with the CMN. The overall coverage estimates fell below the minimum SPHERE standard. According the admission trend data from 2011 – 2015 the overall SAM and MAM admission trend is decreasing in the ASAL counties. The main barriers associated to access and uptake of services were the following;

[1] As a result of the CMN training in 2012, a subgroup of the NIWG was established with the specific aim of integrating coverage methods and information in to programming.

- Long distance
- Shortage of staff due to high turnover
- Migration
- Inadequate mobilization and poor active case finding
- Low ownership of CMAM programs by some health facility staff
- Perception of nutrition products as food hence encouraging sharing.
- Poor adherence to protocol leading to wrong admission and exit criterion.
- Nutrition supply Stock out including essential drugs
- Lack of awareness of malnutrition by caretakers
- Perceived rejection of beneficiaries due to measurement variations from community health workers.
- Competing activities of caretakers/workload
- Low access to nutrition services in some health facilities due to staff absenteeism

In order to strengthen the transformation of the coverage assessment results into action plan, members of the NITWG were invited to present their own experiences. The following organisations presented;

- Islamic Relief Kenya
- Action Against Hunger
- International Medical Corps
- International Rescue Committee
- World Food Programme
- Concern Worldwide

All presentations are accessible here .

Main discussions focussed on challenges to implementing activities to overcome barriers to access. At the end of the experience sharing session (for a details of the discussions, please go to Annexe II), the four key questions below were identified and responded to through group work sessions.

3.1. Issues to Consider when creating an action plan

- Clarity on the problem being identified/addressed
- Timelines for implementation
- Involvement of key stakeholders
- Resources needed for implementation
- Feasibility
- Linking action to specific actors
- Endorsement by key players
- Building in feedback mechanism
- Existing policy and guidelines
- Considering contextual issues (security, gender, culture and geographical factors)
- Sustainability
- Looking at longer and shorter term
- Evidence of what works

3.2 What are the best methods for creating a Good action plan

- Participation by all stakeholders including beneficiaries
- Have a specific activities (SMART)
- Linking recommendation to findings
- Resource consideration internal and external
- Advocacy approach
- Involving the right mix of technical expertise
- Sustainability
- Innovative participatory approach
- Building into annual work plan

(CIDP/CNAP) etc…

3.3 What are the factors affects implementation of action plans?

- Low prioritization of nutrition activities. That is not given resources required and attention. To do more advocacy work
- Inadequate uptake of recommendation by nutrition sensitive sectors.
- Lack of timely follow up of the recommendation
- Resources (inappropriate allocation)
- Security issues
- Poor comprehension of impacts of low coverage
- Staff turnover and capacity
- Recommendation should linked to the project
- Lack of commitment / poor staff morale
- Lack of monitoring mechanism for the Action Plan.
- Lack of stakeholder involvement
- Lack of clear role and responsibility of implementing stakeholders.

3.4 What changes or improvement should be carried out?

- Mechanism for monitoring deliverables
- Involvement of all stakeholder in development and monitoring
- Realistic action points/plans
- High level advocacy
- Embed sustainable approaches in the implementation of action plans
- Ensure the action plan are broken down into immediate, medium and long term
- Incorporation of advocacy into various strategies.
- Structured capacity building.
- More time to develop the action plan and approval by different level

As part of broader discussions on improving access and coverage to IMAM services, the attendees were asked to reflect on relevant priorities for focus and further work. Results of the discussions are captured below.

Table 1: Reflection on relevant priorities in Kenya

			IS THIS PRIORITY RELEVANT TO KENYA	WHAT IS CURRENTLY BEING DONE?	WHAT SHOULD BE DONE?
Enabling Environment	Political Commitment	There is limited evidence-based understanding how to position SAM as a national priority	Yes	• SUN CSA conducting at National and county advocacy. • SHARE Program has a component of advocacy	• Scale up advocacy to other counties • Having appropriate key messages appropriate to SAM • Having appropriate budgeting design
		There are no national level wasting reduction or SAM treatment coverage targets at country level which would mirror WHA commitments	Yes	• Screening at hotspot areas and sentinel sites though inadequate • Caseloads computed/ generated from seasonal assessment and surveys	• Evidence based targeting of SAM cases • Mass screening through community health workers • Strengthening community strategy/sentinel
		The leadership and coordination to influence national policy on SAM needs to be reinforced	Yes	• Policy guideline on identification, treatment of SAM cases • Coordination of Nutrition information through NITWG • Existence of surveillance systems. HIS/NDMA	• Sharing /strengthening linkages with other working groups and inter sector forums • Strengthen Nutrition sharing and utilization at county level
	Financing	The inclusion of SAM treatment in national health budgets is inadequate and/or inconsistent	Yes	• There exist budget for HRH(Nurses/Nutritionist) • Supply of RUTF is donor led (UNICEF) • WFP handed over the supplies to KEMSA • Existing od essential drugs • Costing for treatment of SAM	• Sustained advocacy to include nutrition commodity
	Management	The use of data/evidence for strategic and tactical decision	Yes	• Through NITWG, analysis data is used for programing	• Real time utilization of data • Strengthen the capacity of counties to utilize data for programing

		making on SAM scale-up is limited		• Availability of Nutrition data from Surveys, Surveillance system • Sharing of Nutrition data across sectoral working groups	• Taking lead prompting support
	Coordination	The lack of clear guidance and division of labour that undermine the ability to address SAM and MAM across the continuum of care in emergency and non-emergency contexts	Yes	• Integrated approach to MAM and SAM program/ treatment • Existence of community strategy compartment	• Strengthen the referral system • Ensuring quality program through addressing barriers and capitalizing all boosters • Strengthening the community component
		There are limited joint initiatives between nutrition and health actors/stakeholders to support the integration of SAM into health	Yes	• Already exist because nutrition is under MoH	
Supply	Commodities	The procurement and supply of RUTF occurs outside of regular health supply chain and is unpredictable and unsustainable	Partially relevant	• KEMSA –a government supplies agency piloted in Turkana and Laikipia • UNICEF supplies RUTF up to county level	• Distribution of RUTF through KEMSA (government) • Commodity steering committee.
		Exploring alternative RUTF formulations at country level is made challenging by the lack of expertise in evaluating opportunities (e.g. recipes) and challenges (e.g. production)	Relevant	• Availability of private companies producing Nutrition supplies though not for SAM management	• Explore options of being locally manufacture (RUTF) • Offer/seek technical support in the industries. • Quality control • Sensitize people to produce raw materials.
		The understanding of key issues, challenges and barriers to inpatient treatment remains limited	Relevant	• Limited stabilization centres in both camp and in the host community	• Unpack barriers/sensitize stakeholders on the barriers at different level. • C4D strategy • Advocacy at all levels addressing the myths, HR, Capacity • Capacity development

	HR	The support from health authorities, paediatricians and other senior health stakeholders in-country for SAM integration into health policy and practice (including health training curricula) is limited	Relevant	• Training of doctors, nurses on IMAM	• Integration of Nutrition in to the service delivery of health workers
		There are inadequate numbers of health workers in place that are adequately prepared and/or trained to deliver SAM treatment routinely	Relevant	• Health workers and Nutritionist being employed though not optimal • Training/ Capacity building of Health Workers on IMAM	• Additional of more health workers • Continues on job training on IMAM
		The potential contribution of community health workers to SAM treatment is not maximised	Relevant	• Partners are motivating CHW where possible with no partner support not much being done • Being trained on IMAM and Community health Strategy	• Creating an enabling environment • Inter facility / Service delivery communication
	Geographic Access	There is an inadequate number and distribution of functioning health service delivery points (e.g. fixed and community) providing SAM treatment	Relevant	• The few facilities are doing/providing SAM treatment. Though the facilities are not adequate • Facilities in Non- ASAL areas may not provide SAM treatment optimally	• Increase coverage of Health Facilities • Explore more mobile or outreach clinics.
		The ability of national health actors to adequately evaluate and structure SAM treatment scale-up is limited by basic information about the health system (e.g. # of HFs; resources; days per week)	Not relevant for now	• Plenty of information available • NITWG, universities and research centres • HIS well-structured/working	

Demand	Community Mobilization	Community mobilization initiatives remain limited, and when they do exist, they do not generally support health seeking behaviour on SAM	Yes	• Community engagement done only at camp setting • Community dialogue days • Community Unit structure used as mobilization strategies • Thematic days celebrating (Malezi Bora, WBW • M2MSG, care groups cascades	• Strengthen the community unit in terms of (resources, equipment & training) • Put proper CHEW curriculum in place • Advocacy for the county government t to fund with clear budget lines • Come up with standard tool used for reporting during dialogue days • Clear referral mechanism and document • Clear reporting and management structure • Have clear activities to done during the celebration of thematic days • Engage decision makers at county level eg. MCA's
		There is a limited understanding of how best to empower communities to demand SAM management services, and caregivers to diagnose, prioritise and seek treatment for SAM	Yes	• Empower M2MSG's • CHV's	• Increase community awareness , sensitization on malnutrition and health delivery services • Use C4D approach to address • Equip TBA's with the right information • Involve the community key persons in programming (eg traditional healers, TBA) • Have context specific programming • Communicate clear pathways to seek health services • Documentation/ simplified • Motivation strategies
DEMAND	UTILISATION	Referral pathways to SAM/MAM treatment do not currently result in consistent detection and admission of cases - Distance after referral	YES	▪ Discussion around the cut offs for screening(MUAC) so that MAM especially is adequately identified/detected	▪ Clarity in communication from the health worker(captured/harmonised in the guideline) right from screening of the expected outcome by the caregiver after referral so that

		- Inadequate detection of MAM		▪ Continuous monitoring to see whether the cut offs is fishing out the cases ▪ Employing HR ▪ High level advocacy for Employment of HR ▪ Active case finding	caregiver does not feel expectations not being met ▪ Inclusion of SAM/MAM in the school curriculum ▪ Follow up to ensure SAM/MAM detection is adequately In policy documents like community strategy policy guidelines
		The opportunity cost (including transport, loss of income, official and unofficial fees, etc) associated with SAM/MAM treatment can be too expensive Care givers who depend on casual labor would opt for labor instead of seeking care for children. (missed opportunity for treatment)	YES Not necessarily high	▪ Workplace support guideline dissemination for mothers for MIYCN. ▪ Opening up new facilities ▪ Operationalizing non functional ▪ Increase in outreaches ▪ Continuous advocacy for allocation of resources for increased facilities, number of outreaches	▪ Inclusion of SAM/MAM treatment in workplace support
		The availability, quality, and consistency of SAM treatment services is irregular affecting staff –user interface and compliance with treatment regime Unique to Kenya is insecurity contributing to absenteeism of health workers affecting health facility service delivery. This also affects supplies as nutrition supplies depend on reporting. Lack of knowledge of caregivers on availability of SAM management services.	YES	▪ Using existing structures for security (KRC) ▪ Employing locals to address local security and social dynamics ▪ Supply chain integration(technical staff employed to support, commodity steering committee formed, pilot done, upscale being awaited) ▪ Integration with other nutrition programs like for HIV TB	▪ Follow up of actions and recommendations from steering committee for commodities ▪ Advocacy for adequate staff ▪ Train health workers and CHWs in non-ASAL ▪ Monitor integration of Management of SAM/MAM with other nutrition services ▪ Development of context specific BCC strategy to reduce stigma for SAM/MAM

4. NEXT STEPS AND WAYS FORWARD

- Finalization of coverage guidelines
- The NITWG to share coverage reports with the CMN for update.
- Monitoring/tracking of the coverage action points, recommendation and conducting regular barrier bottleneck analysis before conducting the next coverage assessment
- Integrate BNA with all the activities in the program
- Utilization of the assessment report for advocacy at county level involving all sectors
- Integration of coverage assessment with other activities i.e. Vitamin A coverage to leverage on cost.
- Sharing reports, information and coverage lessons learned with wider stakeholder and other working groups.
- Strengthen the community strategy- Community Units and key actors in the community and strengthen existing structures.

5. ANNEXES

Annex I: Focus of CMN Phase II

During the current phase of the CMN, different tools to transform coverage results in to action have been developed through trainings and workshops, technical support as well as. In order to improve

1. The integration of coverage assessment tools by nutrition programs,
    - Review and adaptation of the methodologies through
        - Active and adaptive case findings
        - Errors in LQAS at stage II of SQUEAC assessments
        - The application of Bayesian Beta-Binomial conjugate analysis
        - A new tools to assist survey implementation
        - Cases studies for MAM and SAM
    - Bottle Neck Analysis
        - Commodity availability
        - Human Resources availability
        - Geographic availability
        - Community mobilization activities
        - Utilization of services
        - Continuity of services
        - Quality of services
        - Online training centre
        - Country level trainings
2. Increased amount of actionable recommendation
    - Support programs in the measuring coverage and actionable solution to overcome the issues encountered
    - Elaboration of the action plan
    - Support in the implementation of the action plan
3. Increased availability and utilization of lesson learned, best practices and information to improving program coverage.
    - Publication of peer review articles
    - Practical tools to overcome barriers to access
    - 9 lesson learned workshops to share experiences

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Annex II: Learning from Partner Presentations

1. What made the activities difficult to implement?
    - Initial resistance from health workers upon integration of nutrition into health service delivery system.
    - Lack of adequate staff at the health facilities.
    - Implementation of recommendation from previous assessments
    - Additional resources would be required especially during the implementation of the action plan rather than the assessment itself
    - Nutrition sensitive action plan are difficult to implement unless they receive some buy-in by the sensitive sectors.
    - More resources are needed to carry out frequent assessments and to follow up on the recommendation made after the assessment is over.
    - Security on implementation of the activities
2. Which activities did you find easier to complete the action plan than expected?
    - Health Worker Trainings
    - On job trainings
    - Supportive supervision
    - Nutrition specific activities as the program have a direct control over
3. How will the activities benefit the IMAM program?
    - Reach more cases - Surge
    - Integrating with national events (Maliza-bora, Community dialogue)
    - The counties allocation of more resources such as hiring of staffs, decentralization of the supply storing system
    - Improving of active case finding, screening and referral
    - Developing joint action plan
4. If you were to test the activities again, what would you change?
    - Sustainable and cost effective method of carrying out outreach activities
    - Refresher IMAM trainings for CHW/CHVs as there are high turn over of staff
    - Use single coverage estimator
    - Conduct barrier analysis and recommendation implementation
    - Advocate for county to contribute the coverage cost
    - Using of health worker from another health facility to support outreach activities in the neighbouring health facility ensured outreach were done consistently and minimized lateness to the outreach sites
    - Add more days for data collection i.e. from 12 days to 15 Days
    - Change the timing of the survey to February or March
    - Thorough supervision
    - Engaging more stakeholders as well as pre- assessment training of the county management teams on the assessment methodologies
    - Conducted a SLEAC rather than 10 SQUEACs (5 sub-counties both SAM and MAM)
    - Use Single coverage estimator rather than point coverage
5. Where are additional resources required? (Internally and Externally)
    - More human (recruitment), logistic (transportation) and financial resources
    - Capacity building (training)
    - Seconding of staffs

- External technical support

6. What would make the activities easier to implement?
    - Steady supply of nutrition commodities
    - Community mobilization and sensitization
    - County commitment to fund nutrition activities
    - Funding of community health strategy by county government
    - Using of health worker from another health facility to support outreach activities in the neighbouring health facility
    - Utilize the coverage decision tree to determine the coverage methodology to employ.
    - Support from NIWG members

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Annex III: Attendance List

No	Name	Organization	Position	Email
1	Kennedy Musumba	ACF-LAC	Program manager	kmusumba@actioncontrelafaim.ca
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3	Salim Athman A	IMC	M&E officer Tana River	
4	Mark Murage	IMC	M&E officer-Nairobi	mgathii@InternationalMedicalCorps.org
5	Felicity Munene	Concern World wide	M&E officer-Nairobi	felicity.munene@concern.net
6	Diana Carter	WFP	Nutritionist	diana.carter@wfp.org
7	Lilian Kasina	IRC	M&E coordinator	Lilian.kasina@rescue.org
8	Valarie Wambani	Kenya Red cross	Nutrition Manager	Wambani.valarie@redcross.or.ke
9	Kirimi Florence	Islamic relief	M&E officer	Florence.Kirimi@islamic-relief.or.ke
10	Maurine Omondi	ACF-Kenya	M&E Specialist	m&e.ke@acf-international.org
11	Ester Komen	Feed the Children	Program Officer	
12	Judith Mutala	WFP	Nutritionist	
13	Edward Kutondo	Unicef	Nutrition M&E	ekutondo@unicef.org
14	Nahashon Kipruto	ACF	FSNS Manager	Fsns.ke @acf-international.org
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22	Beatrice Ochieng	Ministry of Health	Epidemiologist	beatriceochieng@hotmail.com