

A review of SAM management in Afghanistan: Lessons from 2013-2015

June 2016



Funded by:

CONTENTS

1. INTRODUCTION.....	4
2. THE SCALE OF THE PROBLEM	4
3. HOW ARE CURRENT SAM TREATMENT SERVICES RESPONDING TO NEED IN AFGHANISTAN?	5
4. HOW MANY SAM CASES ARE CURRENT SERVICES REACHING?	7
5. HOW EFFECTIVELY ARE CURRENT SERVICES TREATING SAM CASES?	8
6. WHAT PROPORTION OF ALL SAM CASES COMPLETE TREATMENT?	16
7. WHAT FACTORS ARE AFFECTING THE ABILITY OF SAM TREATMENT SERVICES TO TREAT ALL SAM CASES?	17
8. WHAT DO WE KNOW ABOUT THE FACTORS THAT ARE AFFECTING THE ABILITY OF SAM TREATMENT SERVICES TO TREAT ALL SAM CASES?.....	20
9. WHAT NEEDS TO BE DONE TO IMPROVE THE PERFORMANCE OF SAM TREATMENT SERVICES?	31
10. ANNEXES.....	39

List of Figures

Figure 11 Map showing most up-to-date SAM rates across Afghanistan (ACF, SMART data 2016)	5
Figure 2 Line chart showing total new admissions and total reporting OPD SAM sites in Afghanistan over time (Jan 2013-Dec 2015)	6
Figure 3 Map showing number of OPD SAM sites that reported in 2015 per district compared to population of district.....	7
Figure 4 Map showing coverage classifications for districts where assessments have been conducted	8
Figure 5 Line chart showing new admissions to SAM services over time (January 2013-December 2015)	9
Figure 6 Map showing OPD SAM admissions from 2015 (n=137,889) mapped according to province.....	9
Figure 7 MUAC on admission from Nangahar SQUEAC (based on n=1688 new admissions)	10
Figure 8 Table showing median MUAC on admission for six SQUEACs.....	11
Figure 9 Line chart showing discharge outcomes in Afghanistan during 2015	12
Figure 10 Bar chart showing recovery rates per province for 2015	13
Figure 11 Bar chart showing default and death rates by province for 2015	14
Figure 12 Bubble chart showing coverage, cure rate and met need from three different SQUEAC assessments	16
Figure 13 Square graph showing top five barriers for each SQUEAC assessment (n=14)	18
Figure 14 Square graph showing top 5 boosters for each SQUEAC assessment (n=14)	19
Figure 15 Bubble chart showing top reasons for non-attendance as cited by the care-givers of uncovered cases found in the wide area surveys of SQUEACs (n=12) and the SLEACs (n=5). Total responses n= 413	20
Figure 16 Responses from caregivers of uncovered cases during the SLEAC assessments (n=465)	21
Figure 17 How do caregivers find out about services/malnutrition? Source: all covered cases found during the SLEACs (n=199)	23
Figure 18 Treatments tried or considered by caregivers of SAM cases not admitted to the program (n=230) in Badakshan.....	24
Figure 19 Laghman Province with insecure (inaccessible) villages marked in red and secure (accessible) marked in blue	26
Figure 20 Bar chart showing comparison between monthly reporting and OTP card reporting of defaulting and cure rates in Paktya Province (SQUEAC March 2015)	31

List of Annexes

Annex 1 Prevalence rates from ACF SMART data 2016.....	39
Annex 2 Single coverage explanation.....	39
Annex 3 Bibliography.....	40
Annex 4 Coverage Learning Workshop Agenda:	41

1. INTRODUCTION

Since 2013 the treatment of malnutrition in Afghanistan has seen significant changes, resulting in substantial increase in service availability and use. This has largely been down to the move to integrate malnutrition treatment services into the Basic Package of Health Services (BPHS)¹. That said treatment services are still largely provided in a vertical manner independent of other health services) through both parallel funding and BPHS funding. This was bolstered by donor engagement following the 2013 National Nutrition Survey which showed alarming rates of global acute malnutrition (3.7%-21.6%²) as well as increased engagement from the Public Nutrition Department, the Nutrition Cluster and nutrition partners (both national and international).³

Since late 2014 Action Against Hunger (ACF) has supported a series of coverage assessments that have been able to establish the coverage of severe acute malnutrition (SAM) treatment services and, more generally, analyse programme performance. Working hand in hand with BPHS partners and Provincial Nutrition Departments these assessments have shed light on both the shortfalls in achieving high performing SAM treatment services and those factors that have allowed SAM treatment services to perform well.

This report seeks to first highlight the scale of the problem the SAM challenge presents in Afghanistan, second the status of SAM management services and third to present an analysis of the factors affecting coverage taken from the assessment reports. The report finishes by setting out a series of recommendations to improve SAM services, and in some cases integrated management of acute malnutrition (IMAM) as a whole⁴. These recommendations were developed by nutrition partners and serve as a blueprint for change.

2. THE SCALE OF THE PROBLEM

Afghanistan ranks fourteen in the world in terms of SAM burden⁵. The Nutrition Cluster estimates that 2.9 million people are affected by malnutrition, of which 365,000 and 632,000 cases are SAM and MAM respectively⁶, and are therefore in need of treatment. In 2015 and 2016 a series of SMART surveys and rapid nutrition assessments were conducted by ACF and partners giving us the most up to date indication of the scale of malnutrition in Afghanistan. The cumulative prevalence of acute malnutrition (using weight-for-height z-scores, mid-upper arm circumference and oedema) from these surveys conducted in 13 provinces revealed a global acute malnutrition rate of 17.0% and a SAM rate of 4.8%⁷. Figure 1 illustrates SAM prevalence for SMART surveys and rapid nutrition assessments conducted in 2015. There is still a need to assess the burden of malnutrition the remaining provinces not yet assessed but this gives the most comprehensive and reliable picture available today.

¹ Funded by the SEHAT programme

² National Nutrition Survey 2013

³ It must be noted that although the NNS did act as a call for more investment in treatment of acute malnutrition the results are widely understood to have been unreliable due to some of the very high prevalence rates not being in keeping with what was known on the ground (e.g. SAM rate in Nuristan of 11.4%) and being unprecedented for Afghanistan.

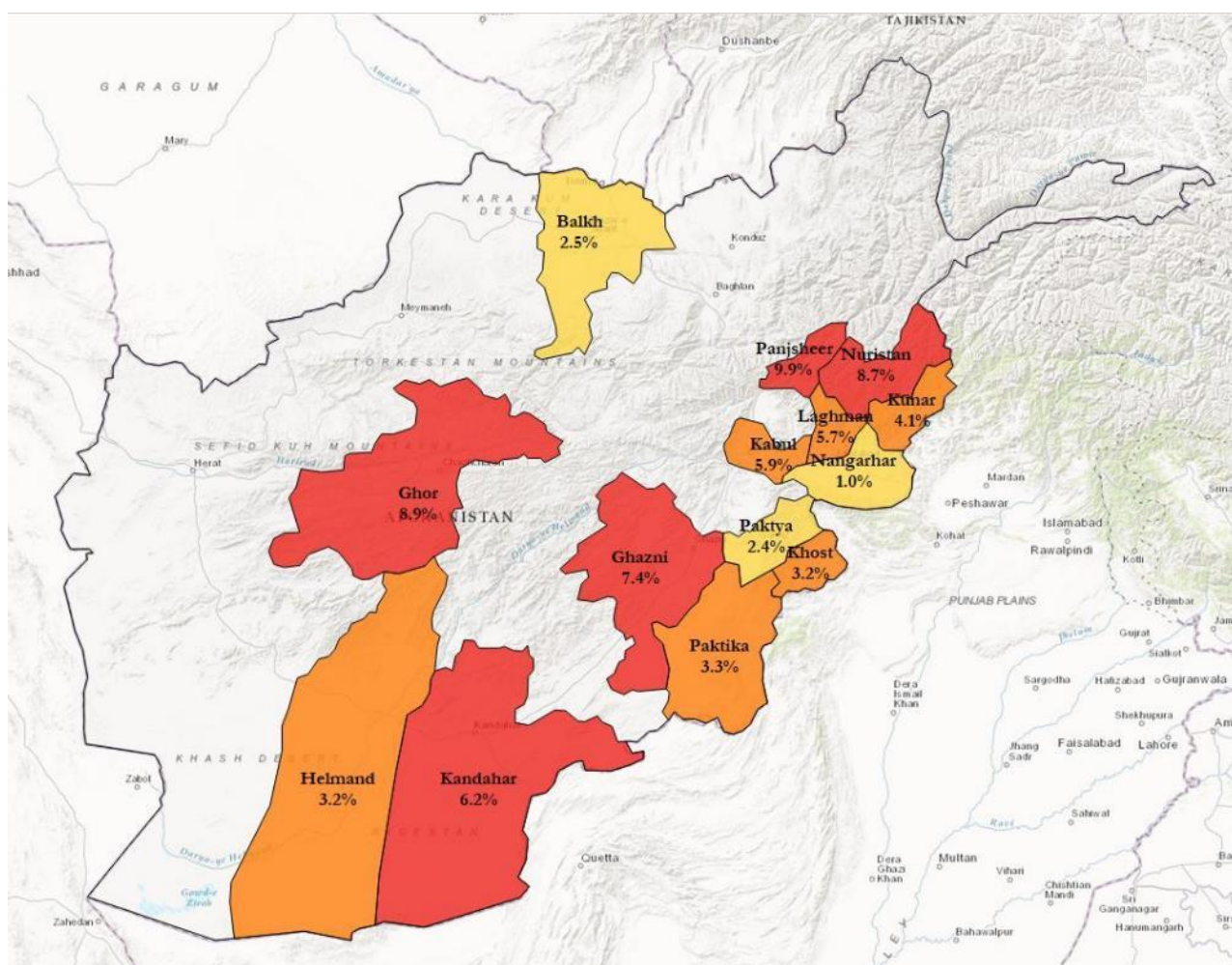
⁴ Throughout the document when referring to IMAM treatment or services this includes the treatment of both SAM and moderate acute malnutrition (MAM) in under-fives.

⁵ WB/WHO/UNICEF Joint Estimates

⁶ OCHA Afghanistan Humanitarian Response Plan 2016

⁷ ACF, SMART data 2016

Figure 1 Map showing most up-to-date SAM rates across Afghanistan (ACF, SMART data 2016)



3. HOW ARE CURRENT INTEGRATED MANAGEMENT OF ACUTE MALNUTRITION SERVICES RESPONDING TO NEED IN AFGHANISTAN?

In Afghanistan, each health district has one BPHS partner (either national or international) that delivers primary health care services including the treatment of malnutrition (both SAM and MAM⁸). This is generally from district hospitals, comprehensive health centres (CHC) and basic health centres (BHC). Typically there would be one district hospital, one to three CHCs and one to five BHCs in any given district. SAM cases with complications are treated on an inpatient basis at the district hospital which is managed by the emergency package of health services (EPHS) partner. There are also sub-health centres and health posts. Sub-health centres typically contain one nurse and are situated in more remote areas that have limited access to a BHC or CHC. Health posts are where community health workers (usually a man and a woman) operate from and should be distributed throughout the district with one health post for 100-150⁹.

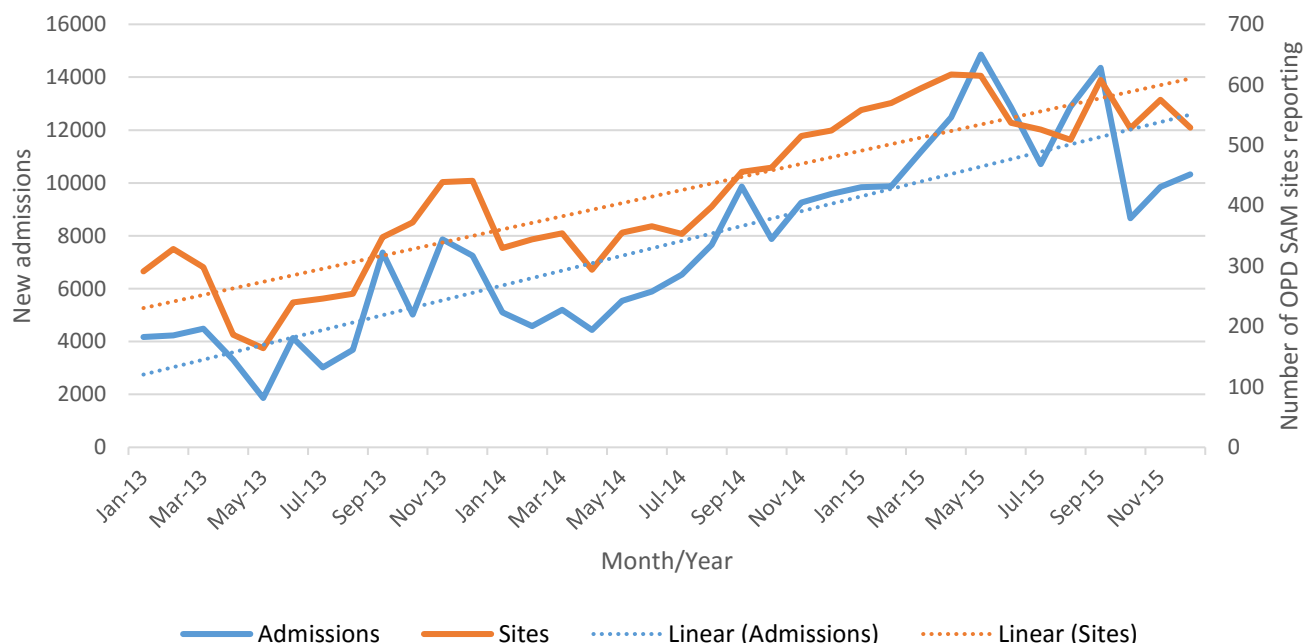
Since 2013 all 34 provinces have reported the implementation of IMAM services however in 2015 only 25 provinces reported the numbers of structures. This included 177 inpatient departments (IPD) and 776 outpatient department (OPD) SAM sites and 616 OPD MAM sites. This is a total of 32% of all CHC and BHC, in 338 districts (83%) in 25

⁸ At present inpatients for the treatment of SAM are provided by UNICEF and MAM by the World Food Programme

⁹ Community-based Health Care Policy and Strategy (2009-2013) Islamic Republic of Afghanistan, Ministry of Health, (Dec, 2009)

provinces (73%).¹⁰ Although in 2015 only 32% of health centres reported SAM services, this represents a steady increase from 2013 (541) and 2014 (611). Figure 2 illustrates the increase in OPD SAM sites over time.

Figure 2 Line chart showing total new admissions and total reporting OPD SAM sites in Afghanistan over time (Jan 2013-Dec 2015)



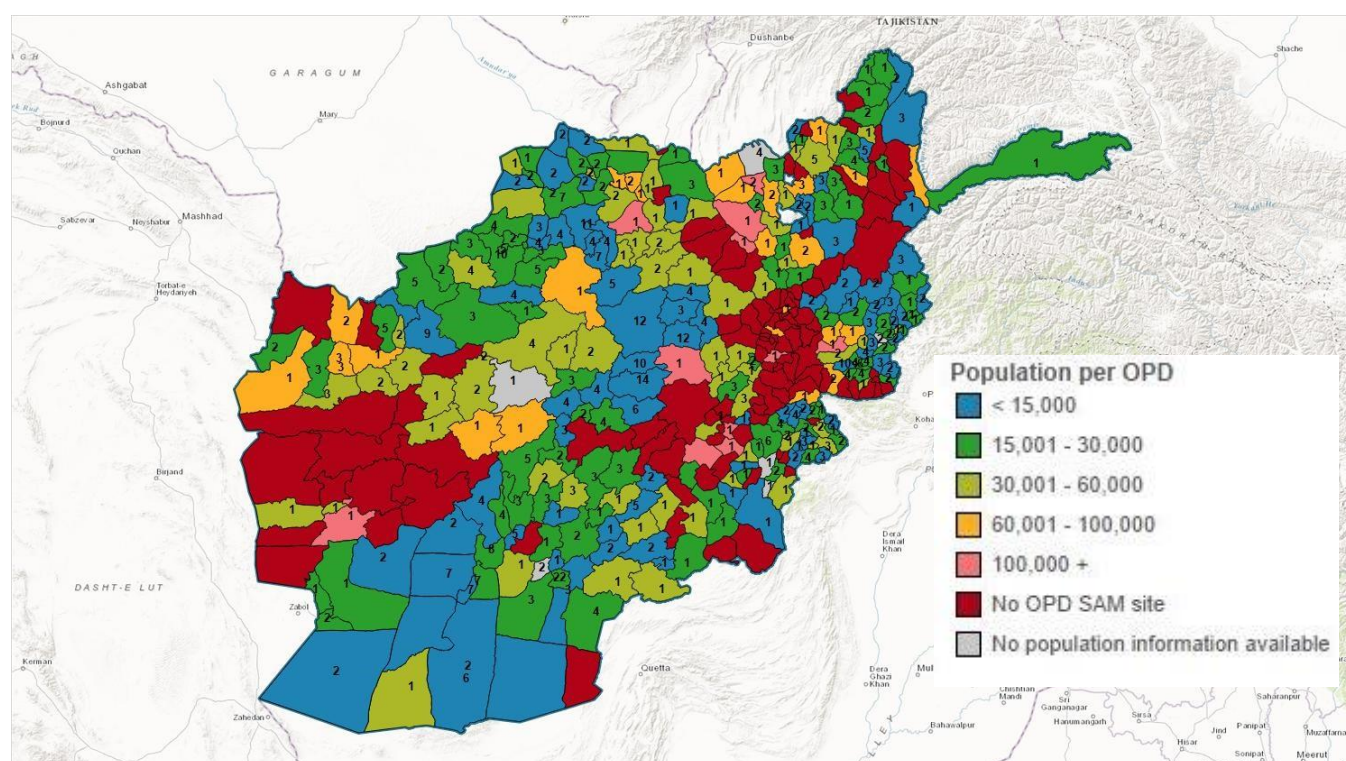
In 2015, 22,271 SAM cases with complications were admitted to IPD and 137,889 and 332,913 in OPD SAM and MAM respectively. This represents a significant work load for the health system in Afghanistan. Figure 2 shows a strong correlation in the increase in numbers of OPD SAM/MAM sites with an increase in admissions. This indicates that if 100% coverage of CHC and BHC with IMAM services was attained service availability could be maximised and the number of admissions is likely to increase significantly.

The decision whether to install an OPD SAM site in a health centre is largely dependent on the ability of the BPHS provider to budget for treatment services and the provision of supplies (particularly ready-to-use therapeutic food). Therefore geographic coverage of OPD SAM sites cannot be said to correlate with need.

Figure 3 shows the number of OPD SAM sites in each district and the colour corresponds to the number per population. The red districts indicate where there are no OPD SAM sites and therefore depending on population, represent the highest priority. The pink and orange districts also indicate the areas of poor geographical coverage of services.

¹⁰ Nutrition Cluster IMAM database Jan- Dec 2015

Figure 3 Map showing number of OPD SAM sites that reported in 2015 per district compared to population of district



4. HOW MANY SAM CASES ARE CURRENT SERVICES REACHING?

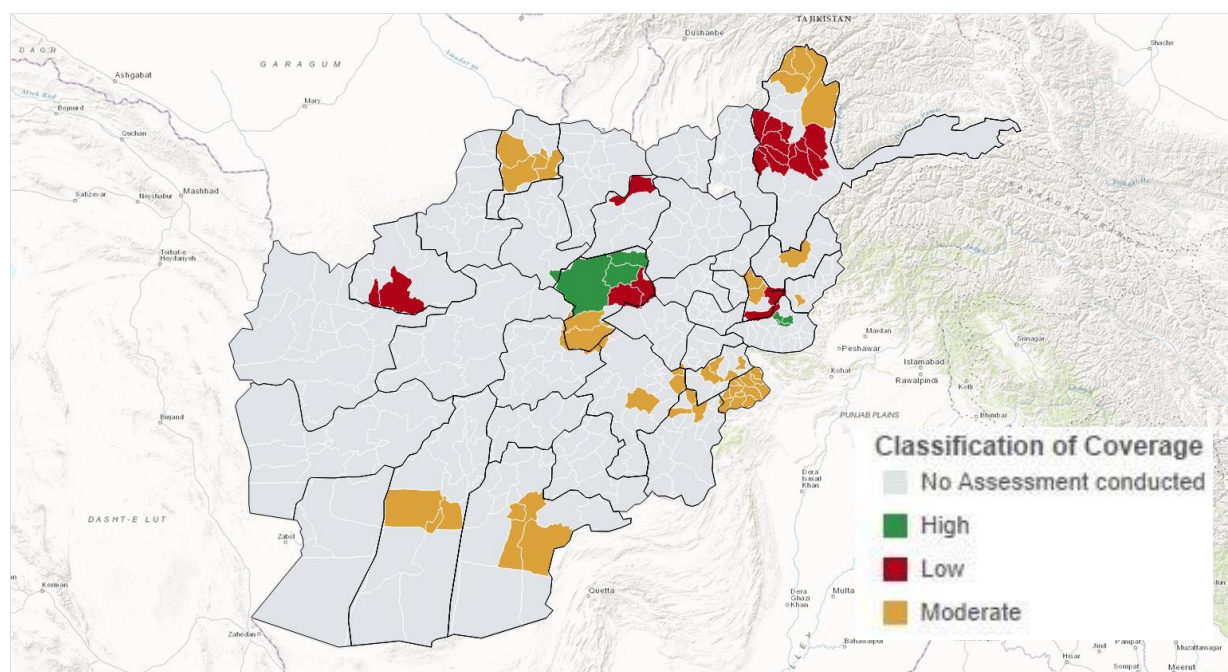
Since 2014 ACF have supported 14 SQUEAC (district or multiple districts) assessments and five SLEAC (multiple districts). Coverage assessments allow for the estimation of coverage of SAM treatment services (that is the proportion of existing SAM cases that are receiving treatment). These estimations are coupled with quantitative and qualitative data collection and analysis. The quantitative data analysis includes routine programme data and additional data gathered from source such as OPD SAM treatment cards. The qualitative data collection and analysis includes focus groups and interviews with a wide range of informants at both community (e.g. village leaders, imams, mothers or fathers) and service delivery (e.g. nurses, doctors or community health workers) level.

This is performed with the three objectives; (1) to find out how many SAM cases the service is reaching, (2) to understand the factors that are affecting coverage both positively (known as boosters) and negatively (known as barriers) and (3) to develop and action plan based on the collected evidence for coverage to be improved. This section deals with the data collected on objective 1.

Across the 19 assessments single or multiple district level estimations were gained for 17 assessments¹¹. The lowest estimate was 14.4% in Bagdhis Province (Qala-e-Naw and Qadis districts) and the only areas to achieved coverage in excess of 50% was Nagharhar Province (districts Kama, Beshud and Jalalabad). The majority of the estimations achieved were in the 30%-40% range or moderate coverage. Figure 4 illustrates the coverage estimations from all assessments highlighting the district where the assessment was conducted and allocating a coverage classification of high ($\geq 50\%$), moderate ($\geq 30\%$ or $< 50\%$) and low ($< 30\%$).

¹¹ Two assessments in Balkh and Ghor were not able to produce an estimation for methodological reasons.

Figure 4 Map showing coverage classifications for districts where assessments have been conducted¹²



These coverage estimations demonstrate that in all but two cases (the districts of Kahmard and Yakawlang in Bamyan Province) SAM treatment services are not meeting the SPHERE standards for coverage (50% for rural contexts and 70% for urban). This provides strong evidence that investments in activities to ensure adequate supply of services (e.g. geographic availability of treatment) and to promote demand for services (e.g. through community mobilisation activities) are needed. The factors affecting coverage are addressed in more detail below.

5. HOW EFFECTIVELY ARE CURRENT SERVICES TREATING SAM CASES?

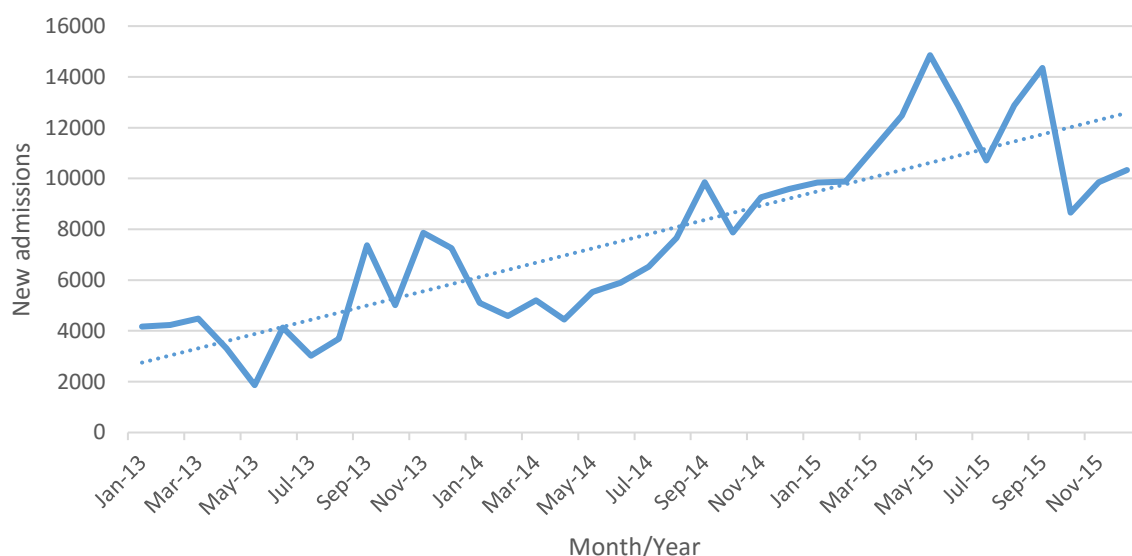
Typically the performance of IMAM services is assessed according to a package of indicators covering admissions and discharges. Indicators related to admission tend only to include the number of new admissions per month. This is an important indicator of demand for services however it does not allow us to see whether cases were admitted in a timely manner or where admissions are coming from (for example). Outcome indicators on the other hand are more nuanced, using recovery, death, default and non-response rates to evaluate performance. By analysing admissions and discharges we are able to assess how effectively current services are treating SAM cases.

ARE SERVICES SUCCESSFULLY ENROLLING SAM CASES?

Between January 2013-December 2015 IMAM services have admitted a total of 275,850 SAM cases, 50% (137,889) were admitted in 2015 alone. Although there have been fluctuations from one month to the next, In Figure 5 we can see a steady increase in admissions over this period. The variations reflect seasonal changes linked to agricultural and disease calendars, and also changes to programmatic activities. For example, we can see increases in admissions during the month of September across the three years.

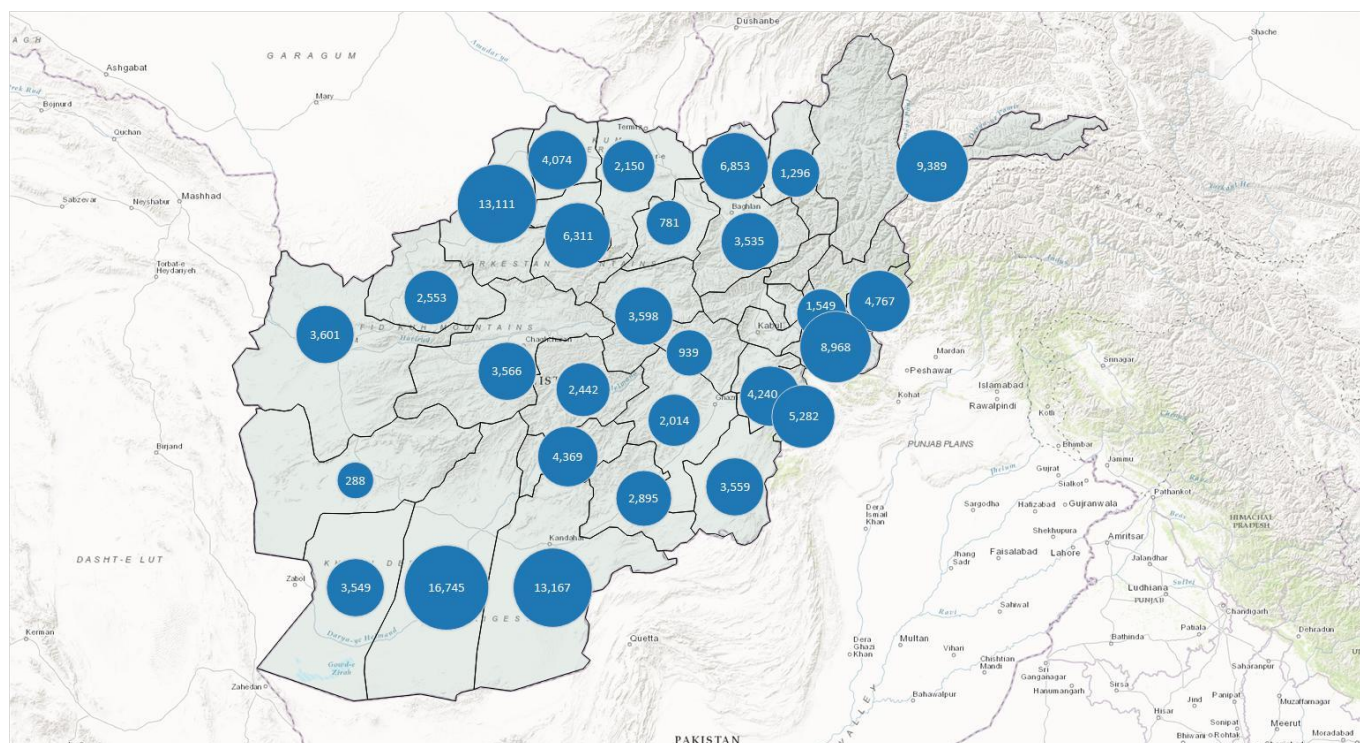
¹² Single coverage estimations were used since this provides the most accurate estimation. See Annex 2 for further explanation. The following classifications were used high= $\geq 50\%$, moderate= $\geq 30\% < 50\%$ and low = $< 30\%$ for both the SLEACs and SQUEACs.

Figure 5 Line chart showing new admissions to SAM services over time (January 2013-December 2015)



When mapping admissions from 2015 we are able to identify the levels of admissions in each province. Figure 6 illustrates that Helmand, Kandahar and Faryab have the most admissions all with over 13,000 each. However we can also see that the provinces of Farah, Samangan and Wardak have under 1000 admissions each. Finally we can see that the provinces of Parwan, Panghir and Kaplan did not report any admissions. This is because they do not report through the cluster or have the same BPHS partner system, instead the Ministry of Public Health provides the health services under the Strengthening Mechanism. Since nutrition indicators are not reported here we cannot make any assertions over IMAM performance in these areas.

Figure 6 Map showing OPD SAM admissions from 2015 (n=137,889) mapped according to province

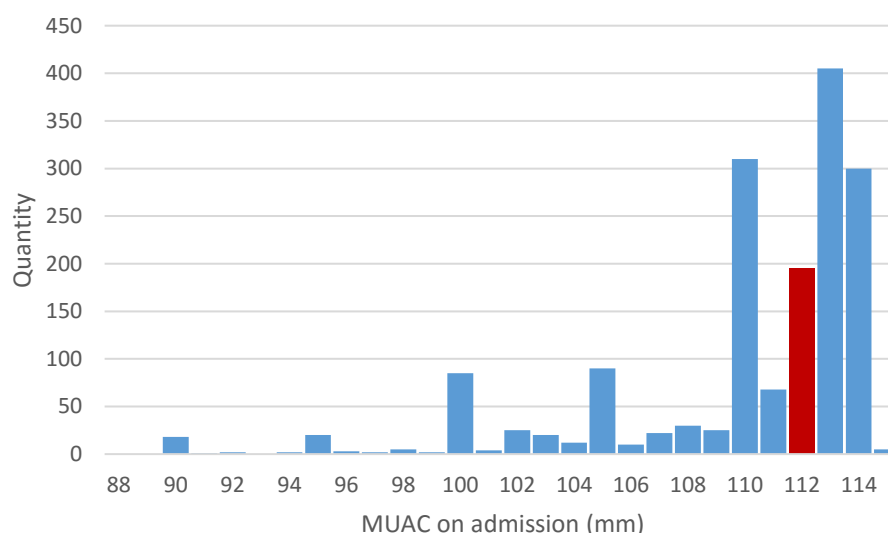


SQUEAC assessments go a step further in the analysis of admissions including analysing whether SAM cases are being admitted and an early (for example with a MUAC between 110-114mm) or late stage of admission (MUAC

<110mm). This also provides an indicator of the effectiveness of case-finding. Are the health services managing to screen children regular to ensure timely admission?

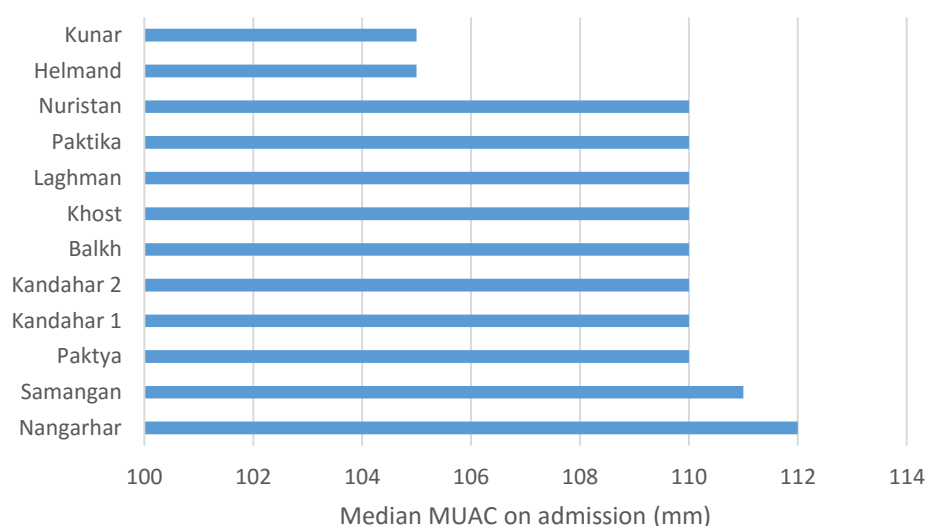
Figure 7 shows an example from the Nangarhar SQUEAC we can see that 77% of the admissions can be considered early (110-114mm). 19% are late (110-100mm) admissions and 3% critically late (<100mm). The median is 112mm indicating that overall SAM cases are not being admitted late. This could be due to a combination of factors including good case-finding (actively and passively) and good awareness of malnutrition and services. In a SQUEAC assessment this would then be triangulated with other information such as qualitative data. That said it highlights that a significant amount of cases are being admitted late and therefore at much greater risk of the long term effects of malnutrition and not recovering.

Figure 7 MUAC on admission from Nangarhar SQUEAC (based on n=1688 new admissions)



An analysis of median MUAC on admission across some of the SQUEAC assessments (see Figure 8) shows that largely values fall within an acceptable range (110-115mm). That said all services should aspire to be achieving a MUAC on admission close to 114mm meaning that children are admitted soon after they become severely malnourished. The SQUEACs in Helmand and Kunar however showed a concerning level of 105mm. This would indicate that services are not well known by the community, caregivers are unable to identify their child as malnourished and screening is limited.

Figure 8 Table showing median MUAC on admission for six SQUEACs



Therefore we can see that SAM treatment services are being accessed but they are not always being accessed as early as they should be. Those services that demonstrate a lower MUAC on admission are likely to be experiencing important barriers to access that are delaying the presentation of the SAM child to the services.

A secondary benefit of the MUAC on admission analysis is that the quality of MUAC measurements can be observed. In all assessments, a preference for measurements with a multiple of 5 (110, 105, 100, 95) was found. This indicates that health workers are rounding up or down and therefore not taking the most accurate measurement.

WHAT PROPORTION OF ENROLLED SAM CASES EVENTUALLY RECOVERS?

Standard programme performance indicators look at the proportion of children that recover from severe acute malnutrition, those that stop treatment before recovering (known as defaulters), those that do not respond to treatment and those that die. In 2015 those provinces that reported (29) on SAM treatment outcomes achieved a 93.1% rate. This is well above the SPHERE standard of 75%. Figure 9 illustrates the recovery, defaulter, death and no-response rate over the course of 2015. Here we can see little variation from month to month.

Figure 9 Line chart showing discharge outcomes in Afghanistan during 2015

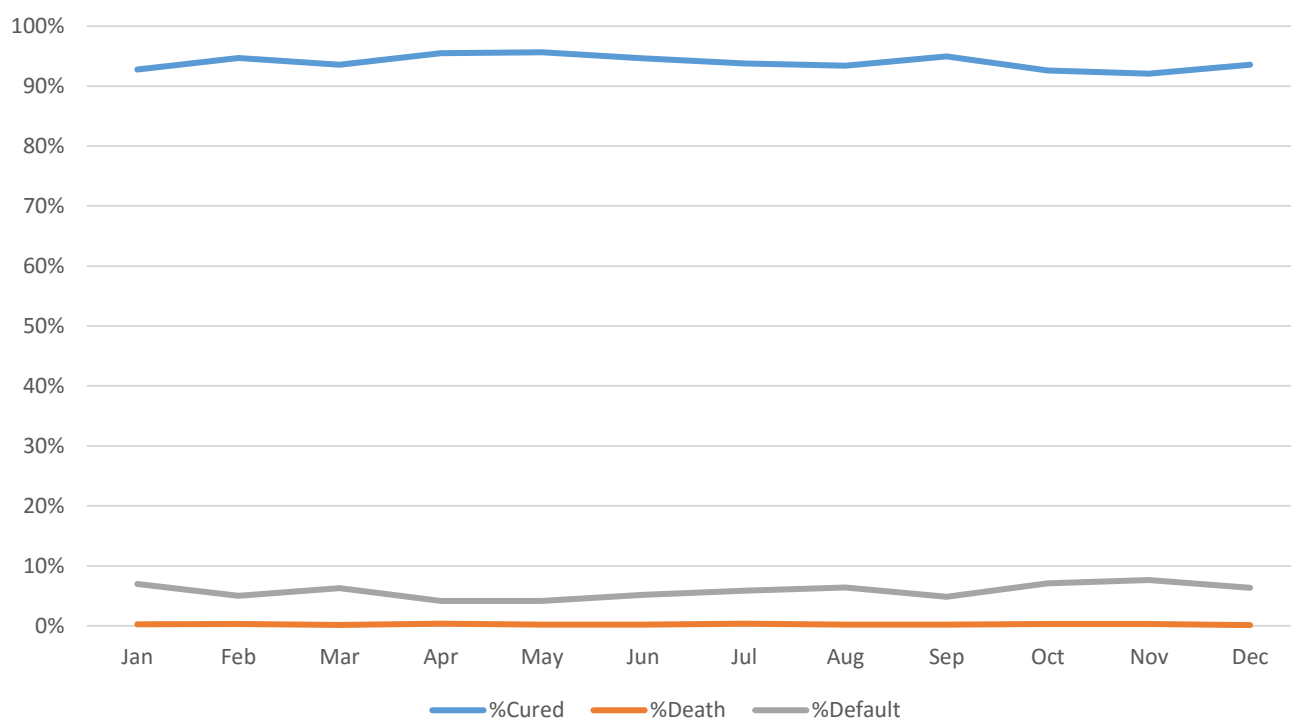


Figure 10 shows the recovery rates per province. Here we can see that the only provinces that have a recovery rate of under 75% are Samangan and Takhar.

Figure 10 Bar chart showing recovery rates per province for 2015



WHAT PROPORTION OF THE ENROLLED SAM CASES FAILS TO COMPLETE TREATMENT?

The children that fail to complete SAM treatment are those that die, default or do not respond to treatment. Good performance depends on the ability of services to keep the numbers of children that fall into these categories low. Over the 29 provinces the death rate was 0.2% which is well below the SPHERE standard of 10%. That said the low levels of recorded deaths suggests that deaths are not recorded, since we would expect a higher rate. 5 provinces (Paktika, Laghman, Wardak, Farah and Takhar) did not report on deaths. This is of concern has information on mortality can contribute to critical adjustment to services. This however is an improvement on 2014 which reported a national death rate of 0%. Death rates per province are illustrated in Figure 11.

Figure 11 Bar chart showing default and death rates by province for 2015

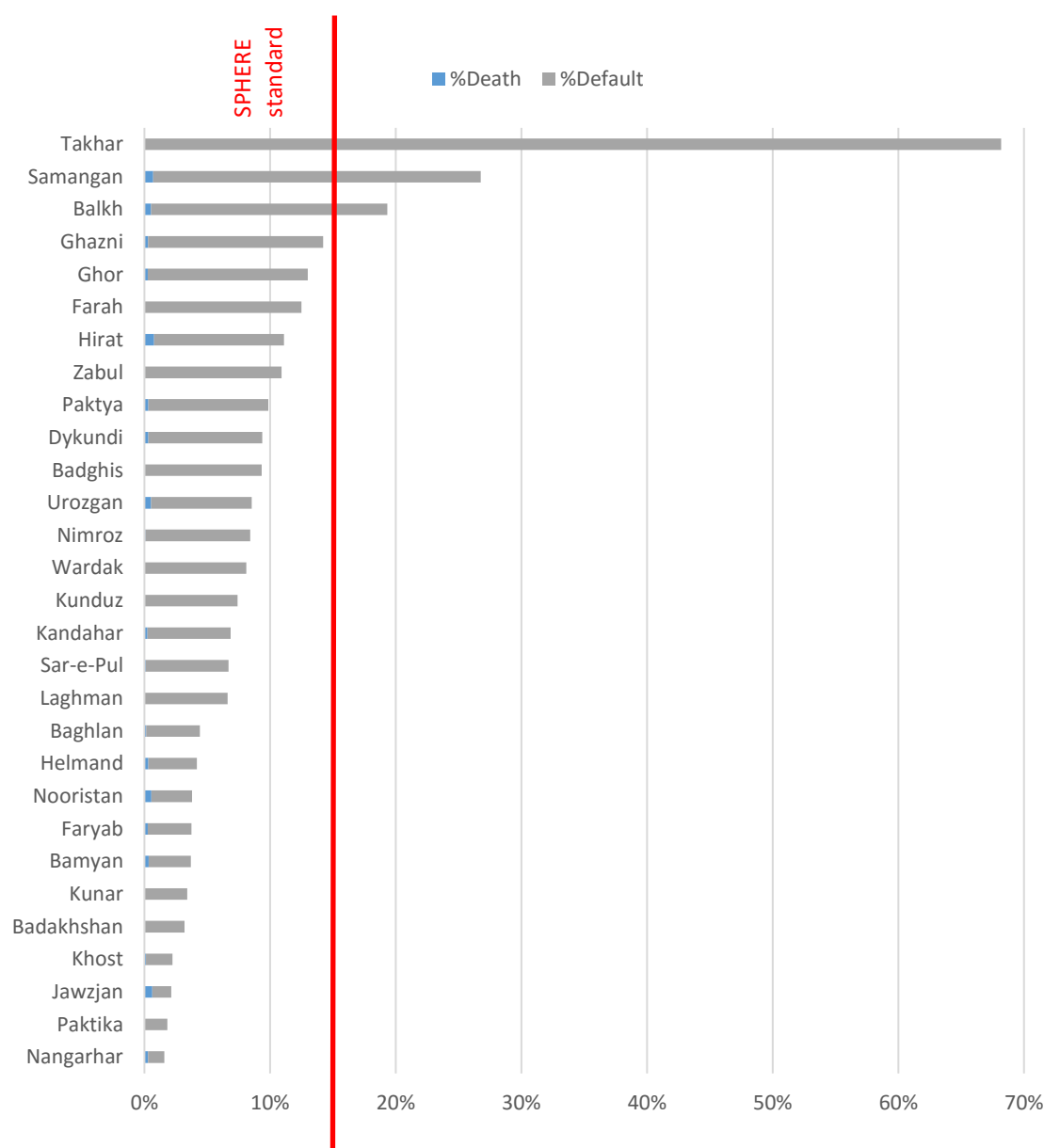


Figure 11 shows that defaulter rates ranged between 1 and 26% in 2015. That is with the anomaly of Takhar at 68%. This was likely due to RUTF supply problems and insecurity. Across the 29 provinces that reported discharges the defaulter rate was 5.8% (5,970 cases out of the 103,627 cases that discharged). In all but three Provinces (Takhar, Balkh and Samangan) default rates were below SPHERE standard of 15%.

The fact of SAM cases not completing treatment has a significant effect on coverage and programme performance. Therefore it is critical for partners to work towards reducing defaulting and ensuring SAM cases undergo treatment until they have reached the discharge criteria. In order to enable partners to take the right action, it is important that a comprehensive understanding of defaulting is achieved.

Unreliable defaulting rates and the absence of a system to record reasons for default, minimises the utility of routine programme data. However the SQUEAC assessments were able to identify reasons for defaulting.

WHAT ARE THE MAIN CAUSES OF DEFAULTING?

The following reasons for defaulting were taken from the SQUEAC assessments. Ensuring consistently low defaulting rates is key to ensuring a high performing programme therefore it is important to identify the reasons

for defaulting and actions to overcome them. Since these cases have already been admitted pre-emptive action can be taken to avoid defaulting. These are presented in the following table:

Reason for defaulting	Explanation	Proposed actions
<i>Economic migration</i>	Economic migration during the summer (June-August) due to increased job opportunities. For example in Nangahar mothers and fathers left the province in search of work.	Encourage completion of treatment before migration and facilitate transfer to another OPD SAM site if possible
<i>Lack of service due to RUTF stock-out</i>	Stock-outs of RUTF or RUSF had an effect on defaulting. Considering there is often little difference in the two products if there is a stock out of one, news spreads that care-givers have been turned away, causing further defaulters. Consistent supply of RUTF in Nangahar and Khandahar was attributed to the low levels of defaulting.	Improve stock management to reduced RUTF and RUSF stock outs.
<i>Family event (celebration/funeral)</i>	Care-givers were compelled to prioritise family events over taking their child to the health centre	Include specific messaging over the necessity to bring the child to the health centre.
<i>Mother sick</i>	The mother was sick and therefore unable make the journey to the health centre	Encourage mothers to find family members to bring child to health centre.
<i>Lack of Mahram</i>	Often a mother cannot walk in public without being accompanied by a male member of the family. If there is not one available she is unable to go to the health centre.	Target male family members with sensitisation to ensure someone is available.
<i>Caregivers or Mahram busy due to harvest</i>	The opportunity cost of going to the health centre increases the caregiver and/or the mahram during harvest.	Work with care-giver to find solution such as giving 2 weeks of rations or support them to identify family member to attend health centre.
<i>Reduced accessibility of roads during winter</i>	From November to March snow can significantly affect the accessibility of roads in certain areas of the country.	Suggest giving of 2 weeks ration. Explore possibility of mobile sites.
<i>Lack of awareness of protocols amongst staff and care-givers</i>	Awareness amongst staff (including length of stay, discharge criteria and absent follow-up process) and/or a lack information sharing with care-givers causes SAM cases to end treatment before meeting the discharge criteria.	Train staff in all areas of protocol including absent follow-up process. Ensure staff adequately inform mothers of treatment protocol and details from the first visit.

The assessments found that most services do not have a system in place to follow up absent cases in order to make sure that they do not default and instead continue treatment. This means that CHWs are not called upon to perform home-visits of absent cases in order to ascertain the reason and ensure they continue treatment.

Such a system was only found in one of the programmes evaluated. In Nangahar the BPHS provider demonstrated that a system to follow-up absent cases (1 or 2 visits missed) allowed the achievement of low levels of defaulting. The partner was able to prevent defaulting by contacting any absentees through the contact details recorded on the beneficiary cards. This involved health facility staff calling care-givers, and if they are uncontactable then

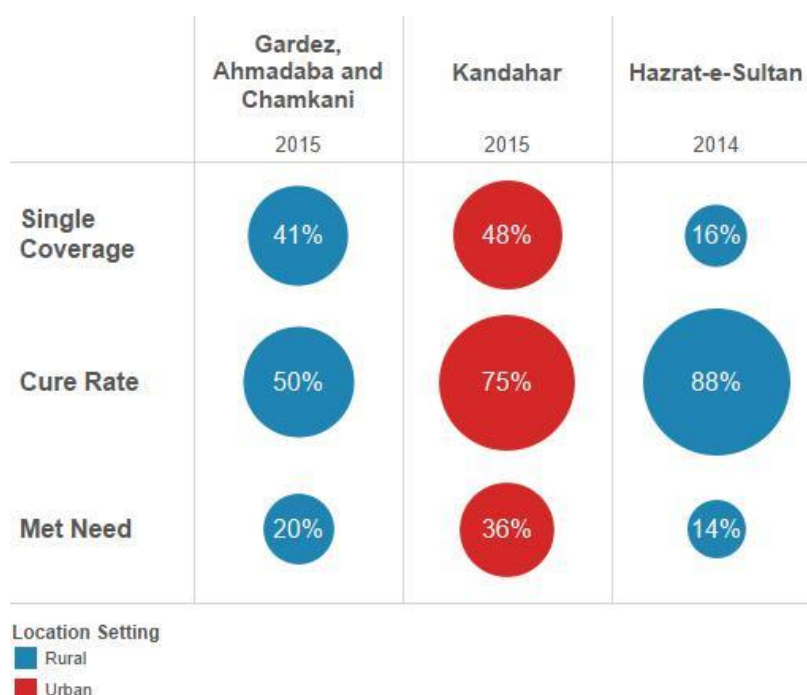
sending CHWs to the care-givers. This however limited to those villages that had a local (and active) CHW, since some villages did not have CHWs, in which case were not followed up. What was missing in Nangahar was a system to record reasons for defaulting.

The majority of defaulting cases defaulted after the first 1-3 visits. It is likely that those defaulting after 1 visit were not aware that they need to go back and those that default after 2-3 visits are not aware that they need to stay until discharge criteria met. And it may be that they have seen an improvement in their child and therefore other priorities take precedent. This is all underpinned by a general lack of appropriate information sharing at facility level. This was witnessed by the SQUEAC teams during visits to the health facilities. For example, in Hazrat Sultan the team witnessed chaotic scenes at the facility where staff were over-worked and unable to take the time to effectively inform care-givers about the course of treatment. Or in Helmand the SQUEAC team witness a poor understanding of the treatment protocol amongst staff who were not aware of when a child was admitted therefore was unable to share this information with care-givers.

6. WHAT PROPORTION OF ALL SAM CASES COMPLETE TREATMENT?

Both coverage and recovery rates are important in order to determine what proportion of existing SAM cases are receiving treatment and successfully recovering. Typically a SQUEAC assessment collects discharge outcomes over time as well as overall discharge rates for the year prior to the assessment. It is by using the annual recovery rate and the coverage estimation that met need can be calculated. Figure 12 illustrates three examples from the SQUEAC assessments.

Figure 12 Bubble chart showing coverage, cure rate and met need from three different SQUEAC assessments



Met need is an important calculation as it allows us to see the real impact of the SAM treatment services and illustrates the importance of achieving both good coverage and high recovery rates. In the Kandahar example, if we were to assess the performance of the programme according to recovery rate (75%) alone (as is typically done) this would give a distorted picture of the actual impact of the programme; that being the proportion of the programme target (children 6-59 months that suffer from SAM) that actually recovers.

Likewise, when looking at the coverage rate (48%) alone, we would over emphasise the programme performance since this figure only reflects the number of children that are admitted, but not the number of these children that successfully complete treatment. For example, if a programme was achieving high coverage rates but was unable to retain cases (i.e. there was high levels of defaulting) then the coverage figure would not reflect this.

So when both the coverage and recovery rates are used we can calculate the actual met need and therefore achieve a more accurate picture of programme performance¹³.

7. WHAT FACTORS ARE AFFECTING THE ABILITY OF SAM TREATMENT SERVICES TO TREAT ALL SAM CASES?

Coverage assessments allow for the identification and in depth look into the factors affecting the ability of SAM/MAM services to treat SAM/MAM cases. Whereas SLEACs only gather information from caregivers of SAM/MAM cases (both covered and uncovered) SQUEACs gather information from a wide-range of informants¹⁴. In the assessments used we only assessed SAM, therefore the factors cited are those that influence coverage of SAM treatment.

Lines of enquiry are based around ascertaining the informants understanding of malnutrition and treatment services, and health seeking behaviour. The objective is also to understand what challenges are faced in accessing treatment sites, including economic, time and physical limitations (e.g. roads blocked due to snow). In addition, the questioning is designed to find out what screening and referral systems are in place, at both clinic and community level, as well as the sensitisation and communication strategies; for example how are services being promoted? It is also important to determine the quality of treatment delivered; for example do staff and CHWs have a good understanding of malnutrition and the treatment protocol, and are they well applied? Finally the perceptions and experience of caregivers of the services must be collected; for example how do caregivers experience their time at the treatment site?

In each SQUEAC, the qualitative information is combined with the quantitative information and the most important factors are determined through an evidence-based weighting according to their impact on coverage and access. Figure 13 is an aggregation of the five most important barriers for 14 SQUEACs.

¹³ Although this is the best quantitative reflection of programme performance there are limitations to this method. Specifically due to the fact that an annual recovery rate is a representation of performance over a given period (a year) whereas coverage is taken at a specific point in time.

¹⁴ For more information on coverage methodologies visit <http://www.coverage-monitoring.org/>

Figure 13 Square graph showing top five barriers for each SQUEAC assessment (n=14)

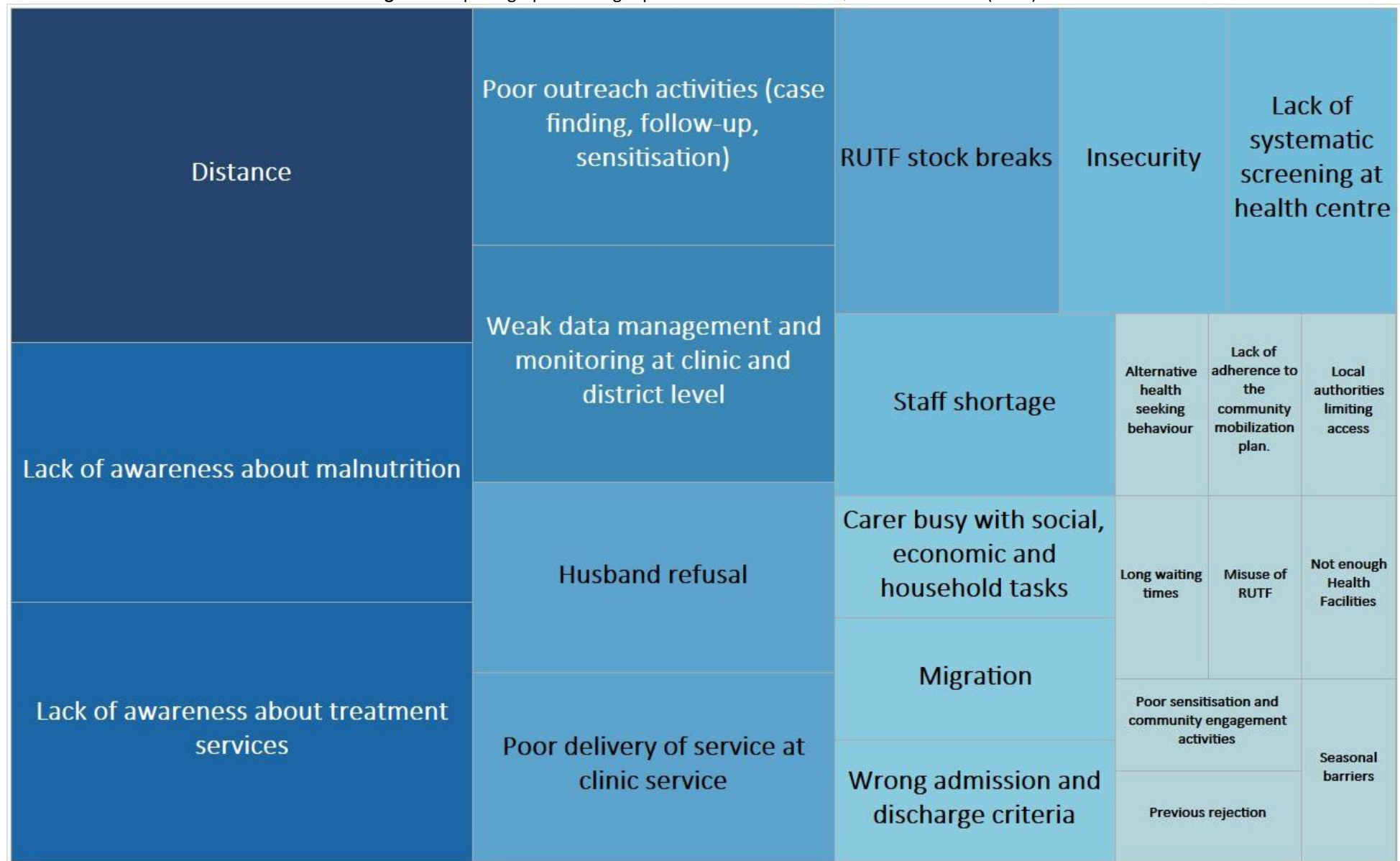


Figure 14 Square graph showing top 5 boosters for each SQUEAC assessment (n=14)

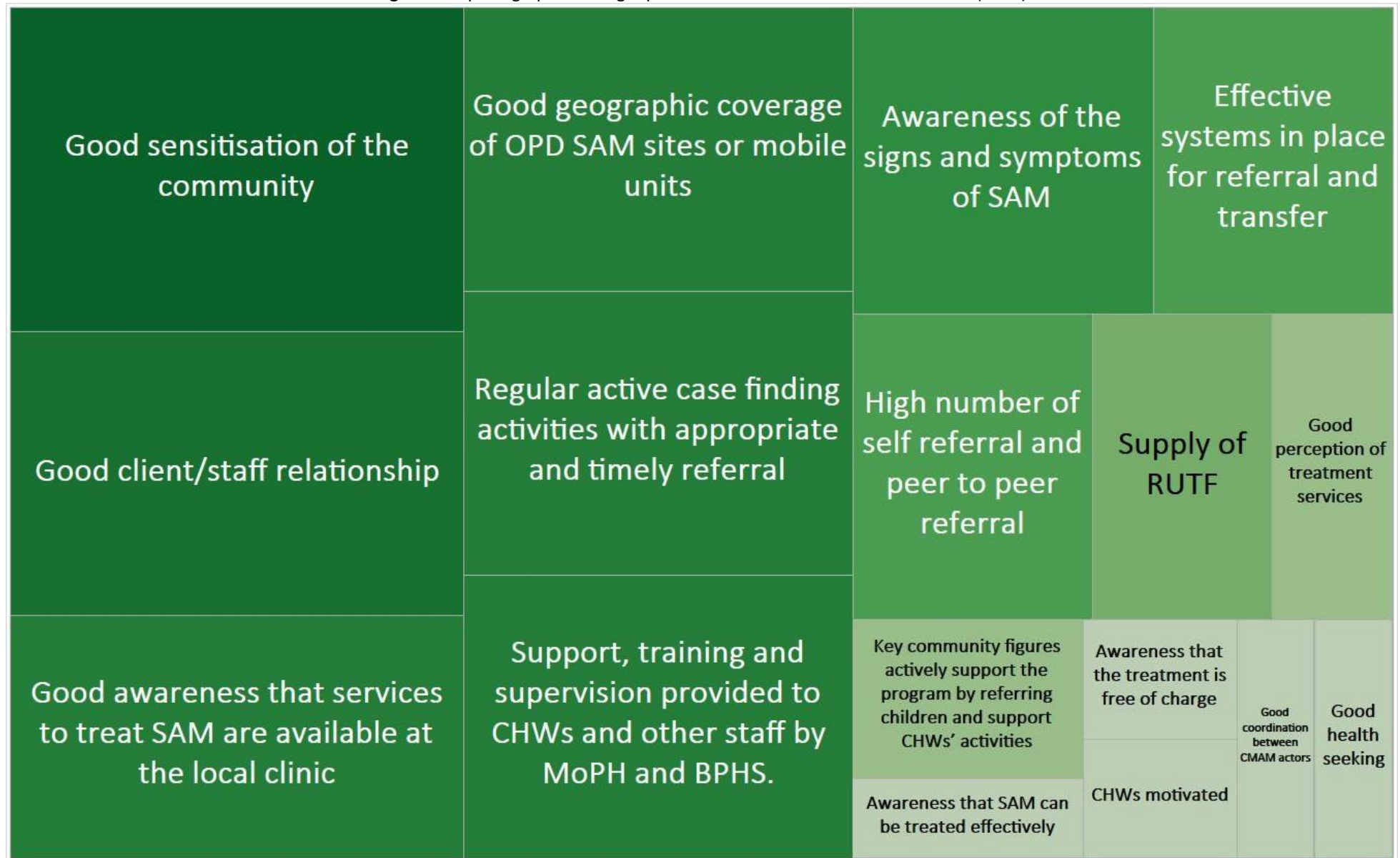
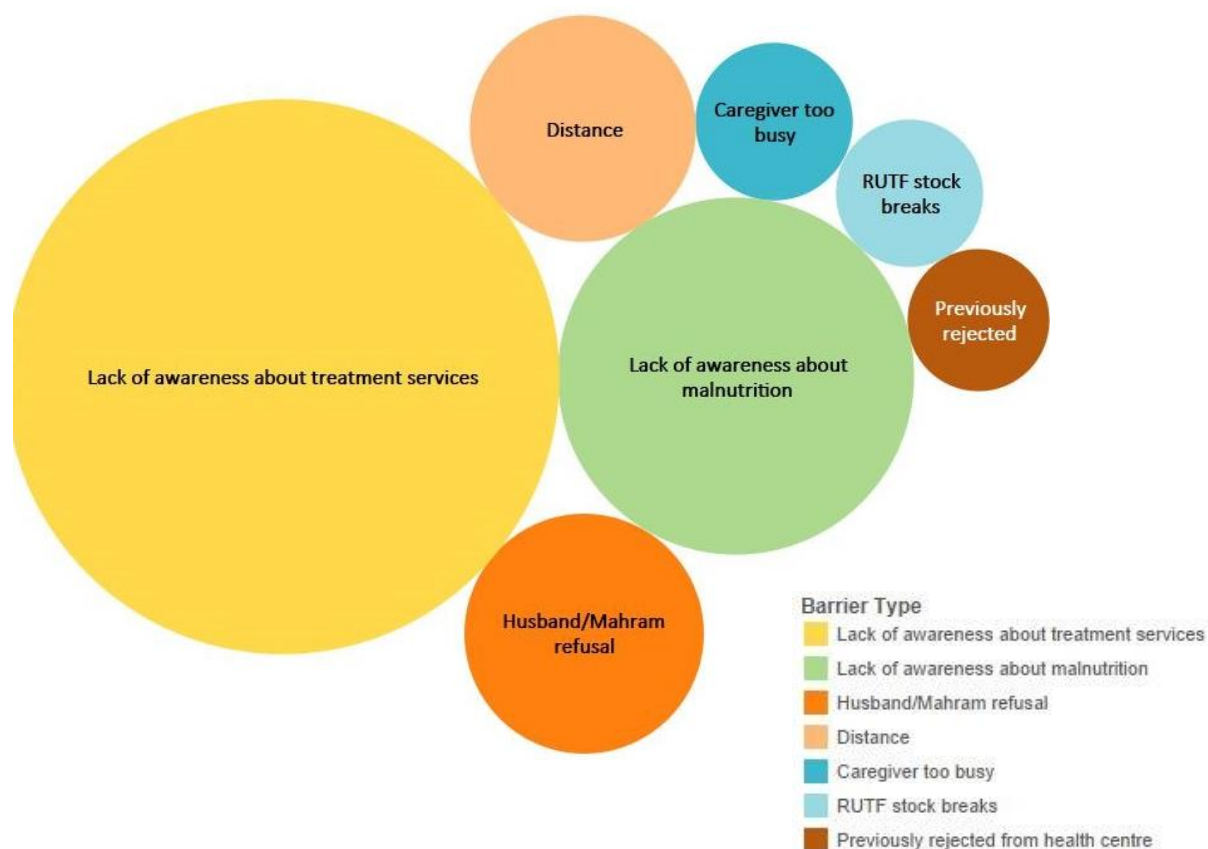


Figure 14 is an aggregation of the five most important boosters from the same 14 SQUEAC assessments. These are the factors that were the most relevant in achieving better coverage and therefore indicate the areas in which to invest in order to achieve the most effective gains in coverage.

During the wide area survey of SQUEACs and the case-finding during a SLEAC the caregivers of uncovered SAM cases are questioned in order to determine the reason they have not been admitted into the programme. Whereas the barriers in Figure 13 are drawn from multiple sources these come only from the caregivers. The reasons for non-attendance as mentioned by care givers are presented in Figure 15.

Figure 15 Bubble chart showing top reasons for non-attendance as cited by the care-givers of uncovered cases found in the wide area surveys of SQUEACs (n=12¹⁵) and the SLEACs (n=5). Total responses n= 413



8. WHAT DO WE KNOW ABOUT THE FACTORS THAT ARE AFFECTING THE ABILITY OF SAM TREATMENT SERVICES TO TREAT ALL SAM CASES?

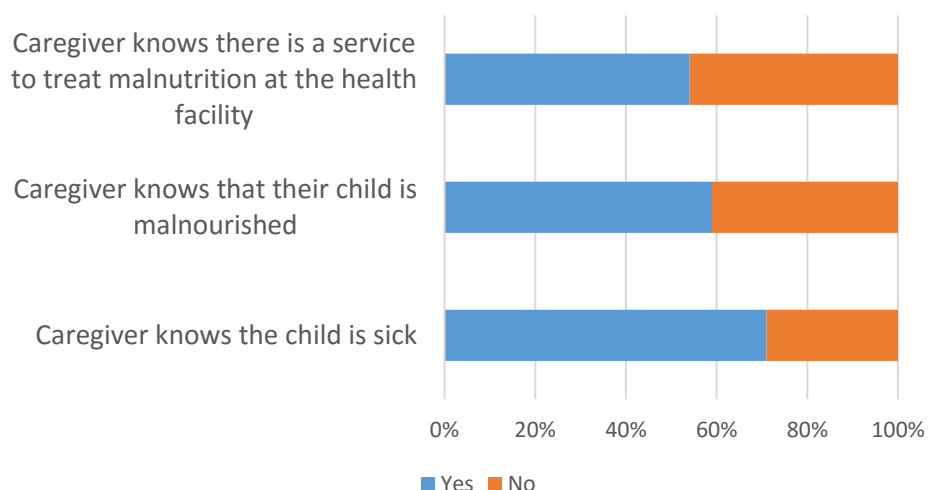
As well as identification of boosters and barriers through the different sources, coverage assessments enable the collection of a rich set of qualitative information that allow us to understand factors affecting coverage in more detail, whether that be community understandings of malnutrition and treatment services, health seeking behaviour, the communication, sensitisation and community mobilisation activities present, physical access to treatment sites, including insecurity, quality of care, continuity of care, human resources for SAM treatment and monitoring and evaluation systems. The following section provides an analysis of the qualitative information presented in the SQUEAC (n= 14) and SLEAC (n=5) reports.

¹⁵ Two SQUEAC assessments (Balkh and Ghor) did not include wide area surveys so this information was not collected

Understanding of Malnutrition

The analysis shows wide variation in the level of understanding of malnutrition and knowledge about the child's condition amongst caregivers of SAM children. While most identify that the child is sick, fewer would know that she/he is malnourished and that treatment is available.¹⁶ For example, during the SLEAC assessments although 71% of caregivers understood their child to be sick only 58% of caregivers knew their child was malnourished (see Figure 16). This indicates that awareness of there being a problem with the child is better than the awareness that this problem is malnutrition. For example, caregivers could identify malnutrition symptoms such as loss of appetite, weight loss, fever and diarrhoea, but could not tell that the child is malnourished.

Figure 16 Responses from caregivers of uncovered cases during the SLEAC assessments (n=465)



It was often noticed that malnutrition is not understood as a disease. The general perception is that malnutrition means that the child is thin. A slightly better understanding was noticed when communities recognized that the child is not gaining weight and/or has no appetite. When asked about the reasons for malnutrition, some caregivers responded that poverty and poor quality of food were the cause. Others mentioned lack of mother's milk and acute diarrhoea as the reasons. This shows that **malnutrition although seen as an outcome of certain practices with health consequences it is not seen as an illness**. It was also noted that the condition is only taken seriously when children become extremely weak and sick, at which point they are likely to be taken to the health facility (if the caregiver is aware of the programme) or a private doctor.

Health facility staff in Ghor province suggested that many SAM cases are being admitted late mainly because there is little knowledge of malnutrition and **because malnutrition is not really considered to be an illness**. Similarly, discussions with family members revealed that not knowing their child was malnourished is the main reason they did not seek treatment. **Some mentioned they believed that the symptoms would get better without treatment,**

Box 1: Stigmatisation

Stigmatisation of malnourished children or their families was raised in few of the assessments. Although not a common phenomenon, it was noticed that some families are ashamed to be seen in public with their sick or malnourished children and therefore they are not likely to take them to the clinic. The reasons shared for feeling shame suggested that when a child fell sick, it would make the family look bad and demonstrate their lack of ability to care for their child. This demonstrates the limited understanding of the various causes for malnutrition.

¹⁶ See also section 2 "Understanding of IMAM Services"

or that the child's thinness is genetic. This shows a big gap in knowledge and understanding of malnutrition, the causes for it, or the consequences it may have.

Understanding of malnutrition was correlated with engagement with key community figures. In Hazrat-Sultan investigating knowledge of malnutrition showed that **when the community mullah was aware of malnutrition and treatment service awareness was better**. This suggests that identifying and targeting key community members would help ensuring vital knowledge is spread. Similarly the assessment in Paktya stressed that mullah and maliks are normally involved in all community affairs and therefore should be involved in promotional activities. In light of poor understanding revealed in most of the assessments, these experiences provide good practices for other programmes.

Understanding of SAM treatment Services

Lack of awareness of IMAM services was a common barrier revealed in the analysis (as mentioned in 15 assessments out of 19). Indeed, not knowing about IMAM services was among the most common reasons cited by caregivers for not seeking treatment. When caregivers did seek treatment, it was highlighted that many of them learned about the services only when they attended the clinic, suggesting low sensitisation at community level.

Incomplete information about the treatment was also highlighted. For example, after admitting the child for the first time, **some caregivers did not know when to return for follow up and therefore did not complete the treatment**. Others, reported that although they knew a treatment exists, they were unclear on how to get their child admitted. Some caregivers explained they do not have money to pay for the treatment, **suggesting that the information they received is incomplete** as the programme is offered for free. Caregivers also complained about not knowing how long the treatment would last. Incomplete information on the treatment protocol and timing had a negative impact seen from the long gaps in treatment, poor retention from admission to cure, and little understanding of the consequences of defaulting.

Significant knowledge gaps in relation to ready-to-use therapeutic food (RUTF) are also evident. Often RUTF was referred to as 'food', and as such something that is shared among the family. Indeed, cases of RUTF sharing were common. Discussion with caregivers of children currently undergoing treatment also revealed that they thought the service is for poor people who do not have food, or for thin children. Finally, there is evidence to suggest that RUTF can be sourced without visiting the health facility. Some caregivers said they tried RUTF after buying it in the market or elsewhere, and only after it has "worked" they went to the clinic.

"We bought medicine from the market. Since the RUTF was working and the child was eating that happily, so we admitted her to the clinic" – Caregiver of recovering case in Dah Yak Sufla

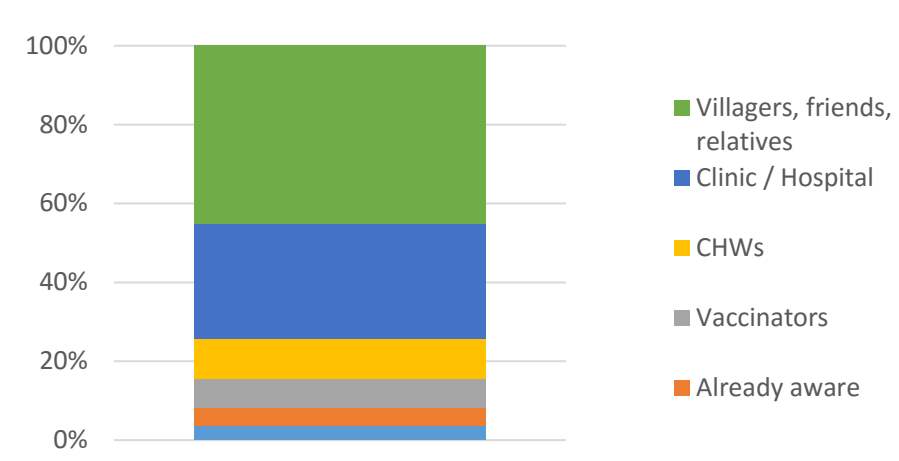
Communication and Sensitisation

Health staff

Rarely were community health workers (CHWs) found to be a strong source of information, suggesting that CHWs play a minimal role in sensitising communities and referring SAM children to treatment (see Figure 17). At the same time, cases referred by **vaccinators** were reported, **indicating that additional informants beyond CHW can take part in sensitisation efforts**. Some caregivers said that information about malnutrition was often not shared by either a doctor, nurse or midwife at the health centre. This suggests that more sensitisation is needed at all levels of the health pyramid.

It was also noted that when information is shared (by CHW or other), **it is often incomplete**. Often caregivers were made aware that their child is malnourished, but not always advised about the treatment available. In many cases, caregivers were only informed about the treatment once they have reached a health facility. This means that information is shared late and children allowed to develop a more severe stage of malnutrition.

Figure 17 How do caregivers find out about services/malnutrition? Source: all covered cases found during the SLEACs (n=199)



Community networks

Where high awareness to malnutrition and treatment was evident, it was noted that existing community structures often facilitated information sharing. The involvement of friends and neighbours was evident, as well as dissemination of malnutrition related messages and treatment services at community gatherings. This had a positive impact on increasing coverage as can be expected. **Weddings and mosques were frequently used to spread key messages to the community**, suggesting that more avenues to increasing awareness can be explored. It was also found that Maliks (village leaders) and mullahs (religious leaders) play a significant role in raising awareness, when they are themselves aware of malnutrition and the treatment programme.

Caregivers of SAM children often reported that they had heard about the programme from other mothers. **Word of mouth is therefore an important way in which information is shared within the community, which was found to have an impact on increasing coverage.** Although in itself this is a positive finding, it also suggest poor activity of CHWs. It should also be noted that while word of mouth and communication within the community is essential, it can also be harmful for the programme if caregivers had negative experiences in the health clinic.

Community Mobilisation

Community mobilisation in the form of sensitisation and active case finding by CHW was seen to be weak in most of the assessment included in this analysis. Nine of 14 SQUEACs reported weak community mobilisation, while five showed some degree of activity by CHW at the community level. The link between the health clinic and CHW was also found to be weak, as demonstrated by poor follow up on patients. It was noted that some villages do not have an appointed CHW at all, while others that do are not benefiting from active sensitisation or screening.

Links with the Health Clinic

The relationship between CHW and the health clinic was seen to affect caregiver's behaviour and perceptions. Health clinics that gave no preference to CHW referrals resulted in long waiting time for caregivers, which diminished CHW creditability in the community and reduced CHW motivation as a result. **This has led to some caregivers ignoring CHWs referrals.** In light of the limited incentives offered to CHWs, support and empowerment from the health facility is needed. This will contribute to greater trust and acceptance of CHWs in the community. Weak follow up of defaulting patients also suggest that the link with the health facility needs to be strengthened.

Weak links between health facilities and the community were also noticed. The assessment from Helmand province highlighted that this is particularly true when Health Shuras¹⁷ are not actively engaged with the services. **Health**

¹⁷ Islamic governance structure. Shuras are highly involved in public life and therefore an important entry point to communities.

Shuras can share information about IMAM services, promote active case finding, and generally mobilise the community hence their involvement is desirable.

Case Finding

Many caregivers reported that their children were only screened once they had reached the health facility. While it is encouraging that screening is happening at health facilities, this suggests case-finding is not happening at community level. As access to IMAM sites is often a challenge for caregivers, it is crucial that case findings takes place at community level. Case finding by other actors such as **vaccinators or health facility outreach workers** was also reported. Information sharing and sensitisations similarly happened through immunization teams or at vaccination posts. **These present more opportunities for screening at community level in order to increase coverage.**

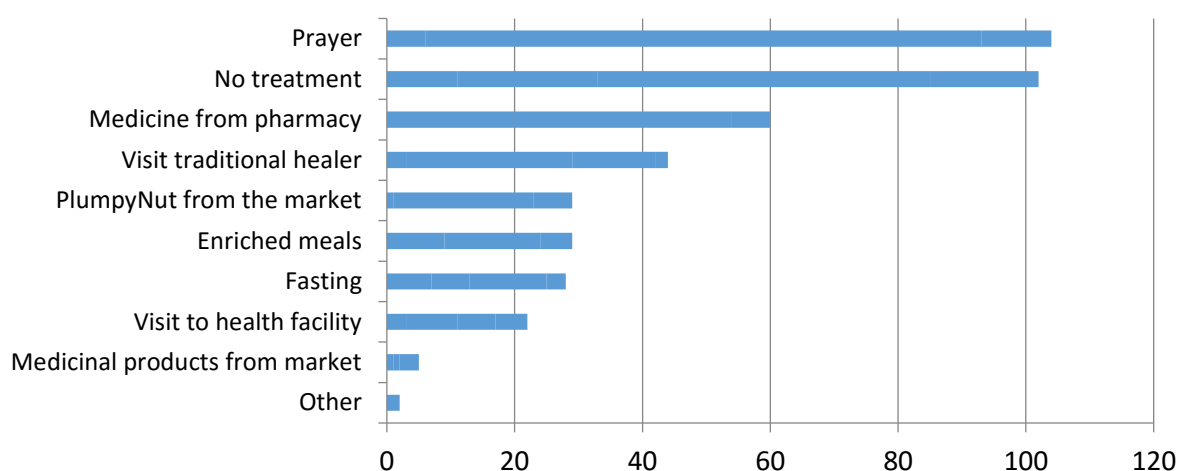
Box 2: Community health workers

The analysis revealed a number of possible reasons that contribute to the poor functionality of the CHW network. These include a lack of supervision and support from health centre staff and limited capacity to complete their wide range of activities. The lack of resources for supervision visits means that CHWs are unable to visit the health centres and community health supervisors are unable to perform supervisions of CHWS at village level. It was also found that insufficient numbers of CHW means that CHWs are allocated to many households.

Health Seeking Behaviour

10 out of 19 assessments showed different SAM and MAM treatment pathways considered by caregivers, including traditional roots and herbs, prayer, the pharmacy and enriched meals (see Figure 18 for an example from Badakshan). This suggests that there are various actors involved in the treatment of SAM/MAM children who could be involved in screening in order to ensure children are admitted as quickly as possible once they become malnourished.

Figure 18 Treatments tried or considered by caregivers of SAM cases not admitted to the program (n=230) in Badakshan



As we might expect, a correlation between levels of knowledge about malnutrition and treatment services, and using alternative methods was found, highlighting the importance of awareness as a booster for increasing coverage. It was also evident that caregivers would often go to the health clinic after they have tried different treatments. **This is likely to result in late admissions to the programme**, as can also be seen from evidence on MUAC on admission analysis. Whereas these practices indicate low coverage they present an opportunity to increase coverage if these practitioners (pharmacists, traditional healers) can be trained to screen for MUAC and refer malnourished children.

The assessment from Kunar province showed additional reasons for caregivers' preference to seek alternative treatment. Visiting private doctors in the local community was often prioritised **because it was closer and faster than going to the health clinic**. Furthermore, some women said that it was easier to convince mahrams (male

chaperon) to accompany them to the nearby private doctor. Similarly, home-made treatment alternatives such as mixing herbs with milk and beans was reported when distance to the health facility was too great. **There is therefore a clear link between distance to the clinic and health seeking behaviour.** The further the clinic the more likely caregivers are to use alternative treatments.

At the same time, the assessment from Helmand province showed that caregivers' first preference was to go to the clinic when the child was sick, explaining that the treatment is free and effective. It was noted that **the Mullah in the community had good awareness of the programme and was actively disseminating messages and urging early treatment-seeking behaviour**, normally during prayer time and other social gatherings. Therefore we can see that **sensitisation with actors such as mullahs, pharmacies or traditional healers will lead to less alternative treatments being used, especially in villages that far from a health clinic.**

Finally, insecurity was also a factor leading caregivers to prioritise alternative treatment. Caregivers mentioned that when they can't make the journey to the facility they would send the child to see the village mullah or use medicines from the market. It is notable that none of the informants affected by security considerations mentioned CHWs as their point of reference.

Accessing treatment sites

Access to the health clinic was revealed to be an important factor influencing coverage. Specifically, it was evident from the analysis that physical challenges are among the top barriers to access. This is due to the long distances, not being able to pay transportation costs and lack of suitable transport. **All of the assessments** included in this review discussed access to IMAM sites as a factor influencing coverage.

Distance

Distance was the main barrier in relation to accessing IMAM sites. In itself, distance was not necessarily a reason for non-attendance, however, when coupled with other limiting factors such as weather conditions, security conditions or availability of transportation, distance is an important factor to consider.

According to the IMAM guidelines¹⁸ travel time to the clinic should be maximum 2 hours by foot, however several assessments reported longer travel time, with 6-9 hours and even 6 days journeys reported in the most extreme examples. One assessment conducted a mapping exercise showing that distance between some villages and the OTP is up to 80 km. Indeed, many caregivers mentioned that there should be more clinics closer to their villages.

Lack of resources to make the journey was often discussed in relation to distance. Specifically, **cost and availability of transportation.** Caregivers often reported that they can't afford transport costs, but also that they can't pay for related costs such as subsistence and accommodation when the clinic is particularly far. Long distances were also mentioned as a challenge due to the time caregivers had to spend far away from home, especially when they have to prioritise livelihood activities such as farming or preparing for the winter. Security concerns were also evident in some areas with reluctance from drivers to visit volatile areas.

Poor road access and challenging terrain in mountain areas pose further challenges, especially in times of extreme weather conditions - rain, snowfall, seasonal flooding and extreme hot weather were all described as additional difficulties. On the other hand, inaccessibility was less a concern in urban settlements and close to major roads. This suggests that more resources are needed in rural areas to either create more facilities, or find alternative solutions such as mobile health teams and clinics.

¹⁸ Integrated Guidelines for the Management of Acute Malnutrition, Ministry of Public Health/Public Nutrition Department (2014)

Box 3: Mobile Health Team (MHT)

The assessment from Kandahar province demonstrate that active mobile health teams can be a useful mechanism to ensure coverage where access to IMAM sites is challenging. In addition to five health posts available in the programme area, two mobile health teams conducted weekly visits to all villages within the catchment area. These teams included one supervising nurse, a midwife, two community mobilizers (male and female), a vaccinator, and a nutrition nurse. These frequent visits ensured delivery of necessary services and therefore distance to the OTP site was not identified as a major factor affecting coverage.

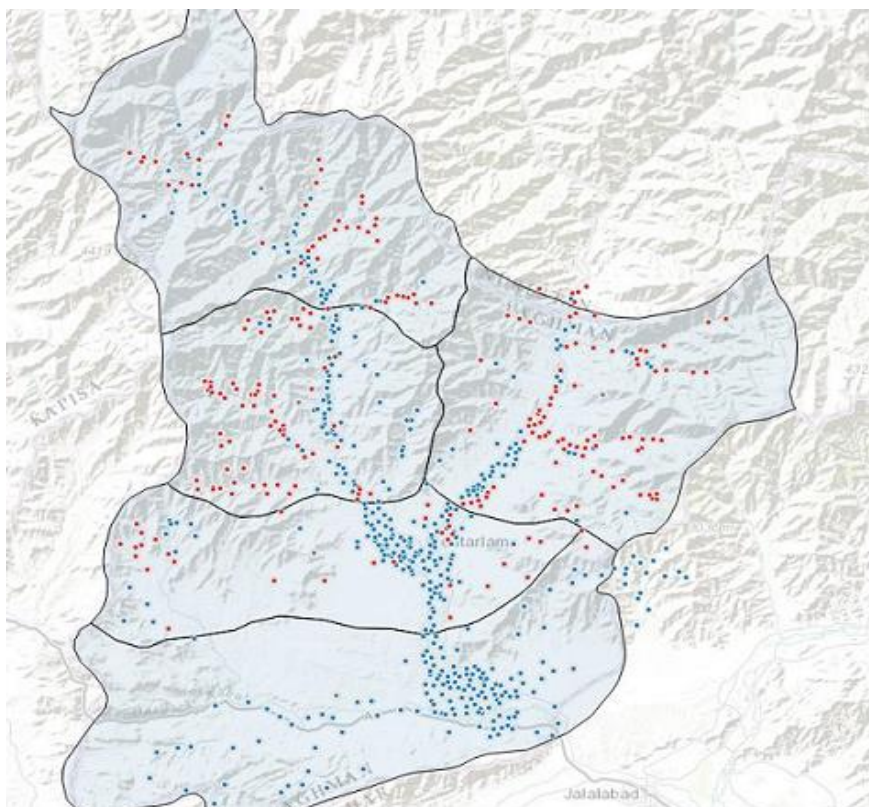
Workload of caregivers

Mothers often need to prioritise between numerous household duties, livelihood activities and care for the family. Among the household related factors influencing coverage, **not having anyone else available to care for other children and sick family members** was cited as the most important factor. This means that caregivers are unable to visit the health facility unless the family supports the mother and helps taking care of other members. This was particularly true in areas that families migrated to in search for better economic opportunities. It is assumed that without the wider family and full social networks mothers would struggle to find support with childcare. Other household restrictions that were discussed included the carer being too busy with other duties and refusal by the husband.

Insecurity

Insecurity was found to be a **recurrent and complex** factor affecting IMAM treatment in across Afghanistan. Various sorts of insecurity were found with a number of different effects on IMAM treatment. Insecurity dominates service delivery, in some cases the majority of a province is deemed insecure. Figure 19 illustrates the impact insecurity has with those villages classified as insecure at the time of the SLEAC assessment marked in red. In order to develop appropriate strategies to overcome or mitigate the effects of insecurity, it is important that we understand the types of insecurity first.

Figure 19 Laghman Province with insecure (inaccessible) villages marked in red and secure (accessible) marked in blue



Causes and types of insecurity

Causes of insecurity were found to include fear of being caught between the cross fire from fighting between armed opposition groups (AOGs) and government forces and also different AOGs fighting each other. This limits caregivers from being able to access clinics and health staff from accessing clinics for re-supply or monitoring.

"The security situation was not good when we were coming to the clinic in the way we saw the fight among Taliban and Government security staff" - a visitor to Gamba Clinic, Alishing from Ghazi Abad

Other fears were also cited including; fear of mines and improvised explosive devices (IEDs), fear of abduction (this was largely of health workers) and fear of thieves. These fears were found to have more of an effect on women travelling alone and therefore increased need for a mahram (male chaperone).

Check points also prevent access to clinics both by intimidating the population and actually preventing access. These are often, but not only, present when there is fighting occurring. Checkpoints are often part of a wider strategy to harass and intimidate populations. Assessments found that AOGs threatened residents when travelling to government controlled areas. These are typically the areas where there are functioning health facilities. That said the intimidation was not found to only be associated with AOGs. Residents from AOG controlled areas also reported harassment from government forces (ANA and ANP).

The association of health care with the government and also with foreign intervention was found to be a relevant factor. Certain AOGs are known to be against anything that is associated with the government (education, health care, elections etc.), and if the population engages with these government initiatives, then they will be targeted. This was found to be the most common reason for the harassment of people accessing health care. Association with the government however was found to be stronger for health facility staff, community based health staff such as CHWs, and outreach workers such as vaccinators and health educators. This therefore has an important effect on the geographic coverage of CHW activities.

Effects on services and access

The effect insecurity has on coverage of SAM services is threefold. First, caregivers are unable to travel to the health clinic (accompanied or not). Second, CHWs (and other outreach workers) are not permitted by AOGs to operate at community level. This therefore reduces the amount of screening taking place and also the support that CHS are able to provide to CHWs. Third, health staff from district capitals are unable to access other health centres for a range of activities required for operating the OPD SAM sites, specifically those involving movement from provincial to district level, such as monitoring, training, supervision activities, and supply of RUTF.

The decision whether to open new health centres and OPD SAM sites was also affected by security. AOGs have been known to threaten taking over health centres if they were opened and also controlling the distribution of drugs. In another example, health facilities were not being supplied with medicines since five World Food Programme (WFP) trucks were recently attacked.

Mitigating approaches

Insecurity was found to be a very challenging factor for services to deal with putting lives at risk. That said courageous approaches were found that allowed services to mitigate the effects and increase access. **Building relationships with community figures and working with community networks was found to facilitate activities for programme staff.** Long-term relationships with community members and groups facilitate safe visits for known staff to certain areas. It is considered that personal risk is significantly increased when staff visit more remote and volatile areas where they are not known to local leaders. Therefore long-standing relationships with local leaders and networks comprise a crucial mechanism for access and activities.

Insecurity is fluid and localised, therefore frequent and on-going communication with key community figures can provide information and support to service providers. This can allow for an adapted and reactive approach that seize opportunities and take a nuanced and locally specific approach.

“Since September when the situation got worse, we are not able to supply [health centres]. There is a plan with local maliks, mullah, health shura and some Jihadi leaders about how to get the supply to the clinics. Officially it is not part of the job, but it’s an important part of keeping the clinics supplied and supported” Management staff, implementing partner

Quality of Care

Quality of care is defined as the extent to which a child is treated effectively, without mistakes, from admission to discharge, leading to full recovery of the child and a good perception of the services from the caregiver. During SQUEAC assessments analysis of quantitative data allows us to determine whether treatment is delivered correctly, and the qualitative components allows us to complement that with observations at facility level and also understanding how caregivers experience treatment.

The caregivers experience is integral to quality of care since it can have a significant impact on caregiver’s likelihood to return for treatment and their perception of IMAM services. Ensuring caregivers have a positive experience is essential in order to maintain a good reputation in the community. 17 out of the 19 assessments mentioned quality of care as either having a negative effect on caregivers’ attitudes towards the IMAM programme or a positive effect, illustrating the importance of quality of care in achieving good coverage.

Caregiver experience at health centres

Assessments have shown that poor experience for the caregiver at the health centre has resulted in them not returning or discouraging others from going. **This poor experience was found to be made up of a variety of factors including; long waiting times, rude behaviour of staff, and unfair or discriminatory behaviour.**

Long waiting times meant that mothers were spending more time than necessary at the centres and can be explained by poor organisation of the clinics or overcrowding. **Overcrowding at health centres** was a common feature during the assessments. **Understaffing was also a recurring theme** that impacts on the ability of clinic teams to deal with all patients efficiently. Clinics should endeavour to reduce both overcrowding and waiting times, but **communication with caregivers whilst they wait is also critical**. Improved organisation (leading to better patient flow) and separate waiting areas (from where screening and consultation happens) can also facilitate a calm and dignified space for care.

Although IMAM services should be provided whenever the centre is open some caregivers have been turned away. This is usually because there is no RUTF or because the right staff are not available. In any case, **sufficient information should be passed to explain the reason for rejection** to reduce the possibility of the caregiver not returning. Condescending or aggressive behaviour towards caregivers was also reported. This further increases the risk that caregivers will not be willing to return.

Finally, preferential treatment or rejection from the health facility was also highlighted. Discrimination based on the ethnic group or the area caregivers are from was noted, as well as preferential treatment to beneficiaries from the villages of health centre staff, or rejection based on other reasons. For example, in Hazrat-e-Sultan it was found that centre staff were rejecting caregivers if they were not from a village within the health centre catchment area. Whatever the reason, rejection from a health centre is damaging to the reputation of the health centre and therefore to coverage.

On the other hand, friendly and welcoming staff were shown to have a positive impact. The Nangahar assessment reported good relationships between caregivers and health centre staff. Although the waiting time was reportedly long, caregivers did not mention it as a problem since they were well informed of how long the wait would be. **This suggests that friendly environment may improve the waiting experience for caregivers at the health facility.** Indeed, the reception of patients and caregivers in the centre seemed to play a key role. In a different assessment

women who were interviewed mentioned that this positive attitude is one of the motivations to return to the clinic. Specifically, respondents appreciated the fact that people who travelled far, or are very unwell, were given priority.

Whatever the reason, when a caregiver has a bad experience at the health centre they are much less likely to return in order to finish treatment for their child. In addition, they are much more likely to discourage other mothers from attending. Therefore whether it be through increasing the efficiency of the centre, ensuring polite behaviour towards all caregivers or ensuring good information is given to caregivers whilst they are waiting, staff should take all measures to ensure caregivers have a good experience.

Delivery of services

A lack of adherence to standard protocols by health facility staff were noticed during visits to centres and analysis of OTP reporting. For example, one assessment noted screening for oedema and general medical examination were not performed to newly admitted children. **A recurring theme is that critical information on the course of treatment was not provided to caregivers**, which meant they were not aware they should return the following week.¹⁹ Other assessments revealed that important messages such as advising against sharing, or mixing the RUTF with water were also missing. At the same time, several assessments reported a lack of systematic screening at the health centre. This included either children not being screened at all, or only being screen for MUAC and not weight-for-height. The IMAM protocol indicates that all children under-5 should be screened for malnutrition using both methods.

Although assessments largely reported limitations in the delivery of services the Nangahar assessment noted that there was good organisation and integration of IMAM services at the centre. All children under five were screened on entry to each facility, then referred to the respective service point. Furthermore, effective tracking and monitoring systems were put in place to prevent defaulting. All the beneficiary cards included contact details of caregivers with the village name. Interviews with CHWs revealed that caregivers are contacted when they miss visits and even followed up in their respective villages. To monitor RUTF use caregivers are requested to return the empty sachets for every additional distribution. Finally, every child who comes to the facility is offered other services including growth monitoring, infant and young child feeding messages and hygiene education.

Continuity of Services

Continuity of services at the health facility is important for achieving trust in the programme and ensuring the needs of beneficiaries are met in a timely manner. Nine of 18 assessment mentioned that gaps in services had a negative impact on coverage, while two only mentioned consistent RUTF supplies as a positive factor. Bearing in mind the numerous challenges caregivers face in terms of access to the health clinic, not receiving services could be extremely frustrating for caregivers and reduce the credibility of the programme.

RUTF or RUSF stock breaks have a negative impact on admission trends and immediate effect on coverage. Indeed, this was cited as a key reason for defaulting in a number assessments. Caregivers mentioned a constant uncertainty as to whether RUTF or RUSF will be available when returning to the clinic, leading to absenteeism and defaulting. Caregivers described their **lack of trust in the programme after making a hard journey to the clinic and being told to come back anytime between one to four months later due to RUTF or RUSF stock out.**

Box 4: RUTF/RUSF supply

Consistent RUTF/RUSF supply depends on a variety of factors, some of which is outside the control of the BPHS provider such as security conditions. However, adequate supply management at the programme level can tackle at least some of the reasons for stock breaks. The Helmand assessment noted that poor warehouse management and logistical problems contributed to limited RUTF supply. For example, limited space in lorries, late requests for supplies and lack of systematic orders result of insufficient stocks at the facility level. This suggest that more attention is needed at the programme management level to ensure consistent supply.

¹⁹ This information was triangulated with the high occurrence of defaulters after one visit.

Human resources for treatment services

Health worker quality varied from one health facility to another, reflecting different levels of training, supervision, support and capacity. Overall, 11 out of 19 assessments considered human resources as having an important effect on the success of the services.

All health workers dealing with IMAM should be trained as per the IMAM guidelines with follow up on-the-job sessions at the health facilities. **Lack of training on IMAM** was evident from documentation at the health facilities, as well as wrong admissions that were observed. **Turnover of staff was a major concern in other areas suggesting that an impact on the quality of services can be expected.** Refresher trainers and more emphasis on good quality on-the-job training should therefore be considered.

Support and supervision to health workers varies as well; **regular supervision of the OPD SAM services was reported in some cases**, with monthly supervision visits followed by feedback sessions. In line with other finding about distance, supervision was found to be inconsistent in remote and hard to reach areas, sometimes due to insecurity (for example in Khost Province).

Box 5: Training in IMAM

The Laghman assessment (SQUEAC) described some of the strategies used to strengthen the capacity of health staff in the programme. A training of trainers (ToT) was offered to the nutrition officer at the provincial nutrition department (PND) so he/she gains relevant knowledge and skills that would enable them to provide similar trainings and support to health workers at the health facilities. Regular supervision was also reported with monthly visits to the health clinic by the BPHS staff, to address challenges and introduce improvements.

As key actors in IMAM, CHWs capacity and the support they receive were also examined during assessments. One area that clearly requires attention is the lack of motivation described by CHWs themselves and others. **Lack of incentives or covering of basic costs such as transport and air-time were mentioned by some CHWs as reasons for not being able to fulfil their roles appropriately.** Others mentioned that the area they cover is too large (with between 800-1000 households reported in the Kandahar assessment whereas the community based health care guidelines specifies 100-150²⁰). It was also highlighted that trainings offered to CHWs are inadequate (in terms of quality and quantity), and that there is minimal supervision of CHWs by CHSs. This further limits CHW's ability to work effectively.

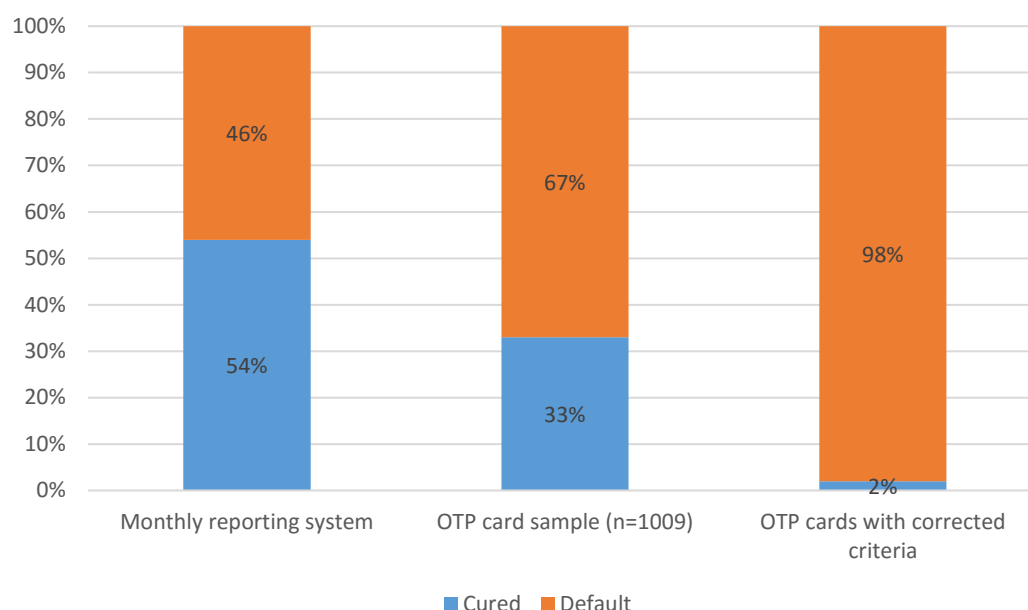
Monitoring and Information Systems

Coverage assessments provide an opportunity to analyse monitoring systems and to assess the quality of data. By analysing the OTP cards SQUEAC assessment teams²¹ were able to triangulate with the data provided in aggregated electronic data bases. This is typically the data reported on a national level. As shown above **we can see that discharge outcomes show unusually consistent defaulter rates.** In three (Helmand, Hazrat Sultan and Paktya) of the SQUEAC assessments a comparison was performed between an analysis of an OTP card sample and monthly reporting data. Figure 20 shows that in the case of Paktya although monthly reporting showed a cure rate of 54% and analysis of a significant sample (n=1009) of OTP cards discharged patients showed a cure rate of 33%. **This suggests that defaulter cases are being classified as cured when reported on a monthly basis.** Furthermore, reporting on the OTP cards themselves was also investigate and found that **most cases that were declared 'cured' in fact had not yet reached the discharge criteria**, and therefore should be classified as default. When these incorrectly discharged cases are accounted for we only have 2% cases who actually recovered before being discharged.

²⁰ Community-based Health Care Policy and Strategy (2009-2013) Islamic Republic of Afghanistan, Ministry of Health, (Dec, 2009)

²¹ Quantitative data analysis does not typically happen in SLEACs

Figure 20 Bar chart showing comparison between monthly reporting and OTP card reporting of defaulting and cure rates in Paktya Province (SQUEAC March 2015)



This demonstrates that reporting on the OTP cards (by clinic staff) and aggregation of OTP cards (typically by management staff) is unreliable and therefore requires attention. And we can safely say that defaulting is likely to be significantly under reported. This is not only a concern in terms of information but also in terms of the programme since the appropriate action will not be taken to ensure defaulting is reduced and cases complete the treatment.

The weak data management at both clinic and management level can be attributed to the weak training and supervision provided for nutrition activities. Data management should be central to the training and support provided to clinic staff.

9. WHAT NEEDS TO BE DONE TO IMPROVE THE PERFORMANCE OF SAM TREATMENT SERVICES?

The analysis represented in this document was presented and discussed during a learning workshop in Kabul on 2nd May 2016 (see Annex 4 for the agenda). During the workshop participants from a variety of organisations (government as well as financial and technical partners) identified specific challenges for action and came up with preliminary recommendations for the following areas:

- IMAM financing
- Supply
- Service delivery at community level
- Service delivery at facility level
- Human resources
- Physical access
- Information systems and reporting
- Governance and leadership

These were then further developed and are presented in the table below. In some cases they will be relevant for IMAM as a whole, in others they are specific to SAM treatment.

In terms of **IMAM financing** the recommendations focus on the inadequacy of current levels of financing and provide actions to ensure appropriate and consistent financing is provided. This includes a focus on increasing available funds for community mobilisation activities. For **supply**, actions are geared towards ensuring consistent and cost-effective ways of supplying RUTF and RUSF.

Actions for **service delivery** are **split into community and facility level**. At community level suggested activities focus on increasing sensitisation, screening and community engagement to ensure more widespread and earlier admission of malnourished children. At facility level, actions focus on improving the quality of care provided by facility staff. These are supported by actions to ensure better availability of appropriate and good quality staff, as well as consistent support and supervision.

Challenges relating to **physical access** are addressed with recommendations to increase the number of service delivery points through existing structures including the introduction of SAM treatment by CHWs from health posts. Recommendations for **information systems and reporting** are provided to improve the quality and availability of information on IMAM treatment. **Governance and leadership** is also addressed with recommendations that aim to improve the management and political ownership of IMAM treatment at a national as well as provincial level. Finally, two recommendations are provided in order ensure **the recommended actions are both further developed and utilised** to allow for a discernible impact on treatment services in Afghanistan.

The table also suggests those actors that should be responsible for each recommended action, as well as an indication of resources and a proposed timeframe. However the **Public Nutrition Department and the nutrition cluster with the support of ACF** should continue to develop the details, as well as the actions themselves, and monitor their implementation.

Area	Challenges		Recommended actions		Responsible actors	Resources required	Timeframe
1. IMAM Financing	1	Inadequate funding allocations for nutrition activities within BPHS (including preventative, supply, and staffing, and limited numbers of sites)	1.1	Include requirement to budget for SAM/MAM treatment in RFP (Request for Proposals)	GCMU to change RFP, BPHS providers to budget sufficiently, IMAM technical working group to support on costing	None	Before September 2016
	2	Lack of information and support for BPHS implementers on costing requirements for IMAM	1.2	Expedite costing exercises currently underway so that BPHS partners can budget for 2017	GCMU, UNICEF, GAIN, WFP and other partners	None	Before September 2016
	3	Poorly function CHW network - lack of supervision from CHS, low motivation	1.3	Integrate CHWs into payroll and budget for CHS supervision	GCMU to change RFP, BPHS providers to budget sufficiently	None	Before September 2016
	4	No budget for community mobilisation activities	1.4	Include allocation for community mobilisation activities see below) in BPHS budget	BPHS partners, nutrition partners to support on costing	None	Before September 2016
2. Supply	5	Stock breaks at district and facility level	2.1	Improve supply management including prompt re-stocking at facility and district level, and purchase of buffer stocks	BPHS partners and MoPH	Cost of buffer stock	Before September 2016
	6	Parallel supply chains for other drugs and RUTF/RUSF	2.2	Integrate RUTF/RUSF supply chain for BPHS to manage with support from other partners	BPHS partners, MoPH and nutrition partners	TBD by costing exercise	Before September 2017
	7	High cost of exporting internationally made RUTF/RUSF and supply chain challenges	2.3	Form working group to further investigate local production capabilities, building on WFP work and experience	WFP and additional partners	None	Before September 2016

3. Service delivery at community level	8	Low coverage of CHW network	3.1	Include in BPHS budget and recruit more CHWs and CHS to ensure 100% coverage as per CBHC guidelines* (150 HHs per health post)	MoPH and BPHS partners	Include in BPHS budget	Before September 2016
	9	Low motivation of CHWs	3.2	Increase supervision of CHWs by CHS	BPHS partners	finances for supervision visits to be budgeted by BPHS provider	2016
	10	Limited and ineffective community mobilisation for CMAM	3.3	Conduct evaluation of current community strategy including CHWs and FHAG	MoPH/PND and nutrition/health partners	Proposal to be developed and finances requested from donors	secure funding before the end of 2016 and implement in 2017
	11	Lack of communication and sensitisation strategy for CMAM	3.4	Revise community strategy to include evidenced based communication and sensitisation approach with tools and IEC materials	MoPH/PND and nutrition partners	Proposal to be developed and finances requested from donors	secure funding before the end of 2016 and implement in 2018
	12	Lack of information on which to build appropriate communication strategy	3.5	Conduct community assessments to identify communication channels, key influencers etc. to communication and sensitisation strategy for CMAM	MoPH/PND and nutrition partners	Proposal to be developed and finances requested from donors	secure funding before the end of 2016 and implement in 2019
	13	Lack of capacity in BPHS providers to develop locally specific community mobilisation plans	3.6	Train BPHS providers (CBHC officers and others) to conduct community assessments and adapt nation strategy to local context	MoPH/PND and nutrition partners	Proposal to be developed and finances requested from donors	secure funding before the end of 2016 and implement in 2020

	14	Restricted movements, low level of screening points and lack of engagement of key actors	3.7	Engage wide range of actors at community level (e.g. mullah, malik, pharmacy, community doctors, TBA) in screening and referral (equip with and train in MUAC measurements)	BPHS partner	None (train CHWs during routine visits to health centres). UNICEF to provide extra MUAC tapes	start before end of 2016 and continuously
			3.8	Train caregivers of SAM/MAM children to take MUAC measurements during visits to health facility and encourage to screen children in community. Give them a MUAC tape.	BPHS partner	None (train caregivers during visits to health centres). UNICEF to provide extra MUAC tapes	start before end of 2016 and continuously
	15	Lack of engagement with community structures and key figures	3.9	Train CHWs/CHS/CBHC to engage with existing community groups and key figures to raise awareness of SAM/MAM and services	BPHS partner	None (train CHWs during routine visits to health centres).	start before end of 2016 and continuously
	16	Lack of communication activities at local level	3.1	Engage mass media (e.g. radio) at local level to promote malnutrition and services	BPHS partner	Include in BPHS budget	2017
4. Service delivery at facility level	17	Weak sensitisation and information sharing with caregivers on treatment at facility level	4.1	Development of job aids to ensure each step is taken (protocol and information sharing)	BPHS/nutrition partners	Include as part of community mobilisation development	2017
	18	poor application of nutrition protocols by facility staff	4.2	Frequent refresher training and monitoring if treatment cards by BPHS Nutrition Officer	BPHS partner	Include training resources in BPHS budget	2017
	19	Inappropriate behaviour of staff	4.3	Include training on medical ethics and ensure all staff are kind and polite to all patients.	BPHS partner	Include training resources in BPHS budget	2017

			4.4	Ensure HF is organised to ensure efficient patient flow and dignified care. Including private (and calm) area for sensitisation.	BPHS partner	Include training resources in BPHS budget	2017
5. Human resources	20	No staff member in charge of nutrition at facility level and often only one staff member able to do nutrition services	5.1	Train one staff member to oversee all nutrition activities and train multiple staff members to do SAM/MAM treatment	BPHS partner	Include training resources in BPHS budget	2017 and on-going
	21	High turnover of staff results in low numbers of trained staff	5.2	Ensure all new staff are trained in SAM/MAM treatment	BPHS partner	Include training resources in BPHS budget	2017 and on-going
	22	Low levels of support and oversight of IMAM at management level	5.3	Increase capacity for supervision and support of IMAM services in facilities by budgeting for and recruiting a Nutrition Officer	GCMU and BPHS partners	Include in BPHS budget	2017
	23	Lack of or limited IMAM services in some districts	6.1	Increase number of treatment points. Include IMAM services at all CHC, BHC, Sub-centre, pharmacies and private doctors	BPHS providers	Include in BPHS budget (training, equipment and supplies)	2017
6. Physical access	24	Restricted access due to distance, cost of transport and insecurity	6.2	Investigate, pilot and advocate for treatment of SAM by CHWs	Nutrition partners	Proposal to be developed and finances requested from donors	Funding secured before the end of 2016
			6.3	Train CHWs and community actors to provide support to caregivers having difficulty getting to clinic	BPHS providers	Include in refresher training	2017

7. Information systems and reporting	25	Poor reporting at facility level	7.1	Ensure good understanding of protocols by staff with refresher trainings	BPHS providers	Cost of BPHS staff movements to CHC/BHC	Before June 2016
			7.2	Ensure on-going support and supervision from BPHS staff including checking treatment cards	BPHS providers	None	Start before September 2016 and on-going
			7.3	Develop data quality checklist and visual job aids	Nutrition partners	None	Before the end of September 2016
	26	Limited nutrition data in HMIS system	7.4	Advocate for the integration of nutrition reporting into HMIS and therefore expand indicators	Nutrition partners	None	
	27	Limited district level analysis and data use	7.5	Train BPHS partners to improve district level data analysis and use, beyond HMIS (such as admission: # of admissions, MUAC/W-H, median MUAC on admission and discharge: cure default, death, reason for default)	BPHS providers with nutrition partner support	Training costs	Secure funding before end of 2016
	28	Nutrition information (SMART data, NNSS data, routine data, coverage data) uncoordinated	7.6	Develop M&E Framework for Nutrition that integrates SMART, coverage and routine data, and investigate how NNSS can be linked	BPHS partners and nutrition cluster	None	On-going

8. Governance and leadership	29	Limited coordination and support between PNO and BPHS partner	8.1	BPHS partner staff (Nutrition Officer and others) to work closely with PNO to ensure continuity (supply) and quality of IMAM care	BPHS and PNO	Budget for Nutrition Officer in BPHS	Fro June 2016 and on-going
	30	National level leadership needed to force change	8.2	MoPH and PND to take leadership role in ensuring change to SEHAT and BPHS to allow inclusion of this action plan	MoPH and PND	None	immediately and on-going
	31	Lack of transparency over funding allocation and BPHS partnerships	8.3	Publish rational for decisions and ensure minimum standards, allocation and quality are ensured as well as cost effectiveness	GCMU, MoPH and PND	None	as part of current BPHS funding process
	32	BPHS guidelines do not allow for and support adequate resources (HR, financial, supply) for treatment of SAM and MAM	8.4	Advocate for sufficient allocation of resources and integration of SAM and MAM treatment in the BPHS package	PND/MoPH, donors and nutrition partners	None	immediately and on-going
9. Action Plan	33	Need for custodians of action plan to ensure continued development and implementation	9.1	IMAM technical working group to further develop action points and ensure continuation of them	IMAM technical working group	None	Before the end of May 2016
			9.2	ACF and nutrition cluster coordinator to monitor and follow-up on all action points	ACF and Nutrition Cluster Coordinator	None	immediately and on-going

*Community Based Health Care Policy and Strategy

10. ANNEXES

Annex 1 Prevalence rates from ACF SMART data 2016

Province	Sample	frequency	Point Estimate	SE	Low	Upper
Helmand	1157	37	3.2%	0.01	2.2%	4.2%
Khost	1225	39	3.2%	0.01	2.2%	4.2%
Nangarhar	704	7	1.0%	0.01	0.3%	1.7%
Kandahar	1111	69	6.2%	0.01	4.8%	7.6%
Kunar	1185	48	4.1%	0.01	2.9%	5.2%
Nuristan	759	66	8.7%	0.02	6.7%	10.7%
Paktika	913	30	3.3%	0.01	2.1%	4.4%
Paktya	1133	27	2.4%	0.01	1.5%	3.3%
Ghor (RNA - Alayar)	471	41	8.7%	0.03	6.2%	11.3%
Laghman	925	53	5.7%	0.01	4.2%	7.2%
KIS (RNA)	375	22	5.9%	0.02	3.5%	8.2%
Ghor (RNA-Maidan)	472	42	8.9%	0.03	6.3%	11.5%
Khost (RNA-Gulat camp)	752	65	8.6%	0.02	6.6%	10.7%
Helmand (RNA)	481	19	4.0%	0.02	2.2%	5.7%
Panjsheer (RNA)	495	49	9.9%	0.03	7.3%	12.5%
Balkh	475	12	2.5%	0.01	1.1%	3.9%
Ghazni	946	70	7.4%	0.02	5.7%	9.1%
Total	13579	696	5.1%	0.00	4.8%	5.5%

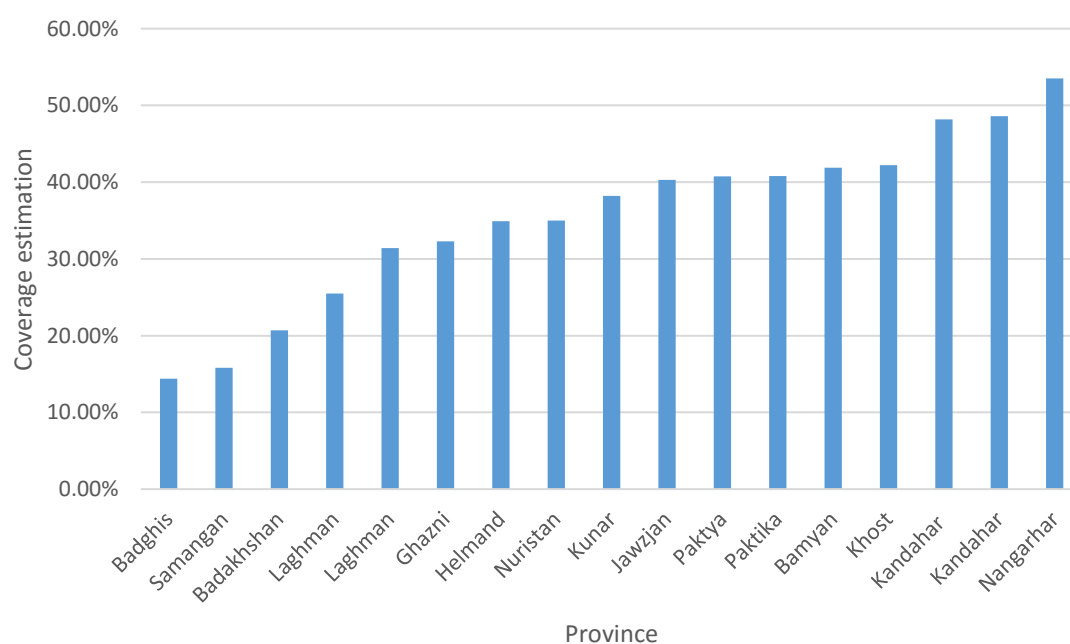
Annex 2 Single coverage explanation

All coverage estimates here are using the single coverage method. This is currently the most reliable estimator since it reflects coverage achieved by retaining cases. By including recovering cases (cases that are no longer SAM but have not yet reached the discharge criteria) and estimating recovering cases that are not being treated, we can more accurately estimate the coverage of services. The method and formulas are explained in Myatt, M et al, (2015).

District	Province	Organisation	Date	SQUEAC /SLEAC	Single Coverage Estimate
Mitherlam, Qargayi, Alingar, Alishing and Dawlat Shah	Laghman	SCA	Sep-15	SLEAC	31.40%
Darwaz, Darwaz-e-Bala, Shiki, Kof Ab, Shignan, Fayzabad, Yaftali Sufla, Shahri Buzurg, Argo, Darayem, Khash, Jurm, Baharak, Tishkan, Shuhada, Ishkeshim and Wardak	Badakhshan	CAF/AKHS	Oct-15	SLEAC	20.70%
Bamyan, Shebar, Yakawlang, Sayghan, Panjab and Waras	Bamyan	Move/Baran	Nov-15	SLEAC	41.90%
Qala-e-Naw and Qadis	Badghis	Move	Dec-15	SLEAC	14.40%
Sheberghan, Khwaja Doh, Aqcha, Fayzabad and Khaniqa	Jawzjan	Save the Children	Nov-15	SLEAC	40.30%
Hazrat Sultan	Samangan	AADA	Nov-14	SQUEAC	15.79%

Gardez, Ahmadaba and Chamkani	Paktya	HN-TPO/ACTD	Mar-15	SQUEAC	40.74%
Laskargah, Nad-Ali and Nawa-e-Barakzaye	Helmand	ACTD	May-15	SQUEAC	34.90%
Kandahar City	Kandahar	Medair	May-15	SQUEAC	48.20%
Kandahar City, Damaan and Speen Boldak	Kandahar	SCI	May-15	SQUEAC	48.60%
Chawkay	Kunar	PU-AMI	Mar-15	SQUEAC	38.20%
Qara Bagh,Deh Yak, Zanakhan	Ghazni		Dec-15	SQUEAC	32.30%
Kama, Beshud and Jalalabad	Nangarhar	SCUK	Apr-15	SQUEAC	53.52%
Mattoon, Gurbuz, Tani,Mandozai, and Nadershakot	Khost	OHPM	Aug-15	SQUEAC	42.20%
Yousaf khail, Meast, Mata khan, Sarhawza, Sultani	Paktika	OHPM	Aug-15	SQUEAC	40.80%
Mehtalam and Qarghayi	Laghman	SCA	Jan-16	SQUEAC	25.50%
Paroon	Nuristan	IMC	Sep-15	SQUEAC	35%
Balkh, Wazir Abad, Charbolak, Dehdadi, Noor khuda, langar-khana, Aq-koprak, Khulm, kaldar, Chorkent	Balkh	ACF	Aug-15	SQUEAC	
Chagcharan, Shahrak, Lal wa Sarjangal, Dolaina	Ghor	ACF	Aug-15	SQUEAC	

Coverage estimates presented in a bar chart



Annex 3 Bibliography

- Myatt, M et al, (2015) A single coverage estimator for use in SQUEAC, SLEAC, and other CMAM coverage assessments, p.81 Field Exchange 49

- Integrated Guidelines for the Management of Acute Malnutrition, Ministry of Public Health/Public Nutrition Department (2014)
- 'AFGHANISTAN - Prevalence of Wasting, NNS 2013 Summary'. UNICEF
- 2013 National Nutrition Survey, Afghanistan
- A Basic Package of Health Services for Afghanistan – (2010/1389) Islamic Republic of Afghanistan, Ministry of Public Health
- M Myatt et al 2012 Semi-Quantitative Evaluation of Access and Coverage (SQUEAC)/Simplified Lot Quality Assurance Sampling Evaluation of Access and Coverage (SLEAC) Technical Reference. Washington, DC: FHI 360/FANTA
- OCHA Afghanistan Humanitarian Response Plan 2016
- Community-based Health Care Policy and Strategy (2009-2013) Islamic Republic of Afghanistan, Ministry of Health, (Dec, 2009)

Annex 4 Coverage Learning Workshop Agenda:

Date: 2nd May 2016

Location: UN OCHA, Kabul

Principle objective: To contribute to improved access and uptake of IMAM services in Afghanistan.

Objectives:

1. Share analysis of coverage assessments and current state of SAM treatment in Afghanistan and collectively outline key challenges
2. Share experiences, best practices and lessons on SAM treatment services in Afghanistan
3. Develop key actions and set clear way forward to improve coverage and quality of SAM treatment

TIME	TOPIC	LEAD
0800-0830	Prayer, welcoming, introductions and outline of agenda and objectives	PND/ACF
0830-0900	State of SAM services in Afghanistan	UNICEF/ACF
0900-0930	Afghanistan country profile: including mapping of coverage assessments, overview of trends in programme data.	ACF
0930-0955	An analysis and factors influencing coverage	ACF
0955-1000	Introduction: shared experiences, lessons learnt, and best practices on SAM treatment services	ACF to facilitate
1000-1020	Save the children	Save the Children
1020-1040	IMC - Nuristan	IMC
1040-1100	Break	
1100-1120	AKHF- Badakshan	AKHF
1120-1140	Medair - Kandahar	Medair
1140-1200	Plenary session on partner presentations and additional experiences from participants	ACF to facilitate
1200-1300	Lunch	

1300-1315	Introduction of Group work: forming the groups and briefing	ACF to facilitate
1315-1415	Identifying specific challenges and improvements needed and develop actions, identify those responsible for, resources needed and timeframe required.	All participants
1415-1445	Review of group work followed by feedback and discussion	All participants
1445-1455	Conclusion	UNICEF
1455-1500	Thank yous and closure speech	PND