Meta-analysis of Barriers and Boosters from 78 coverage assessments supported by the CMN

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Executive summary

Coverage assessments are one of the most important tools to analyse and improve access to CMAM programs. During its first phase, The Coverage Monitoring Network (CMN) carried out over 70 coverage assessments. The purpose of this present study, which has used a total of 78 CMN assessments, is to provide an in-depth analysis of the barriers and boosters identified during the first qualitative phase of coverage assessments in order to identify common trends. Moreover, to support a more global analysis, the barriers and boosters were grouped into five overarching categories;

- **Geographic**
- **Temporal**
- **Socio-cultural**
- **Financial**
- **Quality of care**[1]

For this analysis a total of 385 barriers have been collected which were sorted in to 27 different categories. From this analysis, the five main barriers identified are **1/ Poor outreach activities** (14%[2]), **2/ Distance** (10%), **3/ Poor delivery of service** (8%), **4/ RUTF stock breaks** (7%) **and 5/ Lack of awareness about malnutrition and lack of awareness of the program** (7% both). Under the global categories mentioned above, **quality of care** (43%) is the most commonly occurring barrier directly impacting upon access to the program.

With regards to boosters, a total of 367 were collected from the reports and sorted under 25 categories. From this analysis, the five main boosters identified are **1/Awareness that SAM can be treated effectively** (13%), **2/ Effective system in place for referral and transfer** (10%), **3/ Key community figures actively support the program** (10%), **4/ Awareness the service to treat SAM is available** (9%), **5/ Regular active case finding activities** (7%). Under the global categories mentioned above, **socio-cultural** (43%) and **quality of care** (38%) are the most common categories of boosters.

This study demonstrates that socio-cultural and quality of care either as boosters or barriers are the main categories to focus on for improving and/or continuing the access to CMAM programs.

[1] Maternal and child nutrition article (2008) Peter K. Streatfield, Tracey P. Koehlmoos, Nurul Alam and Malay K. Mridha

[2] The percentage represents the number of specific barriers (listed, refer annex 1) cited in the 78 SQUEAC reports as a proportion of the total barriers collected for the meta-analysis

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Acronyms

ACF	Action Contre la Faim/ Action Against Hunger
B&B	Barriers and boosters
CHW	Community Health Workers
CMAM	Community Based Management of Acute Malnutrition
CMN	Coverage Monitoring Network
ECHO	European Commission Humanitarian Office
HC	Health Centre
MoH	Ministry of Health
OFDA	Office of US Foreign Disaster Assistance
OTP	Outpatient Therapeutic Program
ReCo	Relais communautaire (=CHW)
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SC	Stabilisation Centre
TBA	Traditionnal Birth Attendent
THP	Traditional Health Practitioner

Introduction

The CMN is an inter-agency initiative led by ACF, Save the Children, Concern Worldwide, International Medical Corps and Helen Keller International. The project aims to increase and improve coverage monitoring globally and in particular across West, Central, Southern and Eastern Africa. It also aims to identify, analyse and share lessons learned to improve CMAM policy and practice across areas with a high prevalence of acute malnutrition.

The CMN Project was launched in July 2012 with support from the European Commission Directorate-General for Humanitarian Aid and Civil Protection (ECHO) and USAID's Office of Foreign Disaster Assistance (OFDA).

The focus of this phase of the CMN project was on building the capacity of nutrition stakeholders to design, implement and analyse coverage assessments. Additionally and most importantly, the CMN project has sought to create a national cadre of nutrition workers capable of carrying out, and advocating for the use of, coverage assessments.

Given the amount of reports completed by the CMN since the project was launched, it became necessary to take a step back and collectively analyse the data so far obtained. Consequently the need for this meta-analysis was recognised. Although the CMN have been collecting and analysing barrier data throughout the programme, this has been limited to barriers identified in the third stage of the methodology where a questionnaire is administered to caregivers whose chid is not in the programme. The main objective of this

study was therefore to identify common trends in **barriers and boosters** through all SQUEAC coverage assessment reports[3] identified during stage 1[4] of the methodology.

A **barrier**[5] can be defined as anything that restrains, obstructs, or delays access to a program or restrains coverage; for example one of the main barriers analysed in this report is poor outreach activities. A **booster** on the other hand is anything that encourages or enables access to a program or leads to an increase in coverage. An example of one of the positive factors identified in the present report is awareness that SAM can be treated effectively.

The identification of **barriers and boosters** is essential in analysing issues related to access and coverage. Barriers and boosters point out where the difficulties or satisfaction in service provision are and enable the development of actions in order to overcome the constraining factor.

Barriers and boosters to a service have been highlighted through the Tanahashi model[6]. The Tanahashi model leads to evaluating whether the identified barriers and boosters have an effect upon the following criteria: availability coverage, accessibility coverage, acceptability coverage, contact coverage and effectiveness coverage.

Barriers and boosters are the roots to the identification of any negative or positive factors to service access and uptake. Hence they are therefore essential in coverage survey assessments.

Furthermore, in order to support a more global analysis, the different barriers and boosters have been grouped into five categories: geographic, temporal, socio-cultural, financial and quality of care.

[3] 78 CMN coverage assessment reports between August 2012 and October 2013

[4] Stage 1: identifies areas of low and high coverage as well as reasons for coverage failure using routine program data, already available data, quantitative data that may be collected with little additional work and qualitative data. *SQUEAC/SLEAC Technical reference Oct 2012*

[5] Definitions of barrier and booster from *SQUEAC/SLEAC Technical reference Oct 2012*

[6] Tanahashi (1978) Bulletin of WHO

Methodology

Review of the SQUEAC reports

In order to determine the methodology for this meta-analysis, 6 CMN coverage survey reports identified by the CMN coordinator were used as a representative sample to understand how the barriers and boosters were reported. The main focus was on barriers and boosters identified during stage 1 that consists in collecting qualitative data and quantitative data. For this study, the work was mainly based on qualitative data.

A comparison of the sources against the B&B, to see whether they differed, was performed. Consequently, to correlate the sources with B&B was interesting in order to highlight the perspective of each source.

A comparison of the summary of the main B&B found by the team with their more comprehensive table (usually found in annex) that may have referred to at least 30 + barriers and boosters from the 6 reports was also made. From the comprehensive table, what would appear to be the main B&B were identified and compared this to what the team had chosen as their main B&B and slight discrepancies were noticed. However, it was notable that by doing this exercise the grouping of some barriers and boosters was made almost automatically because they were mentioning the same issue. Hence the use of categories was seen as useful for a more global analysis.

In the end, a total of 78 coverage survey reports were used for this meta-analysis of stage 1 barriers and boosters.

Classification of barriers and boosters

In order to list and account for the barriers and boosters identified in the reports, the creation of a standard list was needed. The elaboration of the lists was based on the existing list previously done by the CMN team while working on stage 3 findings. In order to facilitate the comparison of the existing stage 3 analysis with the stage 1 analysis from this meta-report it was logical to follow the same format. Consequently for the barriers, a list of 27 standard negative factors[8] was selected in line with the previous work done by the CMN team for stage 3 analysis and coherent with stage 1 of the assessment reports. In addition, a list of 25 standards boosters[9] was elaborated according to the coverage survey reports and the Tanahashi model.

Data processing

The first step consisted of sorting the information from stage 1 by selecting the 5 main barriers and boosters from the lists cited above into a matrix.
Each of the barriers and boosters found has also been associated to their respective sources and added to the matrix for a further analysis of the sources.

The second step consisted of grouping and quantifying the standard barriers and boosters into 5 categories to enable a more global analysis. The 5 categories selected were geographic, temporal, socio-cultural, financial and quality of care. Those categories were defined

[8] Refer Annex 1
[9] Refer Annex 2

according to an article[10], which was based on finding the existing barriers to maternal, child and infant health services in order to facilitate initiatives to mainstream nutrition.

Infrequently reported barriers were grouped as "other" in the standard list. However ultimately the items "other" have been classified within the 5 categories (e.g. water shortage is part of financial category).

The analysis was done using Microsoft Excel.

Analysis
Once the main barriers and boosters from the 78 SQUEAC reports were collected with their respective sources into a matrix, it was possible to sort out the principal findings of the data and to categorize the results for an overall analysis.

Results

1. Barriers

The CMN team has been collecting and analysing barrier data throughout the programme, this has been limited to barriers identified in the third stage of the methodology where a questionnaire is administered to caregivers whose chid is not in the programme. In order to analyse the barriers from stage 3, the CMN team created a list of 22 standard barriers. However, because the sources from stage 1 are not limited to the caregivers whose child is not in the programme, additional barriers were needed to reflect stage 1. Therefore, 5 more barriers have been added to the list resulting in a total of 27 standard barriers[11].
For the purpose of the analysis contained in this meta-report, the 5 main barriers, when available, have been selected from stage 1 of each assessment report,. Below the figure shows the breakdown of the barriers according to the frequency with which they occurred within the 78 assessment reports.

[10] Maternal and child nutrition article (2008) Peter K. Streatfield, Tracey P. Koehlmoos, Nurul Alam and Malay K. Mridha

[11] Refer Annex 1

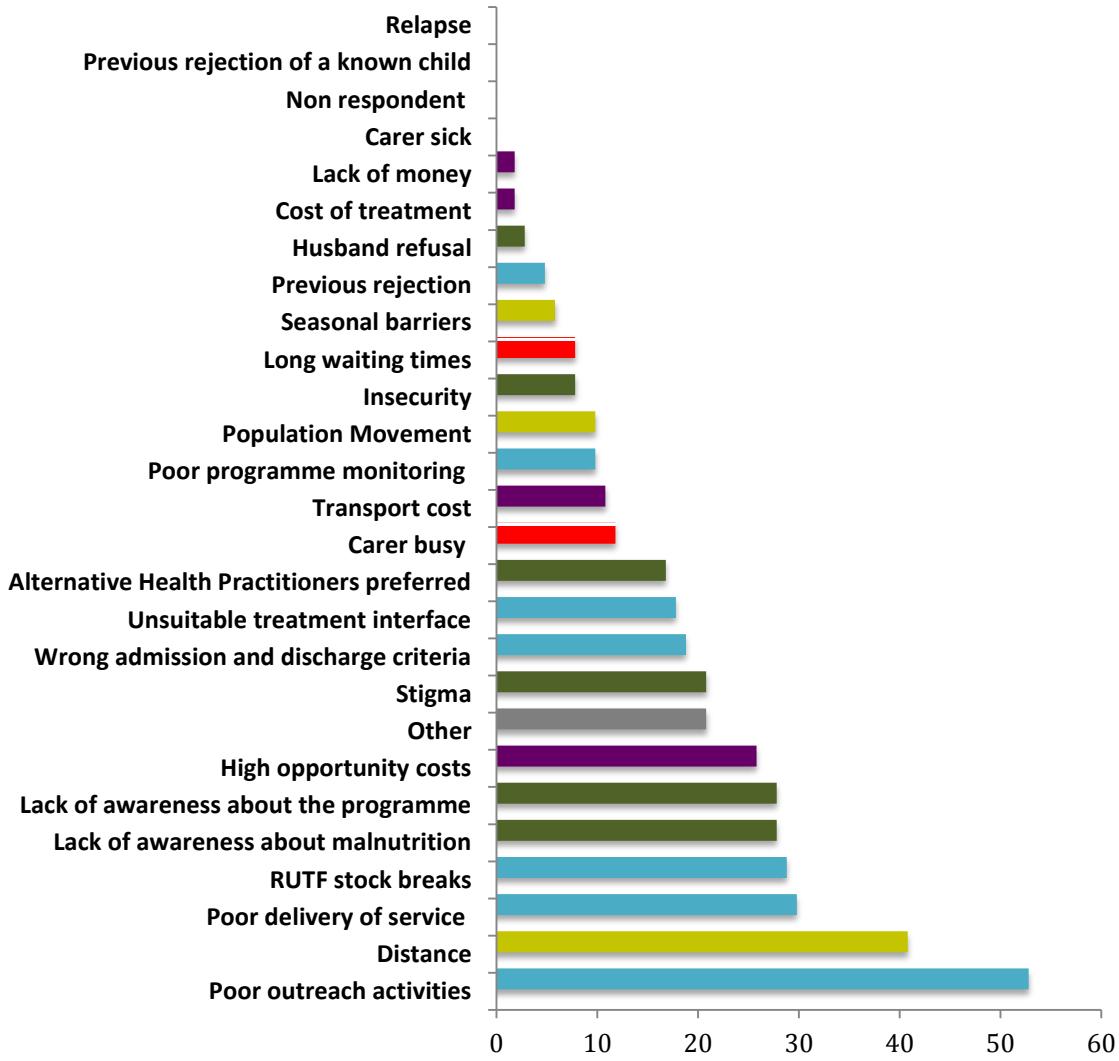


Figure 1: Barriers to access CMAM programs[12]

Poor outreach activities is the major barrier affecting coverage of programs. Included within this barrier are the following elements: lack of active case finding, lack of defaulter follow up, lack of motivation/training for CHW and staff, lack of sensitization. Overall in the meta-analysis, the lack of active case finding was the main activity being cited and the reasons were due to lack of transportation for CHW/ volunteers, lack of motivation, lack of organization from the CHW, non-acceptance from the community, security and seasonal barriers. The lack of a financial incentive for some staff is also cited as part of the problem for ensuring good outreach activities. CHW/volunteers have a tendency to request some kind of remuneration through training, transportation cost or material as bicycle, telephone credit etc. The lack of "payment" also creates conflicts with those of the program staff who habitually receive a salary and this can prevent the success of outreach activities such as case follow up, defaulter follow up etc. A collective effort between the community health workers and the personnel is also essential for the referral system.

[12] Long waiting time is in temporal and quality of care categories and other is in financial, quality of care and socio-cultural categories (refer to Annex 3)

Without appropriate outreach activities, the nutrition service activities will be directly affected by having fewer admissions than expected, more defaulters, bad program performance etc. The outreach activities represent the link between the community and the service offered. Consequently, it is very important to focus on reaching the community whether through increasing sensitization, or developing regular and timely active case finding decided in accordance with the community (leaders, population) and other stakeholders or by improving the proximity of nutrition units to communities in order to increase the awareness of existing programs.

Distance is also an aspect that provided a significant barrier to access. While poor outreach activities would principally concern the staff, distance relates to the beneficiaries that cannot go to the program because it is too far and therefore not within an acceptable walking distance for the mothers/caretakers. The underlying problems linked to the distance were the seasonal barriers leading to inaccessible roads during rainy season, lack of money preventing payment of transport and the carer being busy and having insufficient time to walk a considerable distance while also needing to take care of her family and domestic duties.

Poor delivery of service is directly linked to quality of care and shows the relevance of improving the integration of nutrition treatment. In reality most of the health staff see tending to the beneficiaries of the nutrition program as an increased work burden (specific protocol to follow, anthropometric measurements, registry book and cards to fill out etc.). Furthermore this increased burden of work comes without "benefits" to the health staff because the treatment is supposedly free and consequently often the health staff neither has the patience nor the desire to take care of SAM. Hence there is a need to improve the integration of nutrition treatment into the health system in order to mitigate this issue. However, in poor delivery of service, the barrier included the sharing of RUTF, so even though the staff has a partial responsibility regarding the explanation and follow up consumption, it is also important to encourage total involvement of the mother/caretaker in the SAM treatment as well as to support case follow up via the outreach team.

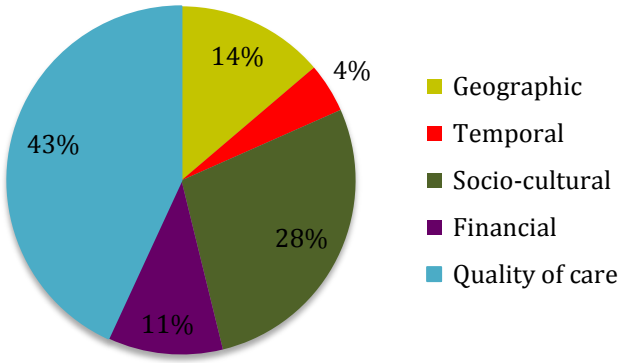


Figure 2: Categories of the barriers

Quality of care is the most prominent category constituting a negative impact on service access and uptake, which demonstrates that the negative factors are mainly influenced by

the service delivery side. The quality of care barrier is principally comprised of poor outreach, poor delivery of service and RUTF stock breaks, and is represented by the program staff and CHW whom are the key actors in improving the quality of care. Analysis of this barrier is more complex because it often involves delicate issues such as staff remuneration or the provision of support from central health authorities.

The socio-cultural barrier is for the most part represented by a lack of awareness about malnutrition and the program, which demonstrates the need for sensitization of the community.

2. Boosters

The list of 25 standards boosters[13] has been selected according to the stage 1 findings however the choice was also made according to Tanahashi model which explains some minor discrepancies compared to the list of barriers.

[13] Refer Annex 2

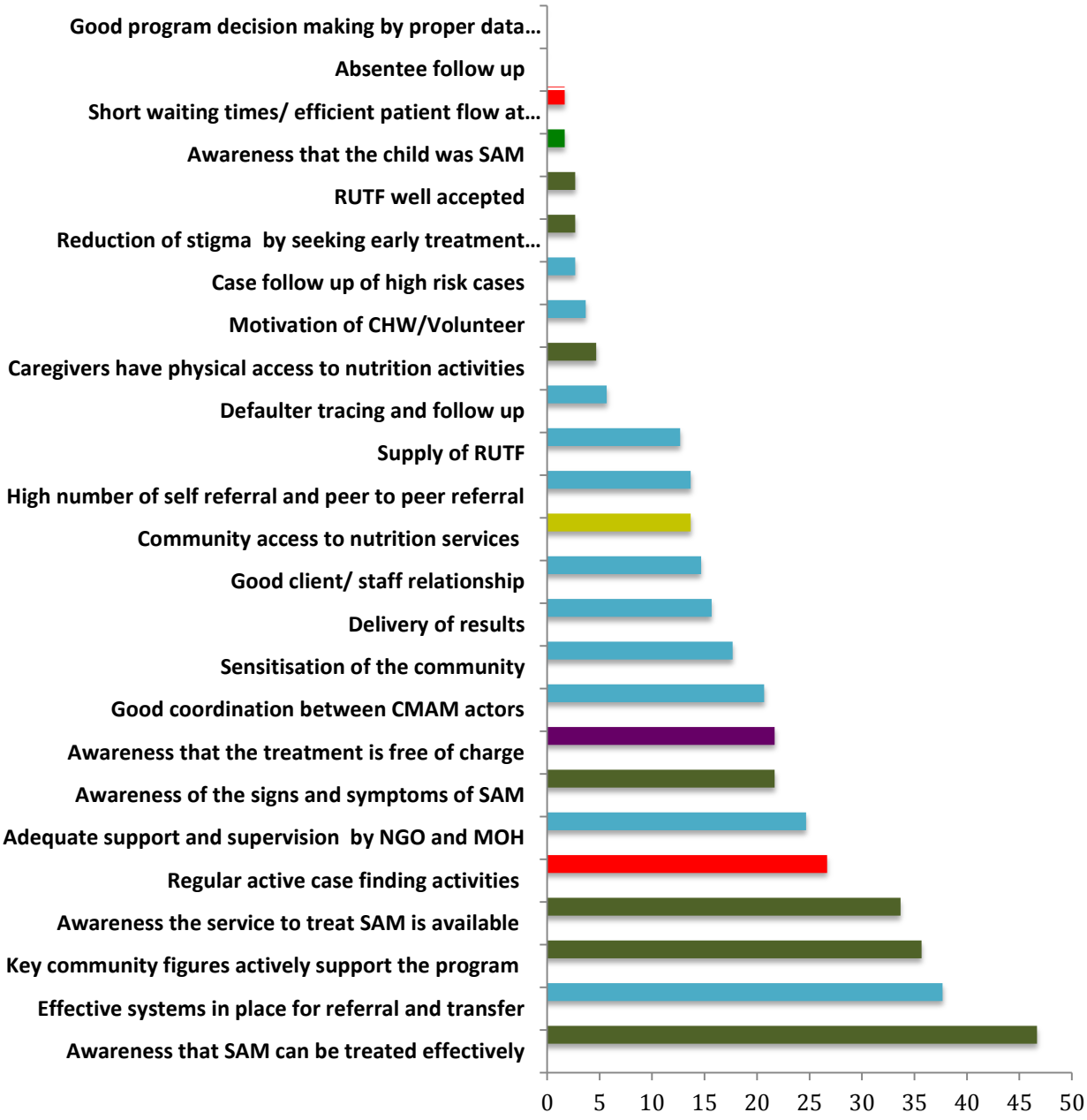


Figure 3: Boosters to access CMAM programs[14]

Awareness that SAM can be treated effectively is the major booster to program access, which demonstrates that overall the population perceives the effective treatment of their child as the key determinant in the decision of whether or not they go to the nutrition centres. It was notable that the perception of the treatment was often associated to whether the treatment was free of charge or whether the community knows the existence of the program.

[14] Short waiting time/efficient patient flow at programs sites in temporal and quality of care categories (refer Annex 4)

The effective systems in place for referral and transfer were also a major booster, which again demonstrates that integration between health and nutrition programs are essential for ensuring positive results in the management of SAM.

Key community figures actively supporting the program has a major impact upon the success of a program. Without community acceptance, the population would not have access to the information provided by outreach team or would not have the chance to have their children measured. Usually the key community figures play a major role in ensuring that the screening of the children is possible, in identifying sick children within the community and in convincing the parents to accept the treatment.

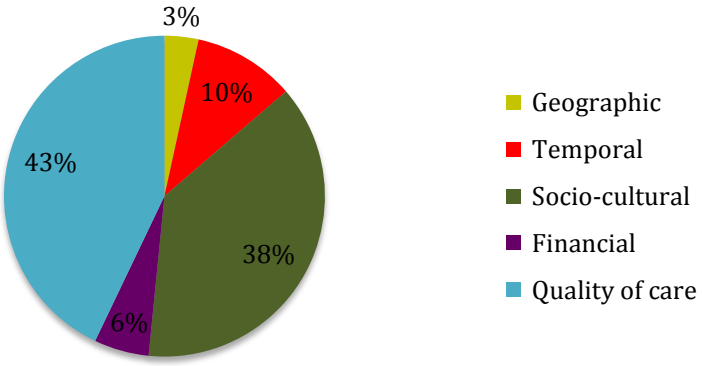


Figure 4: Categories of the boosters

Conversely to what was seen with the barriers, both categories of quality of care and socio-cultural have a major positive impact to service access and uptake. This is explained by the fact that with good quality of service the population will be confident to use the nutrition services and with the involvement of the community any reluctance from the families to use to the program will be reduced.

Moreover, the quality of care booster represents the effective systems for referral and transfer and good coordination between actors demonstrates that rigorous organization is needed for the management of nutrition programs.

While the socio-cultural booster represented mostly the awareness that SAM can be treated effectively and the involvement of key community figures, it shows that in general the community will accept the program and needs to be more implicated into the activities to ensure full commitment.

3. Sources

Validation of qualitative data is possible when it is from multiple sources. In such cases data sources are then cross-checked against each other through the principle of triangulation. Triangulation by source refers to data confirmed by more than one source. It preferable to have data confirmed by more than one type of source (e.g., community leaders and clinic staff) rather than just by more than one of the same type of source. The type of source may also be defined by demographic, socio-economic, and spatial attributes of informants. Lay informants such as mothers and fathers are sources of differing gender. Lay informants from different economic strata, different ethnic groups, different religious groups, or widely separated locations are also different types of source[15].

Consequently this meta-study has selected a list of different sources in order to highlight who were the main sources, and then to further analyzed their different perspectives.

3.1 Sources of the barriers

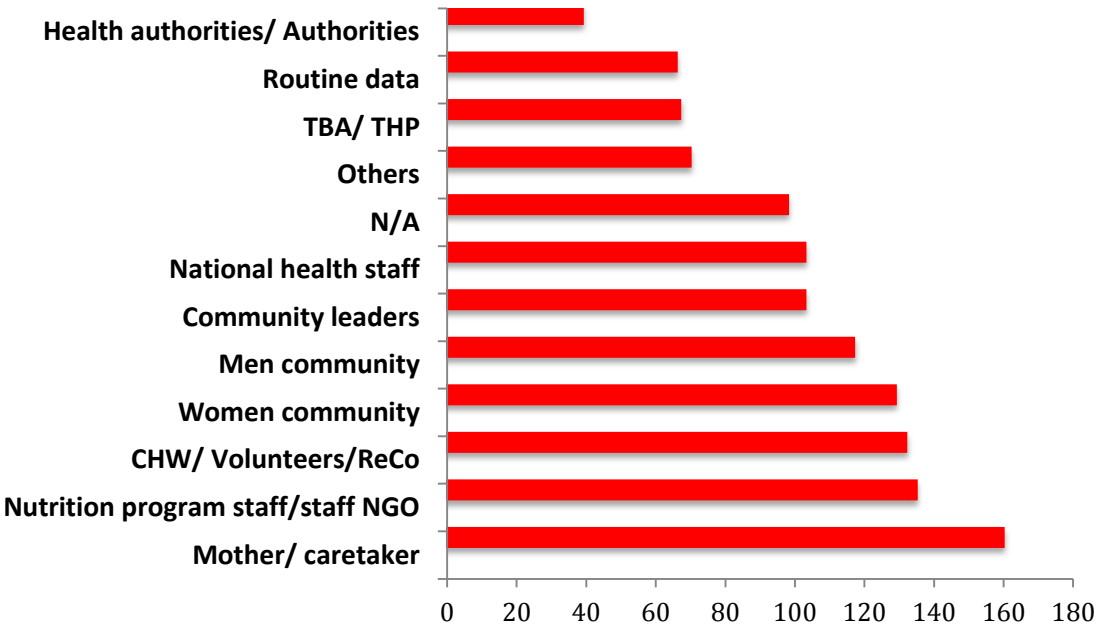


Figure 5: Sources of the barriers

The direct actors such as mothers/caretakers and staff/CHW were included into the qualitative data but also the community (men, women, leaders) was a relevant informant to discuss with. This shows that the coverage survey teams targeted the prominent actors who themselves are the key determinants of success regarding access to the CMAM program (as noted above in the analysis of B&B). Health authorities only represent 3% of the sources of qualitative data collection however national health staff represented 8% of the source data.

[15] Information from *SQUEAC/SLEAC Technical reference Oct 2012*

It could be inferred that the national health staff represents the MoH positioning although this could be a dangerous assumption because opinions at national and local level may differ, as may the opinions of salaried health staff compared with those receiving contributions from NGOs, or even unremunerated staff.

For the below comparison analysis, the sources Mother/caretaker, nutrition staff and CHW have been considered as being the 3 main sources seen in figure 5.

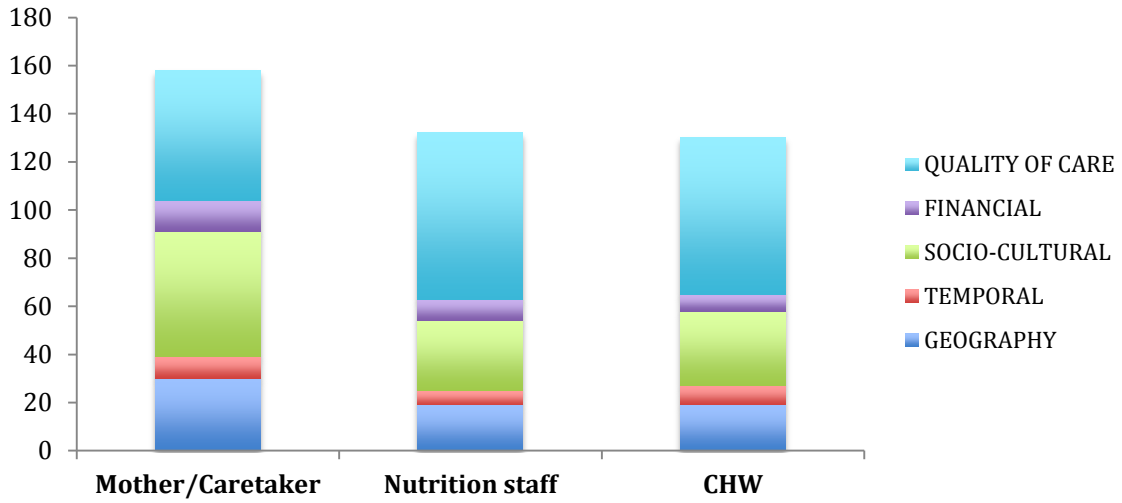


Figure 6: Sources of the barriers

	Main barrier mentioned in GEOGRAPHY	Main barrier cited in TEMPORAL	Main barrier cited in SOCIO-CULTURAL	Main barrier cited in FINANCIAL	Main barrier mentioned in QUALITY OF CARE
Mother/Caretaker	Distance	Long waiting time	Stigma	High opportunity cost	Poor delivery of service
Nutrition staff	Distance	Carer busy	Stigma	High opportunity cost	Poor outreach activities
CHW	Distance	Carer busy	Stigma	High opportunity cost	Poor outreach activities

Table 1: Sources and categories for barriers

The table shows that the different sources provide relatively consistent analysis. Ultimately this reinforces the data and shows the importance of having multiple sources, which permit

findings to be triangulated. Although where there are differences it probably comes down to perspective. For temporal barriers, the mother/caretakers principally cite a long waiting time (which is the responsibility of the program), while the staff and CHW cite the carer being busy (which is the responsibility of the mother/caretaker despite her also having other domestic duties).

Similarly in quality of care, the mother/caretakers cite poor delivery of service as the main barrier (the responsibility of the program), while the staff and CHWs cite poor outreach activities. Poor delivery of service, as identified by mothers/caretakers, reflects the communication from the staff. If the mother/caretakers do not feel welcome or respected (no explanation of what needs to be done and how), they might not have the will to come back. Conversely the staff/CHW need to make an effort to involve each party into their outreach activities. Constant communication by sharing information and sensitization is essential to encourage the commitment to and integration of the program.

3.2 Sources of the boosters

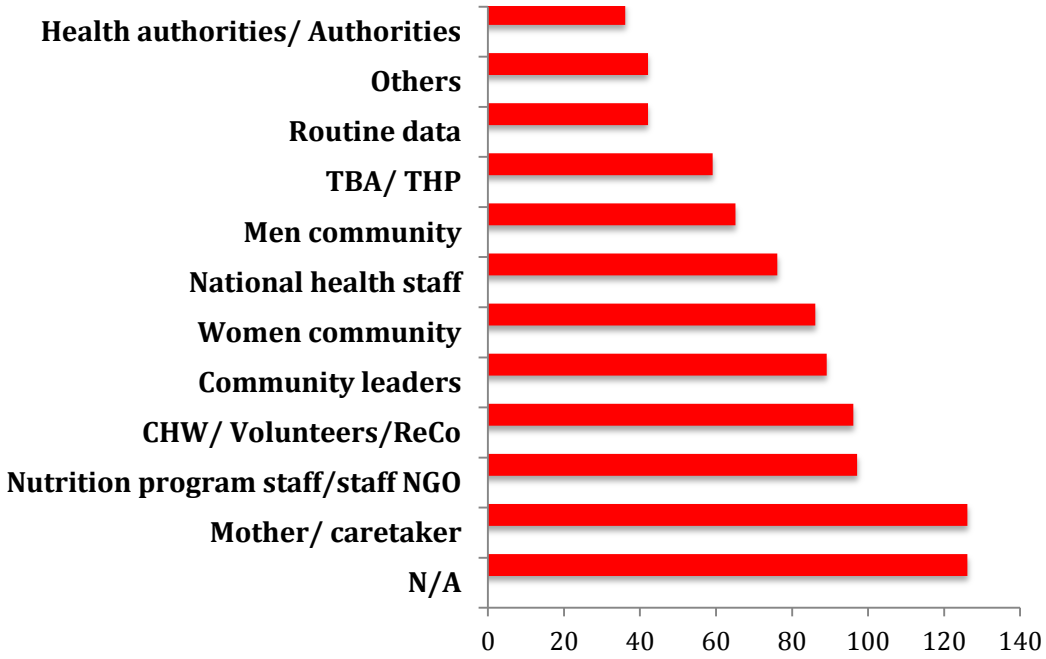


Figure 7: Sources of the boosters

Mother/Caretaker is the main source for 14% but overall the sources are quite evenly distributed. Again mother/caretaker, staff/CHW and community were the main interlocutors for collecting qualitative data with the interviews method. However, health authorities linked to the Ministry of Health were the least represented in the identification of the boosters with 4%. For 14% of the boosters identified in the reports, the sources were not clearly specified or not at all indicated in the coverage reports. In general, the reports focused on identifying the barriers rather than boosters with their sources.

The figure below represents a comparison between the main sources with categories.

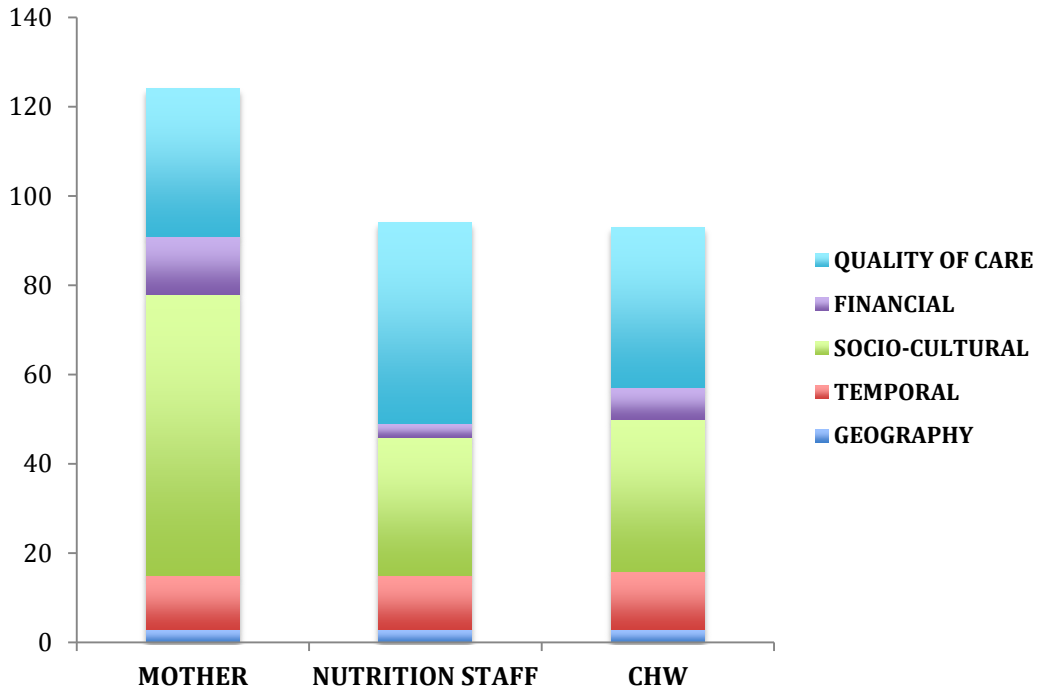


Figure 8: Sources of boosters versus categories

	Main booster mentioned in GEOGRAPHY	Main booster mentioned in TEMPORAL	Main booster cited in SOCIO-CULTURAL	Main booster mentioned in FINANCIAL	Main booster cited in QUALITY OF CARE
Mother/Caretaker	Community access to nutrition services	Regular active case finding	Awareness that SAM can be treated effectively	Awareness that the treatment is free of charge	Effective systems in place for referral and transfer
Nutrition staff	None	Regular active case finding	Awareness that SAM can be treated effectively	Awareness that the treatment is free of charge	Adequate support by MoH and/or NGO
CHW	Community access to nutrition services	Regular active case finding	Awareness that SAM can be treated effectively	Awareness that the treatment is free of charge	Effective systems in place for referral and transfer

Table 2: Sources and categories for boosters

Data from the different sources is largely consistent with variances probably being due to the different perspective of the source groups. The 3 sources have the same opinion except for quality of care that is explained by a different perspective. Mother/caretaker and CHW come from the community and perceive the referral system as essential to access services. The nutrition staff on the other hand mentioned the professional perspective that is, having an adequate support from NGO and/or MoH. The support is usually regarding trainings, supervision and provision of RUTF. For the latter, the availability of RUTF is vital to ensure the running of the nutrition services; any break down would interrupt the activities and will likely have the consequences of increased defaulters because the beneficiaries would not make the effort to come back.
For regular active case finding, this booster definitely plays a major role, as it is from the screening that the mother/caretaker will receive the information about the program and about malnutrition. It is also at this point that there would be an official transfer from the community worker to the nutrition unit.

Overall, whether for boosters or barriers, the 3 main sources are mother/caretaker, staff and CHW; and these three remain the most significant regarding program implementation.

4. Comparison between stage 1 and stage 3

The CMN team have previously worked on stage 3 collection data regarding the main barriers identified, hence it was interesting to see whether this information was different from stage 1. The analysis has only been performed on the barriers according to stage 1 and stage 3.

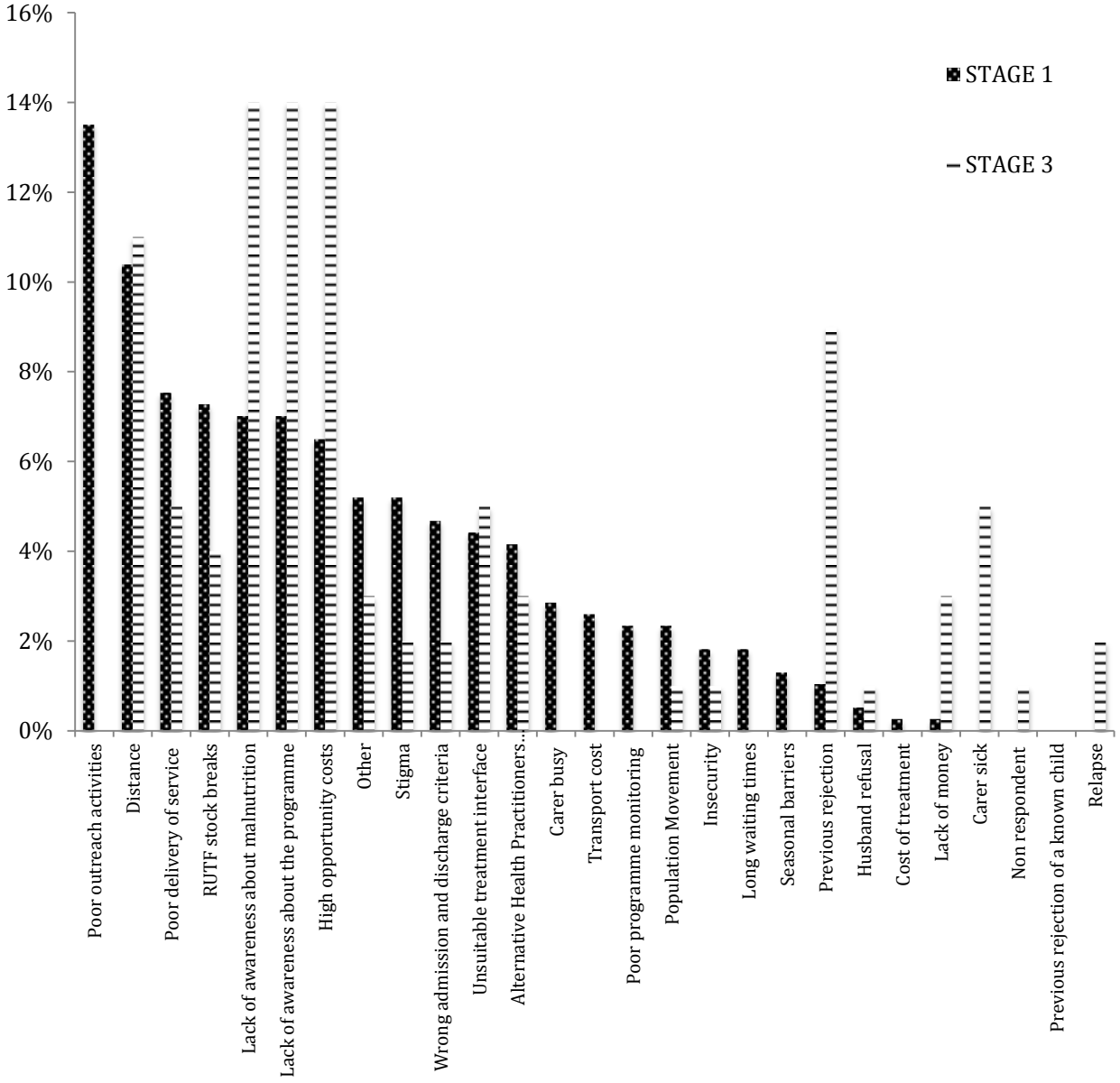


Figure 9: Barriers stage 1 versus barriers stage 3

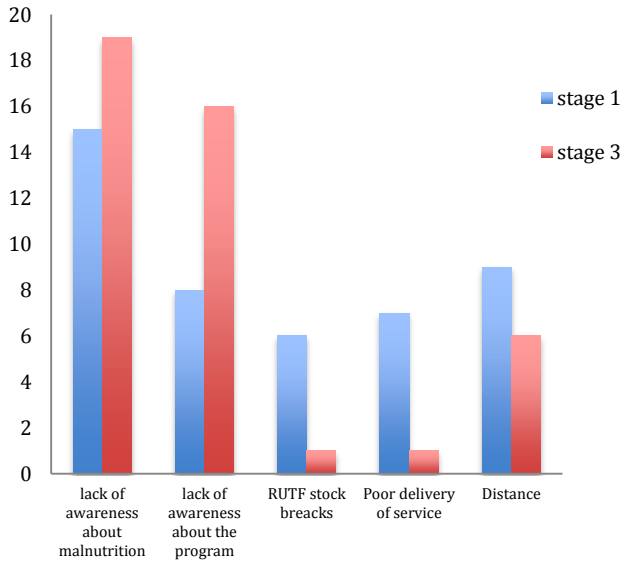
Stage 1 worked on 27 barriers whereas stage 3 worked on 22 standard barriers. Poor outreach activities, cost of treatment, carer busy, poor program monitoring and transport cost are the barriers added for stage 1. The sources of stage 3 consider only the mother/caretaker identified during the wide area survey.

The barriers cited are quite different because for stage 1 when asked to different sources by interview, the questions are on various theme regarding the program whereas for stage 3 the questions asked to the mother/caretaker are directly linked to the fact that they have a malnourished child and the survey team will try to understand why the child is not in the program. From stage 3, lack of awareness about the program and malnutrition are the main

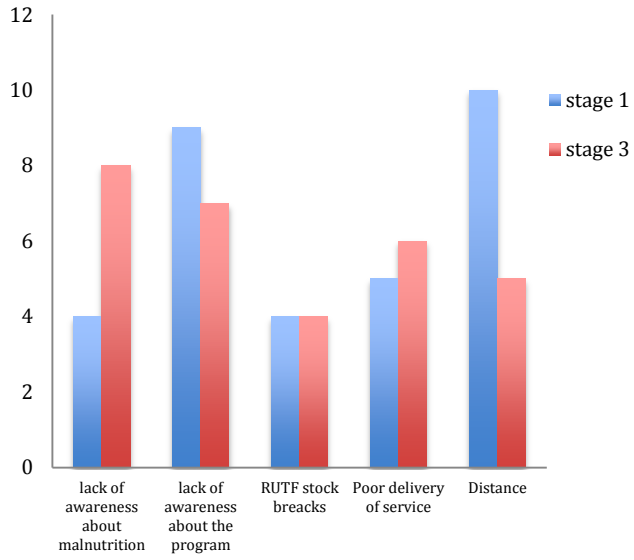
negative factors for not accessing the program, but high opportunity cost demonstrates that women's work is often seen as a priority rather than going to nutrition services.
Previous rejection is also seen as a main factor from stage 3 that has a direct link with quality of care and the misunderstanding perceived by the mother/caretaker regarding rejection. Rejection is really a responsibility of the CHW and the nutrition staff and can be avoided by constant training to the team in order to ensure quality of measurement as well as to provide communication and explanation to the mother/caretaker as to what is happening.

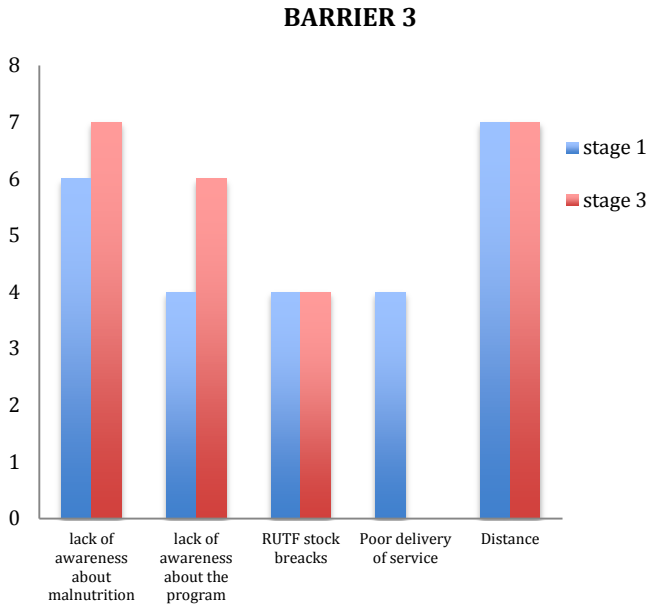
The figures below are a comparison between stage 1 and stage 3 versus barriers/categories. The barriers selected represent the most cited in figure 1. Poor outreach activities have been excluded because it is not a barrier in stage 3.

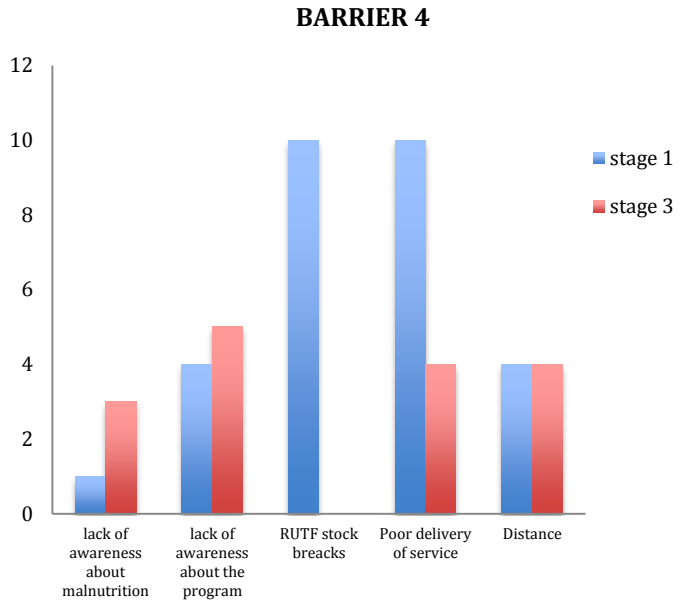
BARRIER 1

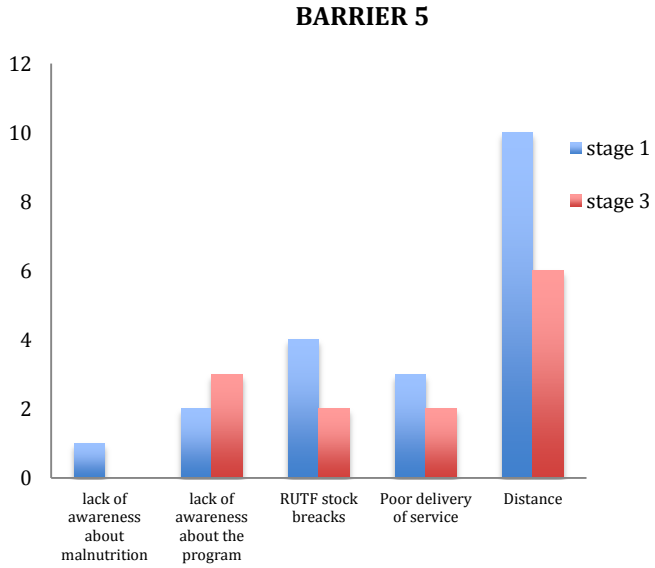


BARRIER 2









Figures 10: Stage 1 versus stage 3 compared with the main barriers from stage 1

Results between stage 1 and stage 3 across the 5 barriers were largely consistent. Distance is quite evenly cited between stage 1 and stage 3, which demonstrates the importance of having proximity nutrition centres because it impacts in any steps of the management of SAM. Similarly lack of awareness about the program is prominent both in stage 1 and stage 3, which highlights the need of sensitization of the community.

However there were some significant anomalies between stage 1 and stage 3 that concerned discrepancies regarding RUTF stock breaks and poor delivery of service, although to some extent this can be explained. Regarding barrier 1, in stage 1 poor delivery of service and RUTF stock breaks are quite high compared to stage 3. The difference is explained by the fact

that for poor delivery of service the mother/caretaker from stage 3 is less familiar with the service offered, and that barrier 1, being the most important, mainly regards the lack of awareness about malnutrition and program. This could also explain a similar situation found in Barrier 3. In stage 3, the mother/caretaker, being less familiar with the services, might not be aware of the RUTF stock breaks and this could explain why it is not mentioned under barrier 4. A further explanation could be that some stage 3 analysis does not extend to 5 barriers, and this can skew comparison between stage 1 and stage 3.

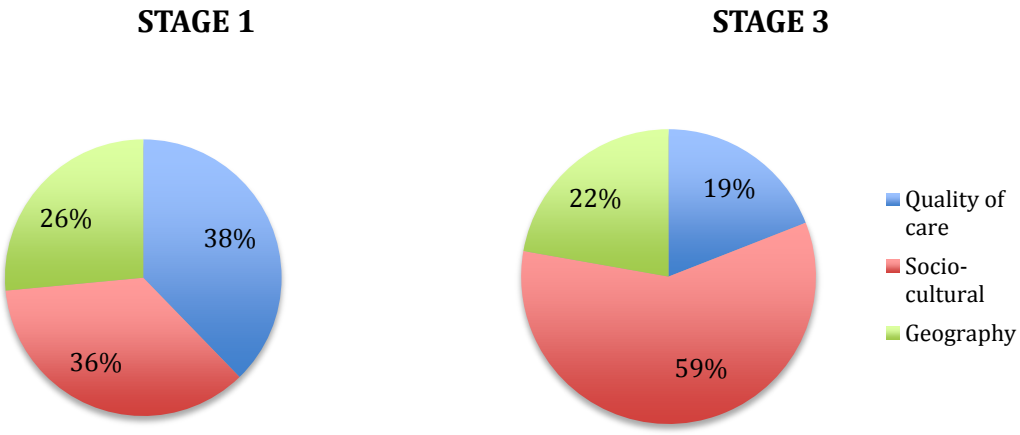


Figure 11: Stage 1 versus stage 3 categories compared according to the main barriers analyzed in figure 10

As seen in figure 11, the geography category is similar for both stages, and this is reflected in the figure 10 analysis. However there are some differences between stage 1 and stage 3 categories. Regarding the balance of quality of care with socio-cultural categories, in stage 1, quality of care and socio-cultural are equally represented (38% and 36% respectively). In stage 3, socio-cultural category is more prominent than quality of care and this demonstrates the importance of sensitization through outreach activities.

Difficulties encountered

Most of the reports recorded the barriers and the boosters very differently, some had a very comprehensive table with all the details boosters/barriers versus sources, and some had no data at all regarding the sources. Moreover, the structures of the 78 reports also varied. Some had a table, others contained narrative reporting of the interviews. The selection of the main barriers and boosters was made according to the judgment of the author based upon the data available in the reports. This explains why some discrepancies could be seen between the barriers and boosters selected in this study and the ones from the assessments reports.

The standard list of the barriers was not easy to work with because it has been compiled according to the findings from stage 3 following the answers of mothers/caretakers only. However, it was important to use the same list as a common base to facilitate the analysis.
The Tanahashi model that was used to elaborate the standard list of boosters was very interesting as it allows keeping it mind the principle of the coverage assessment but because the listing was different to the barriers, it was difficult to do a comparison.

In some reports the differentiation between health staff and nutrition staff was not easy especially as some countries actually work with only health staff because the SAM management is integrated into health system. In such cases, when in doubt, health staff was considered.

Perception of the program is another example where it was sometimes difficult to differentiate between awareness that the service to treat SAM was available at the local clinic, and awareness that SAM can be treated effectively or that the treatment is free of charge. It is only by reading the details of the reports that it was possible to determine the right terminology.

Conclusion

- Socio-cultural and quality of care either as booster or barriers are the main factors to focus on for improving and/or continue the access to CMAM program
- Socio-cultural barriers are the most prominent barriers and make up 43% of barriers reported
- Quality of care boosters with 43% and socio-cultural with 38% of boosters reported are the most significant
- Boosters have a tendency to be outnumbered by barriers in the assessment survey reports, except in refugee camp settings.
- Mother/caretaker, community, nutrition staff and CHW are the main sources and have a major role, albeit at different levels, in the improvement of accessing nutrition programs and sustainability
- Health authorities and/or NGOs should be existent and well coordinated to facilitate the involvement of all stakeholders
- The improvement in integrating nutrition treatment into the health system should be seen as a priority

- Sensitization activities remain essential to facilitate the awareness about malnutrition and about nutrition program

Recommendations

- To have proper identifications and terminologies of boosters and barriers
- A common tool to collect the qualitative data would be relevant to facilitate the collection data for further analysis and for an easier reading/understanding of the barriers and boosters with their sources
- The sources are an important consideration for the CMAM program, indeed referring to the right sources will enable concrete action points to implement in order to improve service access and uptake. But this requires standardized and proper data collection while interviewing the different parties.

Annex 1: List of barriers

1. Lack of awareness about malnutrition
2. Lack of awareness about the programme
3. RUTF stock breaks
4. High opportunity costs
5. Unsuitable treatment interface *No coordination between Health Centre/ OTP or OTP/CHW or HC/CHW, no systematic passive case finding at health centre*
6. Wrong admission and discharge criteria *Including difficulties to follow protocol, inappropriate anthropometric measurement*
7. Poor delivery of service *Staff mean, asked for money, absence, no explanation given to beneficiaries, sharing RUTF, misconception of RUTF*
8. Distance
9. Long waiting times
10. Stigma
11. Lack of money
12. Carer sick
13. Husband refusal
14. Previous rejection
15. Previous rejection of a known child
16. Alternative health practitioners preferred
17. Non-respondent *OTP, SC etc.*
18. Insecurity
19. Seasonal barriers
20. Population movement
21. Relapse
22. Other
23. Poor outreach activities *Lack of active case finding, lack of follow up defaulter, lack of motivation and/or training for CHW and/or staff, lack of sensitisation etc*
24. Cost of treatment *No health insurance*
25. Carer busy *Taking care of other children at home, social event such as wedding/funeral, household chores*
26. Poor programme monitoring *Mistakes in data collection, lack of follow up of registrars and cards*
27. Transport cost

Annex 2: List of boosters

1. Awareness of the signs and symptoms of SAM
2. Awareness that the child was SAM
3. Awareness that SAM can be treated effectively
4. Awareness the service to treat SAM is available at the local clinic
5. Awareness that the treatment is free of charge
6. Supply of RUTF
7. Key community figures actively support the program by referring children and support CHWs' activities
8. Effective systems in place for referral and transfer *(OTP/SC/SFC/HC/CHW), including passive case finding at health centres.*
9. Good coordination between CMAM actors
10. Delivery of results in term of high proportion cured, low mortality, low defaulting and short length of stay
11. Short waiting times/ efficient patient flow at program sites
12. Good client/staff relationship
13. Community access to nutrition services within the coverage area is facilitated through numerous OTP centres or mobile units
14. Sensitisation of the community
15. Regular active case finding activities with appropriate and timely referral
16. Case follow up of high risk cases
17. Absentee follow up
18. Defaulter tracing and follow up
19. Motivation of CHW/Volunteer
20. Reduction of stigma associated with malnutrition by seeking early treatment behavior
21. Caregivers have physical access to nutrition activities *(security, no ethnic or discrimination problem, women can access)*
22. Adequate support *(by providing training, supply)* and supervision given to volunteers, health centre and program staffs by NGO and MoH
23. High number of self referral and peer to peer referral
24. RUTF well accepted
25. Good program decision making by proper data collection

Annex 3: Categories of the 27 standards barriers

Geographic	Temporal	Socio-cultural	Financial	Quality of care
- Distance (8) - Population movement (20) - Seasonal barriers (19)	- Carer busy (25) - Long waiting time (9) - Carer sick (12)	- Alternative health practitioners preferred (16) - Lack of awareness about malnutrition (1) - Lack of awareness about the program (2) - Husband refusal (13) - Stigma (10) - Insecurity (18) - Other (22B)	- High opportunity cost (4) - Lack of money (11) - Cost of treatment (24) - Transport cost (27) - Other (22A)	- Relapse (21) - Poor delivery of service (7) - Unsuitable treatment interface (5) - Wrong admission and discharge criteria (6) - Non respondent (17) - Previous rejection of a known child (15) - Previous rejection (14) - Poor outreach activities (23) - Poor program monitoring (26) - RUTF stock breaks (3) - Long waiting time (9) - Other (22C)

Annex 4: Categories for the 25 standards boosters

Geographic	Temporal	Socio-cultural	Financial	Quality of care
- Community access to nutrition services within the coverage area is facilitated through numerous OTP centres or mobile units (13)	- Supply of RUTF (6) - Short waiting times/efficient patient flow at programs sites (11) - Regular active case finding activities with appropriate and timely referral (15)	- Awareness of the signs and symptoms of SAM (1) - Awareness that the child was SAM (2) - Awareness that SAM can be treated effectively (3) - Awareness the service to treat SAM is available at the local clinic (4) - Key community figures actively support the program by referring children and support CHW's activities (7) - Reduction of stigma associated with malnutrition by seeking early treatment behavior (20) - RUTF well accepted (24) - Caregivers have physical access to nutrition activities (21)	- Awareness that the treatment is free of charge (5)	- Delivery of results in term of high proportion cured, low mortality, low defaulting, and short length of stay (10) - Case follow up of high risk cases (16) - Absentee follow up (17) - Defaulter tracing and follow up (18) - Motivation of CHW/ volunteer (19) - Good program decision making by proper data collection (25) - Effective systems in place for referral and transfer (8) - Supply of RUTF (6) - Good client/staff relationship (12) - Short waiting times/efficient patient flow at programs sites (11) - Sensitisation of the community (14) - Adequate support and supervision given to volunteers etc - High number of self referral and peer to peer referral (23) - Good coordination between CMAM actors etc (9)