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ASSESSMENT OF TARGETED SUPPLEMENTARY FOOD PROGRAM FOR THE TREATMENT OF CHILDREN WITH MODERATE ACUTE MALNUTRITION IN SHASHEMENE ZURIA DISTRICT, OROMIA REGION, ETHIOPIA

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DEPARTMENT OF APPLIED HUMAN NUTRITION

Msc Thesis On:

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By

Olika Tefera Hordofa

A Thesis submitted to Bahir Dar Institute of Technology, Faculty of Chemical and Food Engineering, Department of Applied Human Nutritionfor the Partial Fulfillment of Requirements of Master of Science.

Advisor: D/r Firehiwot Mesfin (PhD.)

JANUARY, 2024

BAHIR DAR, ETHIOPIA

DECLARATION

This is to certify that the thesis entitled "**Assessment of Targeted Supplementary Food Program for the Treatment of Children with Moderate Acute Malnutrition in Shashemene Zuria District, Oromia Region, Ethiopia"** submitted in partial fulfillment of the requirements for the degree of Master of Science in applied human nutrition under faculty of chemical and food engineering Bahir Dar Institute of Technology, is a record of original work carried out by me and has never been submitted to this or any other institution to get any other degree or certifies. The assistance and help I received during the course of this investigation have been duly acknowledged.

Olika Tefera		January 2024
Name of student	Signature	Date

APPROVAL SHEET

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Approval of thesis for defense result

I hereby confirm that the changes required by the examiners have been carried out and incorporated in the final thesis. Name of student **Olika Tefera** Signature Date January 2024. As member of the board of examiners, we examined this thesis entitled "Assessment of Targeted Supplementary Food Program for the Treatment of Children with Moderate Acute Malnutrition in Shashemene Zuria District, Oromia Region, Ethiopia". We hereby certify that the thesis is accepted for fulfilling the requirements for the award of the degree of Masters of Science in **Applied Human Nutrition.**

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Abbreviations and Acronyms

CMAM	Community-based Management of Acute Malnutrition
CSB++	Corn Soya Blend Plus Plus (Super cereal plus)
DRM	Disaster Risk Management
FMoH	Federal Ministry of Health
F-70	Formula 70 milk
GAM	Global Acute Malnutrition
HEW	Health Extension Workers
HP	Health Post
HC	Health Center
MAM	Moderate Acute Malnutrition
OTP	Outpatient Therapeutic Feeding Program
RUSF	Ready to Use Supplementary Food
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
TSFP	Targeted Supplementary Food Program
WFP	World Food Program

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Abstract

Background. Targeted supplementary food program is a nutrition intervention program to manage moderate acute malnutrition among a children aged 6-59 months. Although there have been an enormous efforts made in implementation of targeted supplementary food program, only little improvements are seen and the burden of child acute malnutrition is still significant in Ethiopia. This study's findings aid valuable information to the implementers in effectively managing acute child malnutrition.

Objective: To assess targeted supplementary food program in Shashemene zuria district, Oromia region, Ethiopia.

Methods: A formativeresearch method was undertaken in Shashemene zuria district, Oromia region, Ethiopia. The study involved 41 participants that were selected based on purposive sampling system. The data was collected through key informant interview (KII) and focus group discussion (FGD). Audio recording was taken for each interview, transcribed to verbatim and then translated to English language from Afan Oromo. A thematic analysiswas conducted for the analysis process using ATLAS.ti 23 software.

Results: This study identified themes that could affect the running of targeted supplementary food program in Shashemene Zuria district. Among them good community mobilization and awareness creation activities, routine screening and admission, accessible program services were the good side of the program while weak monitoring and evaluation, weak coordination, inadequate and intermittent supply and workload and working environments inconvenience were those negatively affecting the program.

Conclusion: The program is playing an important role in treating moderate malnutrition in children under five but faces shortcomings in coordination, monitoring, food supplies, and inconvenient working environments.

Recommendation: Stakeholders must collaborate to implement the program effectively. Addressing food supply issues and working environments is crucial. Regular monitoring and evaluations are necessary for better understanding and implementation.

1. Introduction

1.1.Background:

Undernutrition has persistently remained one of the greatest public health threats in the world for developing countries (Yayo Negasi, 2021). The burden of malnutrition across the world remains unacceptably high, and progress is unacceptably slow. Malnutrition is responsible for more ill health than any other cause. Globally, children under five years of age face multiple burdens: 150.8 million (22.2%) are stunted, 50.5 million (7.5%) are wasted, and millions of women are still underweight(Fanzo et al., 2019). The prevalence of child undernutrition in Ethiopia, despite recent economic progress, is among the worst in the world, and it remains a major public health problem. According to the mini-2019 Ethiopian Demographic and Health Survey (EDHS) report, 7.2% of children were wasted and 21.1% were underweight at country level. Somalia and the Afar region registered the highest prevalence of child wasting (21% and 14%, respectively), and both 31.7% of children were underweight(Indicators, 2019).

In Ethiopia, the targeted supplementary food program (TSFP) was developed in 2004 as a 'stop-gap' measure to prevent additional millions of Ethiopian children from dying or becoming malnourished in the meantime(Neitzel, 2011). According to the information in this article, the targeted supplementary food program replaced the provision of blanket supplementary food rations alongside the general relief food distribution. The rationale for a more targeted approach was to better respond to the needs of malnourished individuals at a critical physical and mental development stage in their lives and to ensure better targeting than a blanket distribution.

The absence of a national nutrition surveillance system and weight gain monitoring, the inclusion of many children who are actually not malnourished (46% of the surveyed group), the fact that FDA nutrition education sessions were not implemented at all food distributions and some mothers missed nutrition education as husbands were sent to collect food, the conduct of nutrition education only at distribution session sites, inadequate regional food transport tendering processes, and delayed communication on screening results were some of the identified challenges to the TSF program(Neitzel, 2011).

The Targeted Supplementary Food Program (TSFP) is a nutrition intervention program that provides nutritious food for acutely nutritionally affected individuals, targeting a population group of children aged 6–59 months and pregnant or lactating women (Government of Ethiopia, 2019). Eligible individuals are selected based on anthropometric measurements such as MUAC and weight for age. The program supports those identified as moderately malnourished or that meet the admission criteria, such as: no bilateral pitting oedema; no medical complications; clinically well and alert for children 6–59 months; and MUAC 23.0 cm for pregnant women and lactating women.

The TSF program provides two types of nutritious food supplies: RUSF (ready-to-use supplementary food) for children and CSB++ (super cereal plus) for pregnant and lactating women (Government of Ethiopia, 2019). The provision of food is on a twice-a-month or biweekly basis. According to the national guideline for management of acute malnutrition in Ethiopia, children get 3kg of RUSF and pregnant and lactating mothers get 7.5 kg of CSB++, or Super Cereal Plus, per month. The beneficiaries can stay in the program for up to four months, with a subsequent biweekly ration entitlement.

1.2.Statement of the Problem

The government of Ethiopia is spending a higher amount of money to treat acute malnutrition in children. Ineffective multi-sectoral coordination of nutrition, a lack of accountability among leaders and core actors, and a sense of regard for nutrition as a supplementary activity are among the identified barriers to the implementation of nutrition interventions(Ayele et al., 2020).

According to the study made in Ethiopia in 2020 (Laillou et al., 2020)the impact of wasting alone on the national economy of Ethiopia is estimated to be 225.5 million USD per year. The highest contributor to the economic burden is the cost of supplies and human resources to treat wasting (100 million a year, with the 2019 number of children treated). This represents 44.4–65.9% of the total burden. The second-highest contributor to the economic burden is the loss of the workforce due to child mortality. Presuming an entry into the workforce at an average age of 15 years, the total economic losses from child deaths are approximately 79 million USD, representing 35.2% of the total burden. The economic loss is in both the cost of treating the case and the decreased work force. The study testified that this condition is occurring with an increased reach of therapeutic and supplementary feeding interventions.

In Ethiopia, yet in the districts of implementation, the TSF has failed to reach 40% of the needy children, implying gross under coverage problems (Gebremedhin et al., 2018). The study discussed that low community coverage for screening for malnutrition and MUAC measurement errors have led to high exclusion errors. The majority of exclusion errors are committed due to the low coverage of the nutritional screening activity during the CHD. Conversely, systematic errors in MUAC measurement skewed toward overestimation of malnutrition have led to inclusion errors, which may have a high impact on supply shortfalls.

The sharing of RUF (ready-to-use) products with other family members and/or selling as market commodity, or disliking the taste of the product were significant problems contributing to poor adherence to supplementary food program implementation in Ethiopia (Ersino et al., 2018). This study by Ersino et al. indicated that there was a significant sharing of CSB flour with other family members compared to the RUSF product (PlumpySup). Since RUFs are packaged based on the nutritional needs of

targeted children, the unintended use (such as sharing and selling) of these products decreases the quantity available for the intended child, leading to an increased risk of morbidity and mortality(Ersino et al., 2018). Unlike the CSB, the study has noted that RUF were shared mostly among children 5 years old within the same family.

On the other hand, the study done in Sudan revealed that increased targeted supplementary food program coverage has the potential to further reduce at-risk prevalence, which could lead to a demonstrable effect on the prevalence of moderate acute malnutrition(Abdelsalam et al., 2018).

A targeted supplementary food program has been implemented in full in the Shashemene Zuria district for nearly two decades. However, there is limited evidence on the targeted supplementary food program in the district to identify the existing barriers and facilitators to the program's implementation. As the program is intended to improve the nutritional status of children aged 6–59 months, it must be implemented effectively in a way that meets its guidelines, and therefore the study identified the potential barriers and facilitators in the implementation of a targeted supplementary food program in the district. In an outcome evaluation study of the targeted supplementary food (TSF) program done in Ethiopia, it was stated that the effectiveness of the TSF program was evaluated by comparing between the intervention and control groups the mean change in indicators of nutritional status, including the mean change in weight for height z-score, mean weight gain, and mean change in MUAC, from baseline to each of the three monthly follow-up visits(Skau et al., 2009).

Therefore, the purpose of this study was to fill the gaps by assessing the implementation status of targeted supplementary food program, as well as, it added intervention to improve the program in Shashemene zuria district, Oromia region,Ethiopia.

2. The Study Objective

2.1.General Objective

The main objective of the study was to assess the targeted supplementary food program for the treatment of children with moderate acute malnutrition in Shashemene Zuria district, West Arsi Zone, Oromia region, Ethiopia.

2.2.Specific Objectives

The specific objectives of the study were:

1. To assess how the program's service is being conducted in actual practice towards achieving targeted supplementary feeding program objectives and
2. To identify the potential implementation gaps and the areas where the program's service needs to be improved.

3. Significance of the Study

Shashemene Zuria district is one of the areas involved in targeted supplementary food program intervention by the government of Ethiopia and donating partners, as the district has a high prevalence of acute child malnutrition (Endale et al., 2021). This study done by Endale et al. on the Shashemene Zuria district revealed that the prevalence of child acute malnutrition accounts for 19.91%, which is high as compared to other findings in Ethiopia (Endale et al., 2021). TSFP implementation is prioritized for areas or populations of highest vulnerability according to several criteria, including a GAM rate of greater than 10%, and may be seasonal (McGrath & Shoham, 2019).

Health services for moderate acute malnutrition and severe acute malnutrition are routinely given in the district with a continuous supply of treatment commodities like CSB++, RUSF, RUTF, and Formula-70 milk. However, acute malnutrition among children never shows fast progress from its trend, and the number of cases is still a challenge in the district.

Appropriate utilization of targeted supplementary food programs is a key factor in reducing acute malnutrition caseloads among children and improving nutritional status. Understanding the significance of the best implementation of TSFP in the management of acute malnutrition would help in designing appropriate interventions and strategies. Assessing the implementation status of the program is a key activity to identify the potential barriers and facilitators that will enable good implementation to be encouraged and poor implementation to be corrected, and to minimize the resulted cost of intervention as well as children's suffering from severe acute malnutrition.

Therefore, the findings of this study will provide information to the district, zonal, and regional health offices and bureaus to effectively and significantly manage acute child malnutrition. Furthermore, it will enable the local decision-makers to take appropriate measures to address the situation of child acute malnutrition and target supplementary food program services. It may also give researchers clues to conduct further studies.

4. Literature Review

In humanitarian crises, supplementary feeding is considered as the main intervention strategy for preventing and treating moderate acute malnutrition. According to the Sphere guidelines (Ouyang et al., 2009), it recommends targeted supplementary feeding programs for treating moderate acute malnutrition and preventing severe acute malnutrition.

A targeted supplementary food program helps to manage moderate acute malnutrition when a supplementary ration is targeted to individuals with MAM in specific vulnerable groups. The vulnerable groups usually include children aged 6–59 months and pregnant and lactating women with infants under 6 months of age who have MAM (Government of Ethiopia, 2019). The program also aims to reduce the risk of child mortality and, through an awareness-raising component, aspires to enhance the basic nutrition knowledge of mothers and other women in communities targeted by TSF. The guideline states that specific anthropometric criteria are used to determine those admitted and discharged from treatment.

To reduce child undernutrition, Ethiopia has been implementing different nutrition programs with some success. Nationally, child undernutrition has shown a reduction between 2005 and 2019, with wasting reduced from 12% to 7.2% and underweight reduced from 33% to 21%(Mini & Demographic, 2019; Muluye & Wencheko, 2012). This is an indication that a lot of efforts have been made by the government to reduce child undernutrition.

4.1.Coordination and Engagement in the Program Implementation

In nutrition interventions in Ethiopia, multi-sectoral coordination of nutrition has largely been ineffective(Ayele et al., 2020). The study done by Ayele et al., revealed a lack of accountability among nutrition leaders, core actors, and implementers as they jointly developed programs and action plans at federal and regional levels, but there was no legal mechanism to make implementers accountable. Many, including powerful members of the national nutrition coordination body (NNCB) and national nutrition coordination technical committee (NNTC), still regard nutrition as a supplementary activity and hence do not fully engage in program design, mainstreaming, and implementation.

The scoping review study made in Africa to identify the barriers and facilitators to the implementation of large-scale nutrition interventions (Ezezika et al., 2021b)revealed that inadequate stakeholder engagement occurs when issues such as competing agendas and a lack of stakeholder attention to malnutrition often impede implementation efforts. Poor communication among stakeholders, ineffective coordination, and unsupportive leadership were all factors shown to interfere with effective stakeholder engagement. Furthermore, the idea of multi-sectoral coordination often involves collaboration between different government ministries and organizations. Inefficient multi-sectoral coordination was then mentioned as an obstruction to implementing nutrition interventions, where the absence of effective multi-sectoral strategies prevented sectors from taking responsibility for nutrition planning. The lack of a feasible implementation plan contributes to disorganization across all sectors and the absence of program monitoring, the study stated.

In addition, apart from TSFPs, many other types of support may be offered to families of moderately malnourished children, such as nutrition counseling or household targeted support, e.g., social protection and livelihood support (Brown et al., 2019). Very little information is available on the nature and caseload coverage of such support and the degree to which they are meeting the needs of these children (McGrath & Shoham, 2019). This partly reflects a lack of clarity regarding whose responsibility it is to ensure and track this provision, as well as the multiple agencies that may be involved in implementing this provision across humanitarian and development settings.

4.2.Program Monitoring and Evaluation

According to the study done by Ezezika et al., a lack of established monitoring or evaluation systems and an absence of accountability for program targets were often identified as key barriers.

(Ezezika et al., 2021b).Logistical and methodological issues related to the lack of data availability and accessibility were also a problem for the program's implementation. Inability to pilot data reporting systems, lack of follow-up, and lack of nutrition indicators were also outlined. Furthermore, insufficient implementer knowledge related to appropriate storage practices and inventory management for food-based interventions was highlighted as a barrier in the study. In addition to the study done in Timor-Leste,

(Southeast Asian nation), Sahel region of Africa, including Chad, Mali, Niger, and Sudan, testified that irregular monitoring and supervision, as well as evaluation of data, were among the major challenges and barriers to ensuring adequate program output and outcomes (Heirman et al., 2019; Soriano, 2018) .

According to a predetermined plan, through the empowerment of all owned resources, both human resources and funding, evaluation is necessary to determine program effectiveness (Suryani et al., 2021). In this study by Suryani et al., it is stated that if the results of the program evaluation show that there are things in the program that need to be changed, then the decision makers should take them seriously to avoid failure and achieve the desired goals.

Availability and continuity of information and data at the national and sub-national level help plan for delivery, but many challenges are appearing around continuity and availability of harmonized data(McGrath & Shoham, 2019). Data collection and transparent data sharing are critical to tracking progress, sharing lessons, and adapting strategies as needed, and the collected data must be used to inform change(Bach et al., 2020). According to the study, there is a recognition that data may be controversial, and several government representatives were hesitant to share specific outcome data, which may result in differing government and partner data.

4.3.Coverage and Accessibility

An evaluation study done in the Sahel region of Africa (Heirman et al., 2019)including Chad, Mali, Niger, and Sudan, identified that infrastructure deficits to achieve better coverage and access were problematic for greater monitoring support and the collection and use of data.

Again in another study done in south Sudan (Juba, 2020)identified that poor infrastructure (including roads, shelters in health facilities, and storage facilities for supplies), insecurity, and the limited capacity of health workers and community nutrition volunteers (CNVs) were among the prominent barriers to implementing TSFP and other nutrition intervention programs effectively.

The bottleneck analysis (BNA) study done in Somaliland showed that geographic coverage was found to be good and above the national standard of >70% for MAM services (Ntambi et al., 2019). This level of geographic coverage in Somaliland could be

attributed to the effective integration of the two programs between MAM and SAM management. However, outreach coverage was suboptimal compared to the cut-off (70%) due to the fact that only 44% of volunteers were trained on TSFP to conduct the outreach activities.

In the recent insecurity development in the northern part of Ethiopia, OCHA revealed in its situational update in early January 2022 that a shortage of nutrition supplies due to problems like accessibility issues, damaged infrastructure, and the limited presence of partners was a difficult challenge besides the many complicated funding constraints to support both targeted and blanket supplementary food programs. (OCHA, 2022).

Also targeting errors are often committed in the TSF program of Ethiopia (Gebremedhin et al., 2018). Low community coverage of screening for malnutrition and MUAC measurement errors have also led to high exclusion errors. Conversely, systematic errors in MUAC measurement skewed toward overestimation of malnutrition might have caused inclusion errors. The study found 17% and 40% inclusion and exclusion errors, respectively. Health workers may sometimes decide to enroll marginally normal children into the TSF with the notion of avoiding imminent growth faltering, or a few front-line health workers might dishonestly enroll the non-needy to illegitimately benefit the household or the community.

4.4.Community Mobilization and Nutrition Counselling

Less awareness of the community about the availability of service and quality was problematic, as identified by the study done in the Sahel region of Africa (Mali, Niger, Sudan, and Chad), and hence communication with target groups, effectiveness of case-finding, and community sensitization, all of which may improve targeting, efficiencies, and effectiveness of MAM treatment and prevention programs, was a key recommendation point forwarded by the study (Heirman et al., 2019).

Poor application of nutrition counseling messages at home was a challenge for improving the nutritional status of children and pregnant and lactating women in targeted supplementary food programs. (Soriano, 2018).The provision of foods together with nutrition education has shown a greater impact on child weight gain and growth than either intervention alone or fortifying or increasing the energy density of children's usual diets(Teta et al., 2022). According to this study by Teta et al., a behavior change

communication component delivered through group discussions and individual household visits reinforced the appropriate use of nutritious foods for child feeding.

In a study done in South Sudan to identify the pathways, opportunities, and approaches for horizontal and vertical scaling up of CMAM programs, it was identified that community mobilization activities in South Sudan have emphasized the therapeutic properties of RUTFs(Renzaho et al., 2022). That is, in addition to having attractive packaging, the messages have predominantly focused on RUTFs having a good taste, being nutritious, being a ready-to-use product, and being easy to carry about with ease. Due to effective community communication and advocacy about RUTFs, and through experience sharing and counseling by mother support groups and community nutrition volunteers, community members at large have accepted the product.

In addition to community mobilization and nutritional counseling, clear communication with the child caregivers is critical to improving the effectiveness of the program. Occasions such as diarrhea episodes in children as a result of poor hygiene and early introduction of liquid substances other than breastmilk to young children, poor complementary infant feeding, and more under-fives per mother due to limited knowledge of family planning methods all produce stunting and wasting in young children (Fadare et al., 2019). The study justifies this as more children, particularly under five children, per mother tend to increase intra-household competition for childcare resources such that a child is denied adequate nutritional care.

4.5.Human Resource and Capacity

An adequate workforce, both in number and competency, is critical to the effective implementation of the nutrition policies set forth by a national government (Bach et al., 2020). In order to create greater buy-in and accountability for nutrition, frontline workers need to be better trained and mobilized. Regional and local offices must play an active role in mobilizing these frontline workers, who mainly consist of health extension workers. Although these extension workforces remain robust, several stakeholders, including the international food policy research institute, noted the challenge of significant worker turnover due to remote placement, limited pay, inadequate training, and poor career development opportunities, the study revealed.

4.6.Supplies

Sometimes a food supply shortfall report is a problem for targeted supplementary food program implementation, which impacts the quality of programming and child outcomes, such as increased default rates and slower recovery due to reduced supply (McGrath & Shoham, 2019). According to this study by McGrath & Shoham, factors contributing to this food supply shortfall included limited availability of supplies, weak supply-chain management at multiple levels, poor communication between suppliers and facilities, lack of access due to insecurity, and inadequate reporting.

Stock-outs of commodities were found to be a common bottleneck in TSF program components in Puntland(Ntambi et al., 2019). Only 12% of TSFPs did not experience stock-outs of treatment commodities.

Furthermore, sharing of the supplementary foods at home other than for specific beneficiaries was among the identified significant challenges in the implementation of the targeted supplementary food program, which may have been exacerbated by the high level of food insecurity at the study sites during the follow-up period(Skau et al., 2009). The study discussed that the TSF ration of 1,378 kcal per person per day is much larger than the ration used by many other supplementary feeding programs. It was originally calculated, recognizing that substantial intra-household food sharing would occur. Nonetheless, this study's evidence indicates that the degree of sharing has overcome this compensatory calculation. In addition, the inclusion of non-malnourished children in the TSF program may provide a benefit to individual children, but it decreases the overall nutritional effect of the TSF program(Skau et al., 2009). Not only does it diminish the program's apparent effect, but it also expends valuable program resources on those children who derive the least nutritional benefit from participation in the TSF program.

Therefore, the purpose of this study is to identify the facilitators and barriers to the implementation of a targeted supplementary food program for the treatment of children with acute malnutrition in Shashemene Zuria district, Oromia region, Ethiopia.

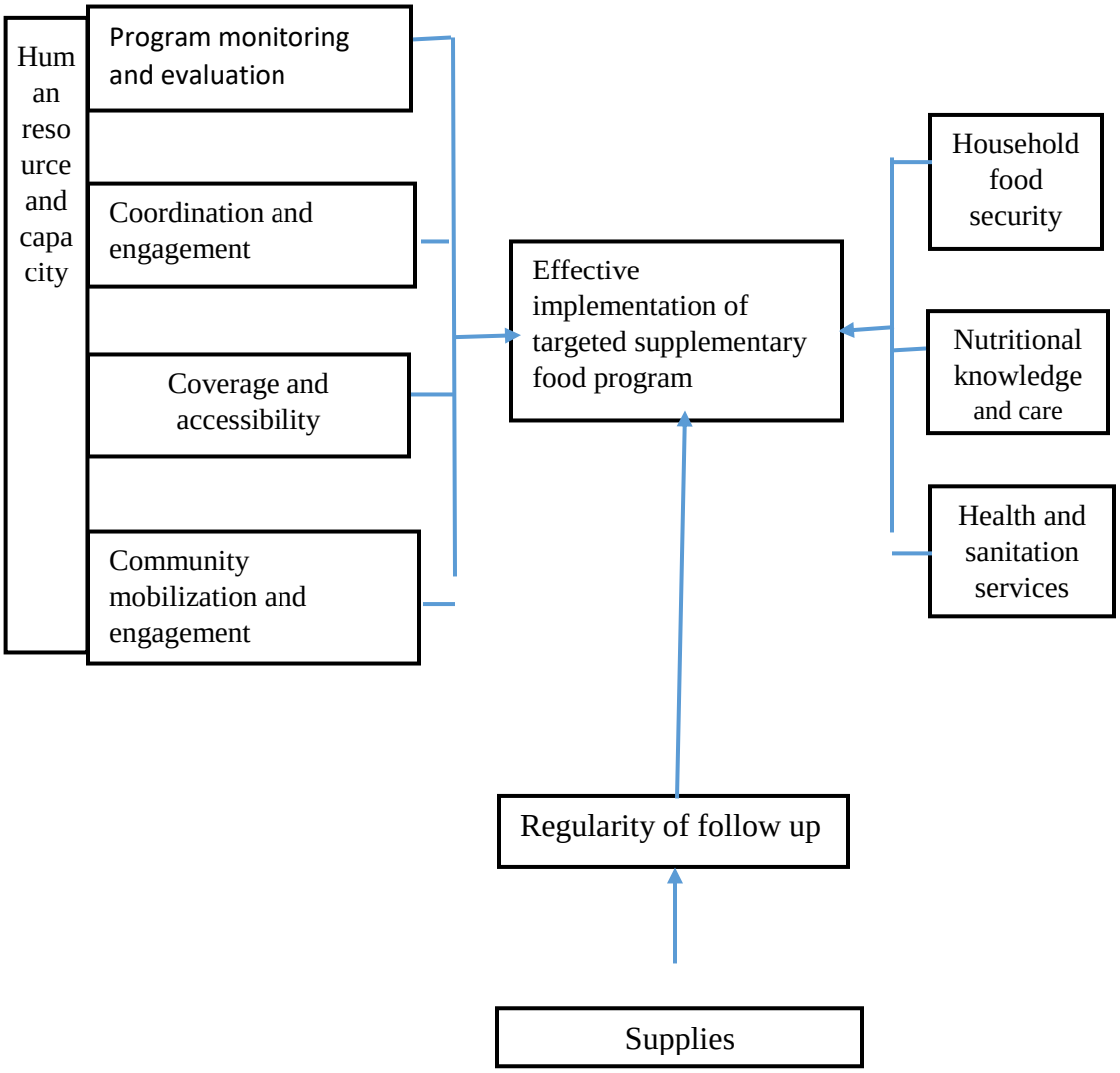

Figure 2.1: This conceptual framework is constructed depending on the factors affecting the TSF program that are discussed under the topic of literature review.

5. Methods

5.1.Study Area, Design and Period

A formativestudy was conducted to assess the targeted supplementary food program for the treatment of children with moderate acute malnutrition in Shashemene Zuria district from February 25, 2023 to March 17, 2023. Shashemene Zuria district is found in the west Arsi zone of the Oromia region of Ethiopia and is located about 254 kilometers away from Addis Ababa, the capital city of Ethiopia, in the southeast direction. A total population of about 242,980 lives in the district. Among these, children aged 6–59 months are estimated to number 39,925. The district consists of 28 rural Kebeles (the bottom administrative structure) and has 7 health centers and 29 health posts.

Shashemene Zuria district has 29(twenty-nine) health posts, and the targeted supplementary food program was on implementation in all health posts with the help of WFP. Recently, the district's health office took all responsibility for requesting and receiving nutritious food supplies, food storage and handling at health posts, food distribution, reporting, beneficiary screening, and admission. However, some activities related to nutritious food supply and management were previously controlled by the district's disaster risk management office(Government of Ethiopia, 2019).

The climatic condition of Shashemene Zuria district is 51.4% lowland, 27% midland, and 21.6% highland. Its altitude ranges between 1,500 and 2,300 meters above sea level. Agricultural activities are the predominant way of livelihood for the majority of populations in the district, and the main crops and products are maize, teff, wheat, barley, haricot beans, fruits and vegetables, and animal husbandry.

5.2.Source and Study Population

To assess targeted supplementary feeding program in the Shashemene Zuria district from different perspectives, KII interviews were conducted with different implementers and stakeholders, including the district's health staff, sectoral staff (the district DRMO/Busa gonofa, children and women affairs, and administration), WFP field monitoring staff in the area, nutrition coordinators at health centers, and health extension workers. Three focus group discussions with members of communities were conducted, including kebele administrative leaders, kebele women's and children's affairs representatives, community health volunteers, local elders, and local women whose children have previously been

served in TSFP, to assess perceptions on the implementation of TSFP for the treatment of children with moderate acute malnutrition in their locality. Furthermore, observations on the program's service delivery like screening activities, documentations or recordings, arrangements during food distributions and food storage conditions were undertaken at health facilities using an observation checklist.

5.3.Sampling

The study participants were selected by a non-probability sampling technique (purposive sampling) based on their engagement with issues of the targeted supplementary food program to conduct the study on the assessment of the targeted supplementary food program for the treatment of children with moderate acute malnutrition. Seventeen (17) study participants for the key informant interview, eight (8) participants for each focus group discussion, including local women whose children have previously been served in the TSF program, and a total of twenty-four (24) participants for the three focus group discussions were conducted. As described in Table 1 below, a total of 41 (forty-one) study participants were reached for key informant interviews and focus group discussions.

No.	Participants	Key informant interviews	Focus group discussions *3	Total
1.	District Health official (Nutrition focal person)	1		1
2.	District Busa gonofa/DRMO official (Nutrition focal person)	1		1
3.	District women and children affairs official	1		1
4.	District Administration official	1		1
5.	WFP field monitor	1		1
6.	Health center staffs (nutrition coordinators)	3		3
7.	Health extension worker	9		9
8.	Local women		2	6
9.	kebele administration leader		1	3
10.	Kebele Women and children's affairs representative		1	3
11.	Community health volunteer		2	6
12.	Local elders		2	6
	Total	**17**	**8**	**41**
	Number of FGD			3

Table 1: The number and type of the study participants

5.4.Data Collection Tool and Techniques

Data was collected using a semi-structured interview guide and an observation checklist. One (1) research assistant who is a health professional assisted in recording a note and facilitating communication with the study participants. The participants for FGD were selected purposefully based on their profile information provided by the kebele leader during data collection. The time convenient for the participant was adjusted depending on their consent, and the discussion was conducted in Kebeles' office area.

KII respondents were interviewed face-to-face in their usual work settings, except for the WFP field monitor, using the prepared questioners in the interview guides that are

intended to assess the targeted supplementary food program in the district. The WFP field monitor was interviewed at his convenient place outside the workplace. An audio recording was taken during the interview for all respondents.

The guidelines were prepared in English and translated into the local language, Afan Oromo, for data collection. The questionnaire included knowledge, attitude, and practice on targeted supplementary food program service delivery, trends of targeted supplementary food program service delivery, trends of caseload of undernutrition before and after the program started, harmonization between nutritional and food interventions, sectoral coordination in a work of reducing undernutrition, program monitoring and support, information and nutritional messages given to mothers and the community regarding undernutrition, challenges, and suggestions to improve targeted supplementary food program service delivery.

5.5.The Study Variables

Dependent variable: Effective implementation of targeted supplementary food program.

Independent variables for the study were:

1. TSFP program service delivery status: program monitoring, data recording and monitoring, documentation, evaluation, consistency of supplies, and harmonization with other humanitarian programs
2. Beneficiary targeting and coverage: beneficiary admission/screening quality, screening coverage, recording, reporting, and ration distribution
3. Knowledge to the program: clear knowledge on admission cutoff points, how to record data and report, ration entitlement and utilization, key nutrition messages against the standard of the program guideline
4. Household food security: level of income in the households and related intra-household food sharing
5. Child care practices: exclusive breast feeding, hygiene, health care seeking, and immunization
6. Environmental health conditions: water supply and sanitation conditions

5.6.Operational Definition

Effective targeted supplementary food program – when a TSF program activities are done in accordance with the national MAM guidelines. They are indicated by the way

beneficiaries are being admitted, give treatment which is periodic and continuous, discharge benefiaries according to protocal and organize recordings.

Supplementary food: additional foods to the normal diet and mostly include specially formulated foods namely CSB++ and RUSF, which are modified in their energy density, protein, fat, or micronutrient composition to help meet the nutritional requirements of specific populations

Food sharing: when the nutritious supplementary food given to a malnourished child has been shared among other children in the household who are not malnourished.

Continuous treatment: A child enrolled in the program is revisited every two weeks and given the nutritious supplementary food according to the national MAM guidelines.

*Child care:*It is the care that mothers or care takers of children in the TSF program provide to children with MAM while they are in treatment.

Child Caregiver: can be the mother or other that is engaged in taking care of the child. The caregiver feeds and watches over the child, gives the child affection, communicates with the child, and responds to the child's needs. If the child is sick, the caregiver is usually the person who takes the child to a health-care provider (UNICEF, 2019).

Nutritional awareness: is an understanding of caregiver/mother that malnutrition is a result of inadequate intake of nutrition, it is possible to recover from malnutrition, the symptoms of malnutrition in children and where they should take their child when they see such symptoms.

Nutritional message: The messages delivered to mothers of children in the TSF program when they come to receive supplementary food for their children. These includes the reasons why malnutrition occurs in children, how to recover from malnutrition, what to do if their child is infected with another disease while he/she is in the TSFP treatment, the benefits of breastfeeding, how to feed their child with the nutritious supplementary food, and etc.

Supplies: a nutritious food supply like CSB++ and RUSF provided for the TSFP beneficiaries.

5.7.Data Management and Analysis

The audio records were transcribed verbatim and translated from Afan Oromo into English. Each piece of collected data was checked for completeness and consistency. The

data were cross-checked against each other for redundancy in the information they provided.

The transcribed data were coded and then combined using ATLAS.ti 23 software to develop a theme depending on similarities in being affecting factors to the implementation of a targeted supplementary food program in Shashemene Zuria district, Oromia region, Ethiopia. The major themes representing the most common barriers or facilitators were selected for further analysis and described in detail.

The participants of this study were nine HEWs, three health center nutrition focal persons, one district's health office nutrition focal person, three sectoral nutrition focal persons, one field monitor from WFP, and three FGDs from the community (village administration structures, volunteers, kebele women's affairs representative, elders, and women from the kebele). Feedback was collected from a total of 41 (fourty-ht) people. All health extension workers and focal persons were interviewed at their workplaces to collect the required information from these bodies. The WFP field monitor was interviewed at his convenience outside the workplace. The FGD was conducted in consultation with the Kebele administration structure, and the participants were asked to come to the Kebele administration office.

The interviews were prepared according to their involvement in the work, and the interviews with the HEW and the District's health focal person took forty to fifty minutes. That of sectors and FGDs took thirty to forty minutes. The collected data were analyzed by ATLAS.ti 23 software by creating their co-occurrence codes as seen in figure below:

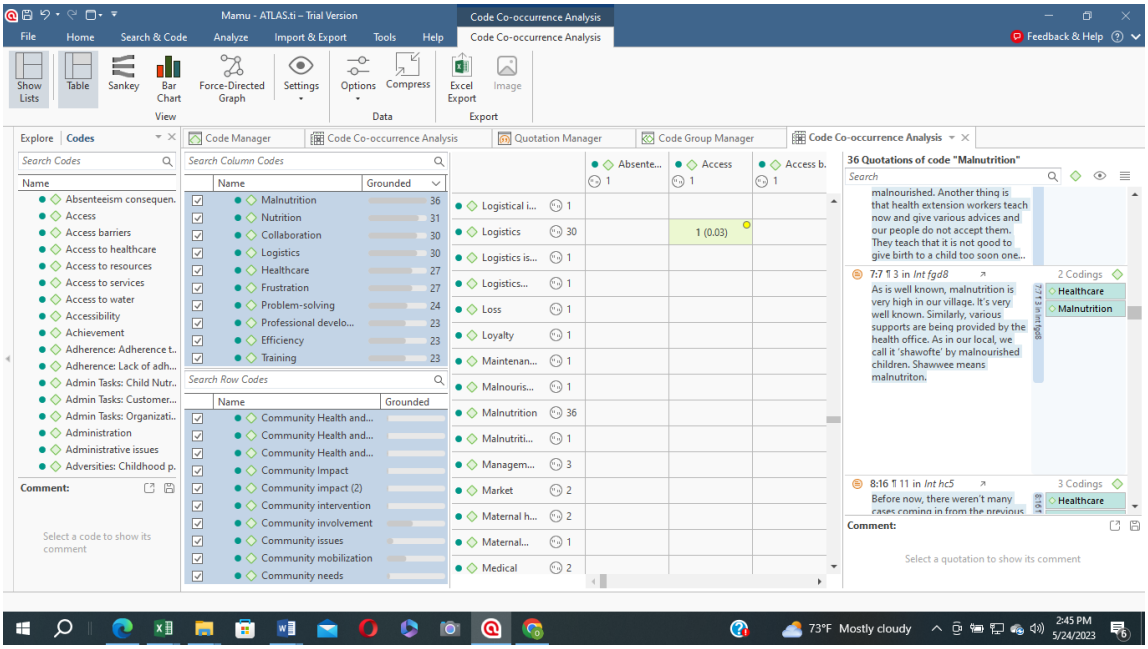

Figure 3.1: Code co-occurrence analysis by ATLAS.ti 23

6. Ethical Issue

The study was reviewed and approved by Bahir Dar University based on the university's research and study policy. A support letter to conduct the study in the selected area was issued by the Oromia Region Health Bureau for the investigator. The confidentiality of the information collected from each study participant was maintained.

7. Dissemination of the Study Result

The findings of the research will be submitted to Bahir Dar University Institute of Technology, the Oromia region health bureau, the West Arsi zone health office, the Shashemene Zuria district health office, and any interested government sectors or local NGOs that are working on the management of child malnutrition. Further attempts will be made to publish in national and international scientific journals.

8. Results

The health extension workers participated in the interviews were all female and has been in the health extension work for seven years and above. One female and seven males from the sectors and health centers have participated in the interview. Their age range from 27 to 40 years. The participants in the FGD were 11 female and 13 male aged between 30 to 54 years.

Obtained information that did affect the targeted supplementary food program was grouped together in such a way as to form themes. Accordingly, the research is divided into eight themes and describes how the TSF program is serving in the district. These themes are categorized under three major points.

8.1.Implementing Practices that Enable Achievement of the Program Objectives

8.1.1. Theme 1: Good Community Mobilization and Awareness-Creation Activities

According to the study, child malnutrition is very common in the district. The community in the district calls the malnourished children "shawofte" in their local language. "Shawofte" means malnourished.

"As is well known, malnutrition is very high in our kebele. It is very well known. Similarly, various support services are being provided by the health office. As in our local language, we call it 'shawofte' by malnourished children. Shawe means malnutrition." (FGD, kebele 1, male participant).

The district has been working on preventing and treating malnutrition for a long time. Community structures, primarily community health volunteers, have been established to improve service delivery and raise awareness. They support health extension workers and ensure all health and nutrition services are provided effectively. Additionally, elected kebele administration structures, such as kebele administration cabinets, children's and women's affairs officers, and women's sector development army organizations, are mobilizing the community for TSFP services. All the health extension workers interviewed mentioned that the role of the community health volunteers is to convey the message to the community to gather and take the education given by the health extension workers.

"If we call all three villages together, there will be more people on screening day. It will be overwhelming. ...The community health volunteer was there to call them by their

villages. There are a couple of people [community health volunteers] in each village who go in and mobilize the community. They gather the community, and we screen them out there and teach what we need to teach. And then they come by their appointment days to follow-up and gain the ration." (HEW: HP 6)

She [HEW: HP6] also cited photos, phone numbers, and roles of women social workers posted on the wall of her health post.

"Now, for example, these are the women's development army whose pictures are posted here on the wall. This is a women's affairs representative. I use these. Perhaps I will teach them [the community] at a meeting when the Kebele administration calls them [the community]. Otherwise, if I call them [the community] village by village, the people will come out, and I can teach well in their village when I have a screening or a vaccine program." (HEW: Hp 7)

Nutrition education is primarily provided to the broader community in the kebele, not just malnourished individuals or families, as it is believed that preventing child malnutrition requires a comprehensive understanding of its causes and nature.

"The reason we focus on the community is because we believe that change cannot come unless we do so. Therefore, if we educate the wider community, we can create greater awareness. Our main focus is on how to conduct malnutrition screening and services, to use balanced diet with what they have in the house, and to feed children under five years old properly."(HEW: Hp4)

It was observed during the interviews that the one health post interviewed was using loudspeaker to teach nutrition messages by opening audio recordings. The loudspeaker was awarded to the health post as a district for doing good work, they said. They also have a document called community and family health guidelines that they use to provide health system education. There, the district is known for its high food insecurity problem.

"When we say we are programmed, we have health education documents. We teach that malnutrition is a problem of insufficient nutrition for the child and mother, not a racially inherited problem. Based on community and family guidelines, we teach about nutrition accurately. We try our best to teach as much as possible. Now the OTP beneficiaries' data is getting low in our kebele. Of all the kebeles, our kebele had the lowest OTP

[caseload]. We receive enough plumpysup, so the children do not go from moderate to severe malnutrition." (HEW: HP 8)

Awareness of nutrition in the community is high, which has helped raise the level of implementation of the targeted supplementary food program service and awareness activities. High malnutrition screening coverage is being done monthly. As can be seen from the analysis of the Sankey chart, community mobilization activities play an important role in ensuring good coverage in the community.

"We reach all the villages and screen them. The highest level of all the health work we do is the screening of malnutrition because people will come properly if they are told that it is a screening program. More than vaccinations and other activities, people come out to these screening program." (HEW: Hp3)

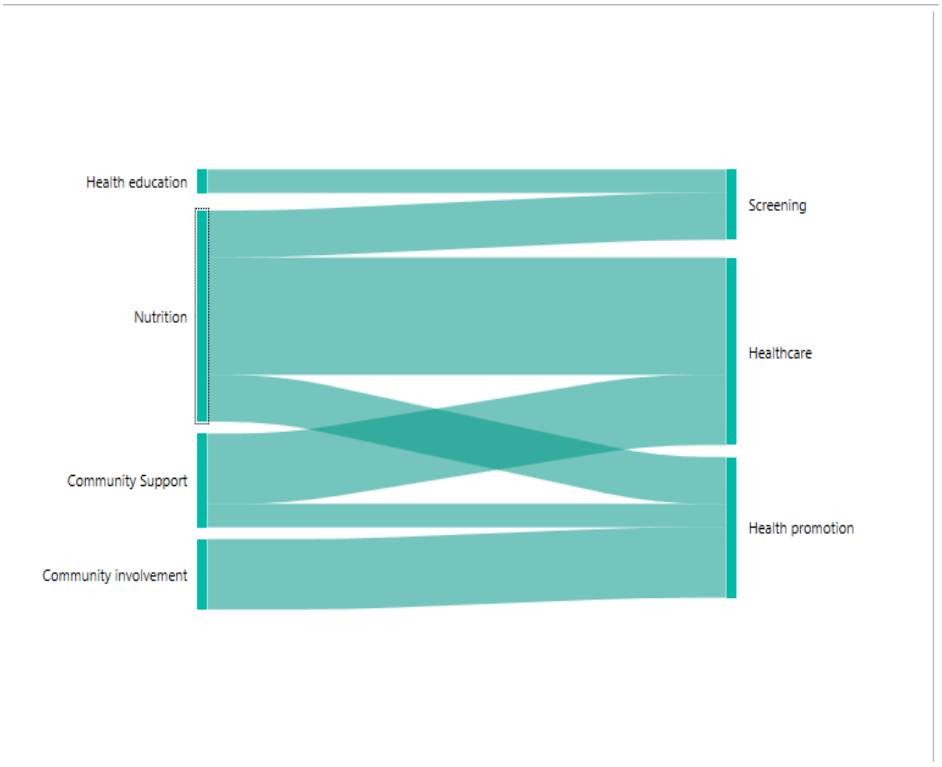

Figure 6.1: Sankey chart- association of community mobilization and population show up for screening

Another one, according to the study, is that very few children default out of the program. All the participants in this study confirmed that the problem of defaulting on the program is not common except for special reasons.

"Defaulters aren't common. We provide health education to beneficiaries from the day they are admitted. We teach them that supplementary food is important and what problems interruption causes; we actually tell them the day they must come back, and if there is no supply interruption as a chance, there will be no defaulter. If there is no supply delivered, they accept." (HEW: Hp 1)

8.1.2.Theme 2: Routine Screening and Admission

Study participants confirmed that they would conduct malnutrition screenings whenever they had the opportunity to find people without being restricted by the regular schedule to conduct malnutrition screenings.

"People also come because this program is very common here. They bring their child and say, 'check my child for malnutrition." (HEW:Hp 5)

Health posts conduct monthly and weekly malnutrition screenings, including during house-to-house vaccine campaigns. They also conduct screenings when community members visit health post with their children for other health services as explained below:

"Our screening coverage is much better. The community always bring their children to us because theyhave a good understanding of the program. Even when we go from house to house, we conduct screening too. That is why we are saying that there is no one who cannot be reached for this screening except that we are sometimes busy with meetings and various campaign activities. " (HEW: Hp 5)

Children will always be enrolled if they meet the TSFP treatment program entry requirements. When asked about the criteria used in the TSFP program, health extension workers found that they were in line with the Ethiopian national guideline for the management of acute malnutrition.

"The first entry requirement is that the child must be under five years of age and between 6 and 59 months of age. Then we use MUAC, and we look at it by MUAC. If his MUAC is less than 11.5, then they take it on a weekly basis, which means an OTP program. If their MUAC measures 11.5 to 12.4, they will be admitted for management of moderate acute malnutrition [TSFP]. That's how we work. The exit criteria is that a child whose

admitted with below 12.5 will be said to be cured when it reaches 12.5 or above. If it is above 12.5 after two visits, we discharge it."(HEW: Hp 7)

8.1.3.Theme 3: Accessible Program's Service

The TSFP program offers its services at the health posts, which are located at every kebele, the most nearest administrative structure to the community. The whole community of a kebele goes to the health posts and served. Screening of beneficiaries can be conducted in different places, for example, by gathering in their village or when health extension workers go from house to house. Or people can be screened when they come to the health post on their own. Food distribution and monthly follow-up are conducted at the health posts. The study participants describe this situation as follows:

"We reach all the villages and screen them. We screen without skipping one village for the sake of distance. We just screen it thoroughly. Instead, the highest level of all the health work we do is the screening of malnutrition, because people will come properly if they are told it is a screening program. "(HEW: HP 3)

A kebele has three villages. The health extension workers develop various strategies to deliver the screening in an equal manner. They do this malnutrition screening more extensively than any other health work.

"As of this year, our kebele has 1524 children aged 6 to 59 months. Every month, we can screen up to 97 percent or more of the target children. We screen the children village by village, and so we can screen a large number of children in a single month. Unless other work interferes, reaching out to everyone is not an issue. We also collaborate because we are two health extension workers here." (HEW: HP 8)

The community is being provided with services in their villages of residence, and there is nothing to limit the accessibility of these services to them, according to the study.

"Fortunately, this work is being done extensively in the community. In this regard, the wider community will have the opportunity to use it. Another reason was that our district was being treated as a transitional district in terms of health this year. Therefore, the officials have been descending from the district to the kebeles. Such assignments are made to support the kebeles. Therefore, these people [officials] have been giving strong support to any nutrition activities, as the main purpose of coming down is to organize such things." (Nutrition focal: HC 3)

Another study participant added that *"in society, there is normally no problem. There was a slight security problem in the kebele called tatesa dadesa, but the health extension workers were still monitoring. Therefore, there is nothing to prevent or intimidate the community from accessing services. To expand its accessibility, health extension workers have a special health development team, and that team is made to deliver information to everyone else in their villages."*(*Nutrition Focal:HC 1)*

When asked if there are any difficulties that hinder them from delivering these services as required, health extension workers answered as follows:

"There is nothing to prevent servitude in society. We can move within the community as much as we want. So there was nothing to influence us. We provide this service as long as the food supply is available."(HEW - Hp 3)

8.2.Implementation Gaps

8.2.1. Theme 4: Weak Monitoring and Evaluation

The study revealed that adequate supervision and monitoring support are not being provided for the targeted supplementary food program. Health center and the District'shealth office experts go to the health post with anintegrated programs that includes a checklist of all health activities.

"They come from the health center to support us. They came sometimes, whether monthly or weekly. They even come with weekly supplies of OTP. When they come, they check the cards and see that we're filling them out. They ask the children's mothers how long their child has been here and why it has been so long. They ask why her child wasn't changing after taking a weekly ration. They deal a lot with OTP but not TSFP records, in fact. They check the OTP weekly anyway. No one from the districtcame to see this [TSFP]. There is nothing regularly followed."(HEW-HP 6)

When they go for visit, they only take a rough look at the work, but they do not investigate it thoroughly and identify where there are shortcomings. The health extension workers involved in this study stated that they [supervisors] did not specifically develop the TSFP checklist program itself and did not take the time to review its functioning in depth.

"If the support was continuous, now the district officials are busy with many things, it would be nice. In fact, some work brings results with support. Even from the health

center, only the leader comes and no one else. He doesn't even look at these records one by one. But he supports us if we ask for something we don't understand. The ones who normally come are those who are working on OTPs. Every week, they come on Thursday. It is run by an NGO. Every Thursday, they bring us plumpynuts, which we give to the children."(HEW-HP 8)

There are transportation problems to follow the work as required. It is difficult to conduct supervision in these kebeles as this work is done extensively in all the kebeles of the district, the participant said.

"Now there is very little access to seeing this work every day and every week. Now there are cars, but it is not enough for that. There are no motorcycles in the department." (Nutrition focal, sector 4.)

In addition, no review session has ever been conducted focusing on this program alone, according to the study participants. Quarterly reports on the overall health work of the district were submitted. It was only presented at the forum as an activity report generally.

"It [evaluation] has been at the district level, and as a health center, yes. As a health center, they used to call us once a month. Now there are a few more different programs overlapping, and they delayed calling us. The district calls us quarterly. The benefit of this review is that it helps us to know where we are and to correct what we have missed. For example, we think we are doing a good job but when we come here to review it, we find a lot of weaknesses. Evaluating the workers means giving them a reminder. This is why a review is needed. There is no review conducted specific to this program, but it is generally handled in health activities." (HEW: HP 6)

The research participants said that the program does not have a separate evaluation and review forum to investigate the work of the program in depth, discuss the existing problems, and provide solutions.

8.2.2. Theme 5: Weak Coordination among Implementers and Stake Holders

The sectors and stakeholders in the districts are not taking their share of the program and working together, according to the research participants. They point out that the health office is almost doing this work alone.

"We don't take part. We only take data of children who are being treated from them [the health office].Their activity in the management of child malnutrition does not have a wide

range of involvement. In terms of malnutrition among children, we know the work is being done, and sometimes we even look on what is being done under our own supervision." (Nutrition focal - sector3)

There are also complaints that there is no facilitated communication to exchange reports on the work of the program. Monthly reports are not given to the horizontal sectors, but the sectors request the reports themselves when they want them.

"The reporting is fragmentary and occasional. We must pressure them to get that too. It's very difficult, and we don't get complete evidence. We send the data we receive to the appropriate office every week through the early warning system. According to our office, the main sectors we receive reports from are health, water, education, and agriculture. We get it right from the agriculture office. The health office's is fragmented. This fragmentation is a problem. It affects these children and mothers. There is evidence, for example, that should not be skipped this week, and if it is skipped, it will affect the next. Sometimes when we need data, we have to beg them. It would be nice if a strong bridge between our office and health was built." (Nutrition focal, sector 2)

Although the coordination in this regard is very weak, the participants expressed their concern that this work cannot be done by a single sector and can bring success.

"First, at the beginning, the issue of nutrition is not just a matter that the health office alone can deal with. At all levels, for example, in education, even at the elementary level, it is said that it should be included in the curriculum. Secondly, when we teach about agriculture, it is very important that agricultural development workers in the field teach about food systems and nutrition. Working with them will help solve this problem from the ground up. Even if there is food and education but no sanitation, it is still a problem, and it is very important to work in coordination with the water sector. To achieve all these and go to a better level, these critical sectors, especially the agriculture office, education office, and disaster risk management office, must work together so that the health office can reduce its burden. Otherwise, if they run alone, they are like someone who has clumps with one hand."(Nutrition focal, sector 4)

As a district, there was a committee to discuss food shortages and various disasters. This committee is called the task force committee. The committee is convened by the district administration and consists of about eight government sectors: the administrative office,

the health care office, the disaster risk management office, the agriculture office, the education office, the water resources office, the women's and children's affairs office, and the social office. Now the committee is weakening, according to the study participants.

"Normally, the taskforce, or districtnutrition steering committee, has been sitting here before, believing that the sectors are important and should work together. Normally, his work has flaws, but there is a platform with all its problems. There is aplanned work to done in various directions, including the agriculture office, water office, education office, health office, children's and women's affairs office, social office, and disaster risk management office. Thus it is important to activate it. Before, there was another organization related to NGOs and government agencies that was supported by UNICEF. At that time, every month and every quarter, we met to improve this service. With the discontinuation of the program, almost no one is gathering without pressure. Now, even occasionally, as a district, it is the districttask force that handles the nutrition issue." (Nutrition focal - sector 4)

In addition, various supports, such as general food assistance, are provided according to the villages. However, all those involved in the study confirmed that health extension workers were not involved in screening the recipients of the food aid. As a formality, they know that their names are in the committee, but the village structure did not invite them when they conducted the screening.

"Our name is on the list of the screening committee, as part of the health extension worker. Our name is posted on the wall of the Kebele administration office for formality, but they do not invite us when they screen. We have never participated in anything. We have seen a screening committee posted there involving health extension workers and agricultural extension workers, but both of us do not participate. What we can add if we participate is that thefamilies of malnourished childrenshould be screened." (HEW:HP 5)

8.2.3. Theme 6: Inadequate and Intermittent Supply

The research participants expressed that the communities are complaining a lot about this issue as there are not enough supplementary foods from the TSFP program available to the screened beneficiaries.

"This work is being done extensively in all the kebeles we have. We believe the program is providing a good service for our community. However, there are some shortcomings in the workplace, and there are times when complaints are raised by the community. Which is why there is a lack of transparency in the appropriate delivery of food to the public. In addition, there is an insufficient supply of this. So apart from these problems, some are being done well."(Nutrition focal - sector 1)

During the study, it was found that a request form was prepared and given to them to request supplementary food for their healthpost. Using the form, they submit the request for supplies to the health post with the monthly report. However, they said the amount of food they requested is not reaching them.

"We request it, but the amount we request is not supplied. We ask based on the number of cases we have on hand. But the amount we receive is small most of the time. We don't know what the reason is. For example, we requested two hundred fifty-nine cartons of CSB++ for this month, but only one hundred ninety cartons were delivered." (HEW - Hp 2)

Not only is the amount of supplementary food supplies shrinking, but the way it is being delivered is fragmented or not continuous. There are interruptions of up to a month or more apart before supplementary food is replenished, according to health extension workers involved in the study.

"There's something that keeps us from doing it consistently. That is, there is a time when this food supply is interrupted. For example, this food allocation is not enough to provide a continuous supply for a child who has to eat and leave after entering and staying for up to three months. There is a time when we have nill stock, and there is a time when it continues for a month. It was delayed and interrupted. Last month, it was interrupted for three months, and now it has come in recent days, and we have re-screened them in a new way. We have screened in a new way, and here there must not be interruption because one has to consume the food continuously to improve."(HEW - Hp 4)

On the other hand, there is no clear role for the food supply request. The caseload quantity is reported to the region [Oromia Health Bureau] as the supply request is being made. There is the condition of the Oromia Health Bureau calculating the caseload and sending us food. The other is the lack of regularity in the food supply. Sometimes it is offered every two months, other times monthly, they say.

"The current form does not ask how much supply is needed. It inquires as to how many balances and cases exist. They [health bureau] also told us that the supply is case-based. It is right, and it should be case-based. But that is not being done. Another was that the offer was bimonthly." (Nutrition focal - sector 4)

Experts involved in the study said that it is creating serious problems for the continuity of the program's services.

"...One is the lack of continuity in this supply. It prevents the child from recovering. If the child does not get a ration continuously or if the supply does not come continuously, the child goes back to the previous status. The lack of continuous supply is a problem."(Nutrition focal - HC 1)

8.2.4. Theme 7: Work Load and Working Environments

There are many activities to be done at the health post level. Participants involved in the study said they are struggling to accommodate the work done or the number of peopleserved.

"Regarding this program, we can say its difficult part is that sometimes there is training or a meeting at the district level. In the meantime, for example, if we plan to do a distribution program today and we need to do it without missing exactly a biweekly appointment, this training and meeting will bring interruption. Again, there's also a different campaign in the meantime. Because of this, there are times when we distribute beyond a month's interval. There were times when visitors came from above and monitored. They saw this and wondered why we skipped the biweekly follow-up. Often, there is a campaign. It is the campaign and various meetings that are holding us back. For example, if we had our schedule today, they might call us on the district. So there are times when what we have to distribute every fifteen days is pushed to the month." (HEW - Hp 2)

On the other hand, many people come to visit this district because it is nearest to the main road or because there are no challenges to their visit. Every time a guest comes to visit, there are more arrangements for their visit. This has also affected the health extension workers' ability to do their normal work, the study participant said.

"Health extension work is extensive. There a lot of work outside of malnutrition management. This year in particular, there was a so-called districthealth transition. They have gotten into a lot of confusion in this regard. Our site is particularly problematic. There are always visitors, and there is always preparation. And this time there is a gap in going from house to house visit. In addition, there are a lot of programs going on there in the health post. I would rather say that the old one that food management is done by the food distributors (FDA) is better. If the top-down program and the manpower we have are coordinated, the health center gets time, and the supporter goes down from the health center and works in coordination with the health extension workers, the gap can be easily solved. Now the main thing is the lack of manpower and time. It cannot be effective unless there is strong coordination."(Nutrition Focal, HC 2)

On the other hand, according to the research, health extension workers travel from the district town, Shashemene. They do not have housing in the nearest health post area. For this reason, there are those who come to work late and close their jobs before the time they are supposed to leave.

"All health extension workers travel from the district or the town of Shashemene. Some things have been tried before. First, there was movement to build a house near the health post. That one didn't work either. It is the health extension workers themselves who have made this fail. Purposefully, that is. Because health extension workers do not want to live in the kebele. Now, if you take Shashemene district, there are very few or no extension workers live in their kebele even where they were born. For example, there is now a health post called Toga, and she lives there because her husband is there.Everyone commutes from Shashemene town, including the remote kebeles. The impact is devastating. overwaste over quality; now quality service is almost compromised. Not only for malnutrition but also the high defaulter rate of EPI and non-immunized children in the kebeles.Meaning that even with other activities, the defaulter increase due to lack of

efficient services, for example, cases on OTP, has a negative impact."(Nutrition Focus, Sector 4)

According to the health extension workers involved in the study, the problem is very serious. They spend a lot of money that is hard to afford every day on transportation. However, they have built a family, and it will be difficult for them to live and work in the kebele even if a house is built.

"Actually, we're commuting from Shashemene town. We both have children and husbands. We travel from there. I have never made my residence here. The town of Shashemane is about 15 kilometers from here. Each of us spends 120 Birr a day on transportation. It's very difficult. There are days when we are absent to save this payment, to tell you the truth. For example, I came yesterday, and I called her and told her to come today. Let this money be saved for us. The main aim is to open a health post and provide services here. I came yesterday, and I wouldn't come today. But they [the health center] called me for a report and told me to submit the monthly report. We decided to come shift by shift sometimes. We leave home on time to come here in the morning. Because our way is long. Now, gasoline prices are increasing. And the drivers don't just come with me alone; they stay until they fill their carrying capacity. We spend a lot of time like this, and there is a time when we arrive at 3:30 [local time] some days. When we get back home, for example, there is a time when I get the vehicle from here at 12:30 [local time]. When I arrive home, it may be 2:30 [local time]. It would have been good if we had worked in the kebele without any expense or effort. I am not lying; even if there is a home built here in the kebele, I find it difficult to stay because I have a husband and children to take care of."(HEW- HP 6)

In this regard, the community is not receiving the services it should have received. There are professionals who spend their working time on the travel and enter work feeling tired.

"...Because they commute from the town, one problem is spending working hours, and the other is getting tired. And in this, there is being fed up. For example, I was supporting a cluster called the Chebi cluster, and I learned from there that the worker is not hospitable in character because he comes tired. So I think the housing for these workers would be there."(Nutrition Focus: Sector 3).

8.3.Theme 8: Suggested Improvement to the Program

The participants in this study have points to focus on when they mention the shortcomings and solutions to the service delivery of this program. All of the participants mentioned that the food supply being provided by the program needs to be improved. They say the supply should not be intermittent and should be adequately delivered as requested.

"If it were to be improved, the food supply in this area is not enough. It doesn't come early, and so I think these should be improved." (Nutrition focal: HC 3)

In addition, they suggested that the parties involved in this program's implementation should work in coordination to make the work of this program effective.

"Normally, by working together, it is possible to reduce this malnutrition even if it cannot be zero. It is necessary to reduce this malnutrition as well as the public health problem in such a way that children are not exposed to death. If they are malnourished, they know where the service is available and its accessibility. It is possible to help them cope with this problem by using existing services." (Nutrition Focal: HC 1)

In this regard, they said it would be more useful if Kebeles should involve health extension workers in general food ration screenings to support households with malnourished children, as their presence could help to target families in need.

"*... As health extension workers, we want to give priority to the poorest parents whose children are suffering from malnutrition. We would love to be involved, and it would be helpful.For example, sometime the mother of a child in OTP who was excluded from the screening came here to us crying. When she cried here, we took her and went to the Kebele officials. This mother often came to us with her child due to a lack of food. The eldest of these children also served with TSF for a long time. When we asked them if they knew the problem she was complaining about and why they hadn't screened her, they accepted our request and readmitted her to the screening.."(HEW - Hp 3)*

Another is health extension workers' extensive activities can be challenging to manage alone. The TSFP work by itself is also extensive, and it would be beneficial to add additional women for food distribution tasks, as the program had been done in the past.

"What we think needs to be improved is that now, for example, our activities are overwhelming. It would help us if food was distributed by the FDA (food distribution

agents) as it used to be. There are eighteen health extension packages that we offer,we are everywhere. Screening by itself is a difficult task, and it will be difficult to say that the quality of the program is maintained when food distribution tasks are added. And I think if there was someone to distribute it, the burden would be lighter"(HEW: HP 6)

The study found that timely and accurate evaluation of the program's work would greatly benefit the implementers, as the current system lacks a review session and timely feedback.

"There has been a quarterly meeting at the districtlevel and also at the health center. As a health center, they used to call us once a month. Now there are a few more different programs overlapping, and they delayed calling us. But they used to call us every month. The districtcalls us quarterly. The benefit of this review is that it helps us to know where we are and to correct what we have missed. For example, we think we are doing a good job. But when we come here to review it, we find a lot of weaknesses. Evaluating the workers means giving them a reminder. This is why a review is needed. There is no review processed specifically according to this program, but it is generally practiced in health activities." (HEW: HP 6)

9. Discussion

The purpose of this study was to investigate factors surrounding the implementation of the TSF program in Shashemene Zuria district. In this research, various themes were identified that could affect the program's implementation.

Initially, it is a community mobilization and awareness-raising effort. Child malnutrition is common in the district and TSFP services have been provided for many years.As a result of this the study confirmed that the community of the district is being given adequate awareness of the services being provided. Community structures in kebeles, including health volunteers, elected administration, children's and women's affairs representatives, and women's development army organizations, are crucial in conveying health extension workers' messages to the community. Public awareness is essential for the program's success, and community mobilization activities ensure good coverage in the community. This approach is vital for promoting the program's service. This finding is supported by a study done in Zambia that stated community involvement in the program (community sensitization, participation, involvement, and outreach) is

prioritized in order to help identify malnourished children early, expand the reach of services, and improve health outcomes(Moramarco, 2019). Most importantly, health extension workers conduct malnutrition screenings whenever they get the opportunity to find people without being restricted by the regular schedule. Defaulters are not common except for special reasons, and health education is provided to beneficiaries from the day they are admitted.

The study found that the TSFP treatment program in the district is easily accessible, with services available at health posts located at every kebele, the nearest administrative structure to the community. Regular malnutrition screenings are conducted at these posts, and there are no difficulties or barriers for health extension workers to provide these services. This finding is consistent with the study done in Pakistan, which reported that nutrition services are largely delivered by nutrition assistants at the health-facility level in the country. A community structure called Pakistan's army of community lady health workers (LHWs) facilitated more proactive provision of nutrition services to rapidly increase coverage in a far more sustainable way(Achakzai et al., 2020).

The study found that the targeted supplementary food program (TSFP) lacks adequate supervision and monitoring support. Health center and district health office experts only review the work in a rough manner, not in depth. Health center expersts did not develop the TSFP checklist program and did not review its functioning in depth. Limited access to supervision in the district's kebeles is also reported. Quarterly evaluations on overall health work are conducted, but no review session is conducted focusing on the TSFP alone. The program lacks a separate evaluation and review forum to investigate its activities, discuss existing problems, and provide solutions.This finding is consistent with the study conducted in Zambia, which revealed that lack of supervision was one of the areas of weakness identified in enhancing the effectiveness of a community-based management of acute malnutrition program in the country (Moramarco, 2019).

On the other hand, there is poor coordination between the bodies conducting this work and the stakeholders. The sectors and stakeholders in the districts are not taking their share of the program and working together, with the health office doing the work alone. The participants expressed their concern that there is no facilitated communication to exchange reports on the work of the program. Monthly reports are not given to the

horizontal sectors, but the sectors request the reports themselves when they want them. In addition, health extension workers are not involved in screening the beneficiaries of the general food aid, and the kebele structures do not invite them when they conduct the screening. But this may help reduce intra-household nutritious food sharing.This finding is consistent with the study done in Ghana, which revealed that lack of coordination among relevant sectors was one of the most pressing challenges to achieving further declines in child undernutrition(Aryeetey et al., 2022).

The research participants expressed concern about the program's inability to provide sufficient nutritious food supplies. They reported that the amount of food requested is not being received, and the delivery of supplementary food supplies is fragmented or not continuous. The lack of regularity in the food supply is causing serious problems for the continuity of the program's services, as it prevents children from recovering if they do not receive rations continuously. Health extension workers reported that the amount of food supply is shrinking and the delivery method is not consistent. This finding is identified as a similar challenge to the study conducted in East and West Africa that stated a significant shortfall in RUSF and RUTF, compromising the continuum of care(McGrath & Shoham, 2019).

Health extension workers face challenges due to lack of housing near their health posts, affecting their work and economy. They spend money on transportation daily, leading to lateness and early departures. This research finding is similar to a study conducted in Ethiopia that revealed the living and working conditions of HEWs were not conducive to the implementation of the health extension program (Stergiopoulos et al., 2019). It was also noted that the overlap of various activities such as vaccination campaigns, meetings, and trainings hindered the continuous provision of these TSFP services.

The participants in this study discussed the shortcomings and solutions to the service delivery of the program. They suggested that the food supply should not be intermittent and should be adequately delivered as requested. They also suggested that the parties involved in the program's implementation should work in coordination to make the program's work effective. Additionally, they suggested that Kebeles should involve health extension workers in general food ration screening to prioritize poor parents with malnourished children. Participants expressed concerns about the extensive activities of

health extension workers and the difficulty in maintaining the quality of the program. They suggested adding food distribution agents to assist with the distribution work, as it used to be done.

The participants in this study stated that if the implementation is reviewed regularly and evaluated, it will be useful for the employees working on the program to balance their activities. There were no review forums specific to this program, but it was generally evaluated along with all health activities. The scoping review study conducted in Africa suggested that program monitoring and evaluation mechanisms should be in place before initial program implementation, and such monitoring tools should be piloted by health workers to ensure that such devices are easy to use and will not delay program progress (Ezezika et al., 2021a).

10. Limitations of the Study

The study was conducted with a sample of health extension workers selected from some health posts, health experts from selected health centers, health office and sectoral nutrition focal persons, and people from the community selected from some kebeles. Therefore it was not the representative of the entire population.

11. Conclusion and Recommendations

11.1. Conclusion

This formative research on the assessment of the TSFP has provided valuable insight into the service delivery situation of the program in the district. Although the program is playing an important role in treating moderate malnutrition in children under five years of age and reducing severe malnutrition, the study identified some shortcomings that limit the program's delivery of services. The results of this research can make the actors involved in this program's implementation aware and take the necessary actions.

The study revealed that the community is actively involved in a malnutrition awareness creation program, with routine malnutrition screenings and no restrictions on accessing the program's services. However, the implementation relies heavily on the district's health sector, with no coordination forum for sectoral discussions. A task force committee for emergencies, food shortages, and malnutrition is no longer active. Health professionals at all level are not providing in-depth monitoring, and there is a lack of visits from health centers to supervise activities in healthposts. The program also lacks an evaluation forum to evaluate achievements and gaps. Inadequate food supplies and irregular follow-ups hinder the program's effectiveness and ability to provide continuous treatment.

11.2. Recommendations

All stakeholders including the government sectors and UNWFP need tostrongly play their partin the program for its successful implementation. The sectors relevant to nutrition in the district, such as the Health office, Agriculture office, DRM office (Busa gonofa), women's and children's affairs office, water resource office, Education office, and District administration should work in coordination to further reduce the problems faced by the program in various aspects specially in advocating the program’s service. The taskforce committee which is composed of the above mentioned government sectors and has already been established should be reactivated and discuss the issues of malnutrition in the district to improve the activities for the management of malnutrition.

Issues and challenges to continuity of service delivery such as food supply interruptions, inadequate food allocation should be addressed by UNWFP, as well as overlap of various activities and an inconvenient working environment for health extension workers should be addressed by the district’s health office. Especiallyit is necessary to select a women

from the community and assign them to help in the food distribution, which is a big task that is difficult to do with a health extension worker alone.

Strong and continuous monitoring targeted at the activities of the program should be provided by the district's health office and health center professionals. It is necessary to establish a regular forum by the Regional health bureau and UNWFP to review the work done and refresh the understanding of health professionals and health extension workers.

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13. Annexes

13.1. Annex 1: Participant Information Sheet and Informed Voluntary Consent Form

My name is _____. I am working as a data collector for the study being conducted on Assessment of the Targeted supplementary food program for the treatment of children with moderate acute malnutrition in this community by Olika Tefera who is studying for his Master's degree at Bahir Dar University institute of technology. You are purposely selected to be participant in this study up on your knowledge to the program. I kindly request you to lend me your attention to explain you about the study.

1. **The study/project title:**
   Assessment of Targeted supplementary food program for the treatment of children with moderate acute malnutrition in Shashemene zuria district, Oromia region, Ethiopia.
2. **Purpose/aim of the study:** The findings of this study can be of a paramount importance for the Shashemene zuria district health office to develop strategies to improve implementation of targeted supplementary food program to reduce the prevalence of the moderate acute malnutrition will benefit all children in the Shashemene zuria district and set baseline for future planning of service delivery. Moreover, the aim of this study is to write a thesis as a partial requirement for the fulfillment of a Master's Program in Applied Human nutrition.
3. **Procedure and duration**: I will provide you the following questionnaire which mainly focuses on assessing the targeted supplementary food program. The questionnaire comprises knowledge to MAM management, coordination among implementers, data monitoring and management, factors affecting beneficiary's outcomes extracted from registration book at health post and obtained through interview. So, I kindly request you to spend your time with me for about 50 minutes and provide relevant information concerning the questions that I will provide you.

4. **Risks and benefits**: The risk of being participating in this study is very minimal; but only taking few minutes from your time. There would not be any direct payment for participating in this study. But the findings from this research may generate important information for governmental and non -governmental agencies that want to work on this area and sets a baseline for future planning and policy design.
5. **Confidentiality:** The information that we will collect from this study will be confidential. There will be no information that will identify your child or yourself in particular. The findings of the study will be general for the study community and will not reflect anything particular of individual persons or housing. The data that we gather from the measurements will exclude showing names. No reference will be made in oral or written reports that could link participants to the research.
6. **Rights:** participation in this study is voluntary. You have the right to declare to participate or not in this study. If you decide to participate, you have the right to withdraw from the study at any time and this will not label you for any loss of benefits which you otherwise are entitled. You do not have to answer any question that you do not want to answer and you think that not important to you.
7. **Contact address:** If there are any questions or enquires any time about the study or the procedures, please contact: Olika Tefera Hordofa: mobile number: 0913907375 Email: olikahrdf10@gmail.com
8. **Declaration of informed voluntary consent:** I have read the participant information sheet. I have clearly understood the purpose of the research, the procedures, the rights and benefits, issues of confidentiality, the right of participating and the contact address for any queries. I have been given the opportunity to ask questions for things that may have been unclear. I understood that I have the right to withdraw from the study at any time or not to answer any question that I do not want. Therefore, I declare my voluntary consent to participate in this study with my initial (signature) as indicated below.

Signature of participant: _____Date_____

Signature of data collector: _____Date_____

Signature of supervisor; _____Date _____

Kebele code_____

13.2. Annex 2: English Version Questionnaires Formats

This questionnaire was developed to collect information on the targeted supplementary feeding program aimed at treating moderate acute malnutrition in children in the Shashemene district of the West Arsi zone. The questionnaires were translated from English into Afan Oromo for data collection purposes.

Interview Guide 1: Health Extension Workers

The program services

1. How do you identify children with moderate acute malnutrition? (Probe: self-referral or on arrival for other services, home-to-home screening, community health day)
2. According to your village, what do you think are the main problems causing child malnutrition?
3. How do you describe the screening coverage in a month in your kebele?
4. Can you describe the treatment protocol for moderately malnourished children in this health post? Probe: admission and discharge criteria? Do health extension workers use protocols?
5. What are the links between the TSF program and other nutrition or food security support programs in your village?
6. Is there a general food ration and/or safety net program in your village? Are you a member of the screening committee? If yes, what is your involvement in or responsibility for user screening? What is your role in screening families with malnourished children for the general food assistance or safety net program?
7. How is the shortage of clean drinking water in your village? What are the public health problems in this regard?
8. What are the main factors affecting the proper implementation of TSFP services in your village?
9. Do you experience defaulting children out of the program as a problem when you provide this service? If yes, why? When do these defaulting most frequently occur within the program? What is the reason for this?

10. Is there a way to get children default out of the program back into the program? Clarify?
11. Can you describe any TSFP-related training you have ever attended? Why do you think this training has been useful to you?
12. Will you receive adequate support from the supervisors regarding this program? Describe the technical support and feedback you receive from your supervisors. (Probe: from whom, how often, adequate understanding of the job)
13. Is there a decrease in child malnutrition in your health post from previous years? Clarify?
14. Do you have a residence home close to your health post? If not, where do you live, and how far is it from the health center? Do you find it difficult to travel to work every day? Why is it?
15. Are there any evaluation or review sessions for the TSFP services you get? What do you think is the importance of evaluation and review meetings?
16. In your opinion, what are your recommendations for improving TSFP services?

Community mobilization

1. What existing community mobilization activities are already underway to increase utilization of TSFP services and awareness of child malnutrition? (Probe: house to house, community meetings, distribution of flyers, etc.)
2. Is screening conducted at the community level? (When and how often?)
3. Who is involved in community mobilization activities?
4. Do you conduct house-to-house monitoring to check the utilization of supplementary food distributed to malnourished children? If yes, what are the shortcomings you notice? What is the action you have taken?
5. Do your dietary messages and education target the entire community or only those in need of TSFP services? Explain how you communicate nutrition messages.
6. What are the main factors affecting access to TSFP services in the community? (Probe: team structure, reporting, how to work with community volunteers)
7. What are the challenges facing the program in carrying out its community mobilization and screening activities effectively? Clarify

8. How is the motivation of the community to bring their children to malnutrition services? What is the reason for this?
9. What is the community's most frequent complaint about the program's services?

Movement and management of supplies

1. Who is responsible for requesting supplementary food supplies for the health post, or what do you know about the process?
2. Do you get enough food supplies for your health post? If not, why?
3. Is interruption of the supply of supplementary food a problem for your health post? Why? How long is it usually interrupted?
4. Do you have enough storage space for the food deliveries? Where do you store it? Clean and free from rodent attack?
5. Has there ever been a theft of supplementary food at this health post? When? What measures were taken? Which types of food supplies were looted (RUSF, CSB++)? Why do you think that type of food supply was chosen for that theft?
6. Have you noticed or received information that the community sells food supplies for treatment? Why do you think they sell? Which food supply will sell more? Why? According to your information, how much is it selling for?

Reports

1. How often do you routinely report? (probe: weekly, monthly)
2. Who collects reports from you?
3. Do they give you feedback? What suggestions do they give you on what points?
4. In this program's reporting system, what do you think is the most appropriate feature? What about the one you say is uncomfortable?
5. In your opinion, what are your recommendations for improving the TSFP reporting system?

Interview guide 2: Health professionals and officials (district health office nutrition focal person and health station nutrition coordinator)

TSFP services

1. How long have you worked as a focal person or nutrition coordinator? What are your primary and most frequent activities? (Probe: hours/week or month of work, motivation, reporting.)

2. What is your role as a focal person or nutrition coordinator?
3. Do you think the existence of TSFP services has helped the community in your district? How'?
4. According to your understanding or evidence, is the number of malnourished children decreasing or increasing? Why? Which type (moderate and severe) of malnutrition is showing the greatest increase or decrease? Why is it?
5. According to your district or center, what are the major problems causing child malnutrition?
6. At what point season child malnutrition increase the most? Why?
7. Do you think the coverage of child malnutrition screening is adequate? What are the challenges you face in this regard?
8. According to your district or health center, how is the shortage of clean drinking water? What are the public health challenges in this regard?
9. Is the training necessary to provide TSFP services being provided to health extension workers and professionals working on the program? Clarify?
10. What are the barriers to providing TSFP services in the community? What are the factors that facilitates opportunities?

Coordination

1. Who are you working with on child nutrition issues? (probe: in-sector, with other sectors, supporters)
2. What are the issues in TSFP service that connect you with other branches of the agency? What do you think are the benefits of the program when you work with other branches of the office?
3. Do you hold regular coordination meetings with relevant sectors in the district or cluster? Describe
4. What obstacles do you face in working with other sectors of the district? (Probe: interest/commitment, structural behavior)
5. Is any attention being paid to the integration of food insecurity assistance programs with other humanitarian assistance programs? Clarify?
6. What are the best opportunities for you to work in coordination with other sectors of the district?

Monitoring and evaluation

1. Do you have problems of getting or collecting monthly program reports from all health centers?
2. Do you get your monthly reports on time? If not, why?
3. Do you organize, analyze, and evaluate the reporting data you have collected? What action do you take when there is a lack of clarity of data in the report?
4. Is there a problem in HEF availability on all working days? How do you describe the details? On which working day in a week are health extension workers mostly absent?
5. Where do health extension workers live? Does their location bother them? How does it affect service delivery?
6. What steps do you take when HEFs are absent at the health center for their maternity and annual leave?
7. Do you have tools or facilities that you use to conduct monitoring? (probe: checklists/formats, transportation, fuel)
8. What are the constraints for your monitoring and control activities? What solutions do you think are needed?

Supply management

1. Who is responsible for the request of supplementary food supply? How is it requested?
2. Will the amount of food supply you request be provided? Explain the shortcomings.
3. What is the most difficult aspect of the supply of supplementary foods?
4. Do you have adequate and secure storage space in the health facilities? What steps would you take to improve the situation? Do you think it is okay to rent and use warehouses in the community?
5. Is food theft a widespread problem in your district? Why? Which food supplies (RUSF, CSB++) are usually looted? Why is it?
6. Is it common for the community to sell food supplies they receive for treatment? Why do you think food supplies can be sold?

7. Is it common to find the supplementary food supplies in local shops? What action will you take as a government? What measures do you think are needed to control this problem?

Recommendations

1. In your opinion, what should be done to improve the overall service of the TSFP?

Interview guide 3: WFP fieldwork monitor

1. How long have you been monitoring the TSFP program in Shashemene district?
2. What were your main focuses in your follow-up activities?
3. Do you consider that the TSFP activities are going well in Shashemene district? Why?
4. How would you rate the TSF program in Shashemene district on overall implementation activities including beneficiary screening, supply chain management, reporting, monitoring, and compiling data?
5. According to your understanding, what are the constraints in the delivery of program services?
6. In your opinion, what is the most encouraging aspect of implementing TSFP in Shashemene district?
7. What are your recommendations for improving the delivery of program services in Shashemene District?

Interview Guide 5: FGD

1. Have you ever seen a malnourished child in your area? What do you call it in your local language?
2. What signs do you see in those malnourished children?
3. What do you think is the reason for the malnutrition?
4. What are your thoughts on reaching out to all communities in the village to screen for child malnutrition?
5. Do malnourished children receive treatment locally? If yes, where do they get treatment? What treatment do they receive?
6. Have you ever had nutrition education sessions? If yes, by whom? Can you tell us some of the points you have learned from nutrition education?

7. What problems have you noticed in accessing supplementary foods for malnourished children?
8. What are your thoughts on health extension workers attendance at the health post every working day?
9. Do you have any information that indicates supplementary food is being sold in the community? If yes, who is selling it? Which type of food is more readily available for sale? Why? Is it common to find it in local shops or markets?
10. Where do you get drinking water, according to your village community? What are the problems you face in this regard?
11. In your opinion, what do you perceive as a problem with the TSFP service? Are there any wide spread complaints raised by the community?
12. What are your suggestions for improving TSFP services?

13.3. Annex 3: Afan Oromo questionnaires format

Foormii Af-Gaaffiiwwanii Hiikkaa Afaan Oromootiin

Qajeelfamni gaaffilee kun kan qophaa'e odeeffannoo raawwii sagantaa nyaata dabalataa kaayyeffataa wal'aansa hanqina nyaataa atattamaa daa'immanii godiina Arsii lixaatti aanaa Shaashamanneetti hojjatamaa jiru odeeffannoo walitti qabuuf kan qophaa'e dha. Gaaffiileen kun kaayyoo odeeffannoo sassaabuutiif afaan Ingiliffaa irraa gara Afaan Oromootti kan hiikamee dha.

Qajeelfama af-gaaffii 1: Hojjettoota ekisteenshinii fayyaa

Tajaajila Sangantaa nyaata kaayyeffataa

1. Namoota hanqina nyaataa giddu galeessaa kan qaban akkamitti adda baafattu? (Qorannoo: of-erguun ykn tajaajila biroof yeroo dhufan, qorannoo manaa gara manaatti, guyyaa fayyaa hawaasaa)
2. Akka ganda keessaniitti, rakkooleen gurguddoon hanqina nyaataa daa'immaniif sababa ta'an maali jettanii yaaddu?
3. Yeroo baay'ee ji'a tokko keessatti daa'imman ganda kee keessatti argaman dhibbeentaa hangam calaluu dandeessa? Maalif?
4. Pirootokoolii wal'aansaa daa'imman hanqina nyaataa giddu galeessaa qabaniif keellaa fayyaa kana keessatti argamu ibsuu dandeessuu? (Qorannoo: ulaagaa seensaa fi bahiinsaa? Hojjetoonni ekisteenshinii fayyaa pirootokoolii fayyadamuu?
5. Sagantaan TSF sagantaalee deeggarsaa sirna nyaataa ykn wabii nyaataa biroo ganda keessan keessa jiran waliin walitti hidhamiinsi isaanii maal fakkaata?
6. Sagantaan gargaarsa nyaata waliigalaa(general food ration) fi/ykn safetynet ganda keessan keessa jiraa? Atihoo miseensa koree calallii keessa jirtaa? Yoo eeyyee ta'e, calallii fayyadamtootaa keessatti hirmaannaan/ittigaafatamummaan keessan maali? Sagantaa gargaarsa nyaata waliigalaa ykn safetynet keessatti maatii daa'imman hanqina nyaataa qaban akka calalaman gochuu keessatti gaheen keessan maali?
7. Akka ganda keessaniiti hanqinni bishaan dhugaatii qulqulluu maal fakkaata? rakkooleen gama kanaan fayyaa hawaasaa irratti mul'atan maali?

8. Wantoonni gurguddoon tajaajilli TSFP ganda/keellaa keessan keessatti sirnaan akka hin gaggeeffamne dhiibbaa geessisan maali?
9. Yeroo tajaajila kana kennitan daa'imman sagantaa keessaa addaan kutuun akka rakkootti isin muudataa? Yoo eeyyee ta'e Maaliif?

- Yeroo kam baay'inaan sagantaa keessaa addaan kutuun kun kan uumamu? Sababni isaa hoo maali?
- Malli daa'imman sagantaa keessaa addaan kutan ittiin gara sagantichaatti deebisuun danda'amu jiraa? Ibsi

10. Leenjii TSFP wajjin walqabate irratti hirmaatte beektu ibsuu dandeessaa? Leenjiin kun/kunniin maaliif na fayyadeera jettee yaadda?
11. Sagantaa kana ilaalchisee deeggarsa gahaa suparvaayizara irraa ni argattaa? Deeggarsa teeknikaa fi yaada supparvaayizara kee irraa argattu ibsi? (qorannoo: eenyurraa, yeroo meeqa, hubannoo gahaa hojii irratti)
12. keellaa fayyaa keessan keessatti hanqinni nyaataa daa'immanii waggoota darban irraa hir'achaa dhufuu isaa ni mul'ataa? Ibsi
13. Mana jireenyaa keellaa fayyaa keessanitti dhihoo ta'e qabduu? Yoo lakki ta'e eessa jiraattuu akkasumas fageenya isaa keellaa fayyaa irraa? Guyyaa guyyaan gara bakka hojiitti imaluun isinitti ulfaataa? Maaliif?
14. Tajaajila TSFP ati kennitu irratti walgahiin madaallii ykn gamaaggamaa jiraa? Barbaachisummaan walgahii madaallii/gamaaggamaa maal fa'a jettee yaadda?
15. Akka yaada keessaniitti tajaajila TSFP fooyyessuuf yaadni gorsaa keessan maali?

Sosochii hawaasaa

1. Itti fayyadama tajaajila TSFP fi hubannoo hanqina nyaataa daa'immanii guddisuuf hojiiwwan sosochii hawaasaa jiran maaltu amma dura hojjetamaa jira? (Qorannoo: manaa manatti deemuun, walgahii hawaasaa, barreeffamoota adda addaa facaasuun kkf)
2. Calalliin sadarkaa hawaasaatti ni gaggeeffamaa? (Yoomii fi yeroo meeqa?)
3. Sosochii hawaasaatiif eenyufaatu hirmaata?
4. Itti fayyadama nyaata dabalataa namoota hanqina nyaataa qabaniif raabsame sakatta'uudhaaf hordoffii manaa manaa ni gaggeessituu? Eyyeen yoo ta'e hanqinoonni isin hubattan maal fa'aadha? Tarkaanfiin isin fudhattan maali?

5. Ergaawwan/barnoonni sirna nyaataa keessan hawaasa guutuu moo namoota tajaajila TSFP barbaadu qofa irratti xiyyeeffata? Akkaataa ergaawwan sirna nyaataa itti dabarsitu ibsi.
6. Wantoonni gurguddoon hawaasa keessatti tajaajila TSFP waliin gahuu irratti dhiibbaa geessisan maali? (Qorannoo: caasaa garee, gabaasa, akkaataa tola ooltota hawaasa waliin hojjetamu)
7. Sagantaan kun hojiilee sosochii hawaasaa fi calallii bu'a qabeessa ta'een raawwachuuf rakkoon isa muudatu maali? Ibsi
8. Hawaasni daa'imman isaanii gara tajaajila hanqina nyaataa fiduu irratti kaka'umsi jiru maal fakkaata? sababni isaa maali?
9. Hawaasni tajaajila sagantaa kanaatiif wanti irra deddeebiin komatu maali?

Sochii fi haala qabiinsa dhiyeessii

1. Keellaa fayyaa kanaaf dhiyeessii nyaata dabalataa gaafachuuf eenyutu itti gaafatamummaa qaba ykn adeemsa isaa maal beektu?
2. Nyaata dabalataa gahaa keellaa fayyaa keessaniif barbaachisu ni argattuu? Lakki yoo ta'e maaliif?
3. Dhiyeessiin nyaata dabalataa adda ciccituun keellaa fayyaa keessaniif rakkoodhaa? Maalif? Yeroo baay'ee yeroo hangamiif adda cita?
4. Nyaata dabalataa dhiyaatuuf bakka kuusaa gahaa qabdaa? Eessatti kuufatta? Qulqulluu fi tuttuqqii hantuutaa irraa bilisaa?
5. Hanni nyaata dabalataa keellaa fayyaa kana mudatee beekaa? Yoom? Tarkaanfiiwwan akkamiitu fudhatame? Gosa nyaata dabalataa kamtu saamame (RUSF, CSB++)? Hanna sanaaf gosti nyaata dabalataa sun maaliif filatame jettanii yaaddu?
6. Hawaasni nyaata dabalataa wal'aansaaf argatu akka gurguru hubattee ykn odeeffannoo argatte qabdaa? Maaliif gurguru jettanii yaaddu? Nyaata dabalataa kamtu caalmaatti gurgurtaaf ta'a? Maalif? Akka odeeffannoo keessaniitti meeqatti gurguramaa jira?

Gabaasa

1. Yeroo hangamiitti idileedhaan gabaasa kennita? (qorannoo: torbanitti, ji'a ji'aan)
2. Eenyuutu gabaasa isin irraa walitti qaba?

3. Duub deebii siif kennuu? Qabxiilee akkamiirratti yaada akkamii siif kennu?
4. Sirna gabaasaa sagantaa kanaa keessatti, wanti mijataadha jettu maali? Kan mijataa miti jettu hoo?
5. Akka yaada keessaniitti sirna gabaasa TSFP fooyyessuuf wanti isin dhaamtan maali?

Qajeelfama af-gaaffii 2: Ogeessota/qondaalota fayyaa (fookaal parsanii sirna nyaataa waajjira fayyaa aanaa fi qindeessaa sirna nyaataa buufata fayyaa).

Tajaajila TSFP

1. Yeroo hammamiif fokaal parsanii/qindeessaa sirna nyaataa taatee hojjatteetta? Hojiiwwan kee inni jalqabaa fi irra deddeebiin hojjattu maal fa'a? (Qorannoo: sa'aatii/torban ykn ji'a hojii, kaka'umsa, gabaasuu,)
2. Gaheen akka fokaal parsanii/qindeessaa sirna nyaataatti qabdu maali?
3. Tajaajilli TSFP jiraachuun hawaasa aanaa keessanii gargaare jettanii yaaddu? Akkamitti?
4. Akka hubannoo ykn ragaa keessaniitti, daa'imman hanqina nyaataa keessa galan hir'achaa jira moo dabalaa jiraa? Maalif? Hanqina nyaataa giddu galeessaa fi cimaa keessaa kamtu caalaatti dabaluu ykn hir'achuu agarsiisaa jira? Maaliif?
5. Akka aanaa/buufata keessaniitti, rakkoolee gurguddoon hanqina nyaataa daa'immaniitif sababa ta'an maali?
6. Yeroo kamitti hanqinni nyaataa daa'immanii caalaatti dabala? Maalif?
7. Uwwisa calallii hanqina nyaataa daa'immanii haala gahaa ta'een dalagamaa jira jettanii yaadduu? Rakkooleen gama kanaan isin qunnaman maali?
8. Akka aanaa/buufata keessaniitti, hanqinni bishaan dhugaatii qulqulluu maal fakkaata? Rakkooleen gama kanaan fayyaa hawaasaa irratti mul'atan maali?
9. Leenjii tajaajila TSFP kennuuf barbaachisaa ta'an hojjattoota ekisteenshinii fayyaa fi ogeessota hojichaa irratti hojjachaa jiraniif kennamaa jiraa? Ibsi?
10. Hawaasa keessatti tajaajila TSFP kennuuf danqaaleen jiran maali? Wantootni carraa bal'isan hoo maal fa'a?

Qindoomina

1. Dhimma sirna nyaataa daa'immanii irratti eenyufaa waliin hojjechaa jirtu? (qorannoo: seektara keessaa, seektaroota biro waliin, deeggartoota)

2. Tajaajila TSFP keessatti dhimmoonni dameewwan mana hojii biroo waliin isin walqunnamsiisan maali? Yeroo dameewwan mana hojii biroo waliin hojjattan sagantichaaf faayidaa akkamiitu argama jettanii yaaddu?
3. Walgahii qindoominaa idilee seektaroota dhimmi ilaallatu wajjin aanicha/kilaastara keessatti ni taasiftuu? Ibsaa
4. Dameewwan mana hojii biroo waliin hojjachuuf danqaa akkamiitu isin muudata? (Qorannoo: fedhii/bakka itti laachuu, amala caaseffamaa)
5. Sagantaa deeggarsa hanqina nyaataa sagantaalee deeggarsa namoomaa biroo wajjin wajjin walitti hidhamiinsa uumanii akka hojjataniif xiyyeeffannoon itti kennamee wanti hojjatamaa jiru jiraa? Ibsi?
6. Carraa mijataan dameelee mana hojii biroo waliin qindoominaan hojjechuuf isin gargaaru maaltu jira?

Hordoffii fi madaallii

1. Gabaasa sagantichaa ji'a ji'aan keellaa fayyaa hunda irraa argachuuf ykn sassaabuuf rakkooleen isin quunnamuu?
2. Gabaasa ji'aa yeroon argattuu? Yoo Lakki ta'e maaliif?
3. Ragaa gabaasaa walitti qabde qindeessitee xiinxaltee madaaltaa? Yeroo hanqinni ragaa gabaasaa irratti mul'atu tarkaanfii akkamii fudhatta?
4. HEF guyyoota hojii hunda irratti argamuu irratti hanqinni jiraa? Bal'inaan akkamitti ibsitu? Torban tokko keessatti guyyaa hojii kam hojjettoonni ekisteenshinii fayyaa irra caalaa hin argaman?
5. Hojjettoonni ekisteenshinii fayyaa eessa jiraatu? Bakki isaan jiraatan kun isaan ni rakkisaa? kenniinsa tajaajilaa kennan irratti dhiibbaa akkamii qaba?
6. Yeroo HEFn boqonnaa dahumsaa fi waggaa isaaniitiin keellaa fayyaa keessatti hin argamne tarkaanfii akkamii fudhattu?
7. Meeshaalee/wantoota hordoffii akka gootaniif itti fayyadamtan ni qabduu? (Qorannoo: cheekliistii/foormaatiiwwan, geejjiba, boba'aa)
8. Hojii hordoffii fi to'annoo keessaniif maaltu danqaa isinitti ta'a? Fala akkamiitu barbaachisa jettu?

Bulchiinsa dhiyeessii

1. Dhiyeessii nyaata dabalataa eenyutu gaafata? Akkamitti gaafatama?

2. Hangi nyaata dabalataa gaafattan isiniif dhiyaataa? Hanqina jiru ibsi?
3. Dhiyeessii nyaata dabalataa irratti wanti rakkisaa ta'u maaltu jira?
4. Keellaalee fayyaa keessatti bakka kuusaa gahaa fi eegumsa qabu qabduu? Haala isaa fooyyessuuf tarkaanfii akkamii fudhattu? Manneen kuusaa hawaasa keessatti kireeffatanii fayyadamuun rakkina hin qabu jettanii yaadduu?
5. Rakkoon hanna nyaataa aanaa keessan keessatti rakkoo bal'aadhaa? Maalif? Yeroo baay'ee nyaata dabalataa (RUSF, CSB++) kamtu saamama? maaliif?
6. Hawaasni nyaata dabalataa wal'aansaaf argatan gurguruun baratamaadhaa? Sababni nyaata dabalataa gurguramuu danda'u maaliif jettu?
7. Nyaata dabalataa suuqiiwwan naannoo keessaatti argachuun baramaadhaa? Akka mootummaatti tarkaanfii akkamii fudhattu? Rakkoo kana to'achuuf tarkaanfii akkamiitu barbaachisa jettu?

Yaada

1. Akka yaada keessaniitti tajaajila waliigalaa TSFP fooyyessuuf maaltu godhamuu qaba jettu?

Qajeelfama af-gaaffii 3: Hordofaa hojii dirree WFP

1. Sagantaa TSFP irratti aanaa Shaashamannee keessatti hojii hordoffii yeroo hammamiif godhaa turte?
2. Hojii hordoffii keessan keessatti xiyyeeffannaan keessan maal maal irratti turan?
3. Sochiin TSFP aanaa shaashamannee keessatti akka gaariitti adeemaa ture jettanii fudhattuu? Maalif?
4. Sagantaa TSF aanaa Shaashamannee keessatti hojiilee raawwii waliigalaa irratti calallii fayyadamtootaa, bulchiinsa dhiyeessii, gabaasa, hordoffii fi ragaalee qindeessuu dabalatee akkamitti madaaltu?
5. Akka hubannoo keessaniitti kenniinsa tajaajila sagantichaa keessatti danqaalee mul'atan maali?

6. Akka yaada keessaniitti TSFP aanaa Shaashamannee keessatti hojiirra oolchuu keessatti wanti baay'ee nama jajjabeessu maali?
7. Kenniinsa tajaajila sagantichaa aanaa Shaashamannee keessatti fooyyessuuf maal yaada kennitu?

Qajeelfama af-gaaffii 4: Seektaraalee

1. Waa'ee hanqina nyaataa daa'immanii aanaa keessan keessa jiru odeeffannoo akkamii qabdu? Aanaa keessaniif qormaataa? Akkamitti?
2. Hojii wal'aansa hanqina nyaataa daa'immanii aanaa keessan keessatti hojjatamu irratti qooda fudhattuu? Yoo eeyyee ta'e gaheen keessan maali?
3. Hanqina nyaataa fi wal'aansa daa'immanii irratti mari'achuuf waltajjii qindoominaa ni qabduu, ibsi?
4. Akka aanaatti sagantaan wal'aansaa hanqina nyaataa daa'immanii akkamii akka kennamaa jiru beektuu? (qorannoo: maqaa sagantichaa waamaa)
5. Hanqina nyaataa daa'immanii fi deebii kennamu irratti gabaasa ji'a ji'aan ni argattuu, ittis ni fayyadamtuu? Yoo eeyyee ta'e eenyu irraa?
6. Tajaajila wal'aansa hanqina nyaataa daa'immanii aanaa keessan keessatti kennamaa jiru irratti rakkoo akkamii argitu?
7. Tajaajila TSFP aanaa keessan keessatti fooyyessuuf yaada furmaataa akkamii kennitu?

Qajeelfama af-gaaffii 5: FGD

1. Daa'ima hanqina nyaataa qabu naannoo keessanitti argitanii beektuu? Afaan naannoo keessaniitiin maal jettuun?
2. Daa'imman hanqina nyaataa qaban sana irratti mallattoo akkamii argitani?
3. Hanqina nyaataa sanaaf sababni maali jettu?
4. Calallii hanqina nyaataa daa'immanii hawaasa gandicha keessa jiru hundumaa bira gahanii sakatta'uu irratti yaadni qabdan maali?
5. Daa'imman hanqina nyaataa qaban naannoo isaaniitti yaala argatuu? Yoo eeyyee ta'e wal'aansa eessaa argatu? Wal'aansa akkamii argatu?
6. Barnoota sirna nyaataa argattanii beektuu? Yoo eeyyee ta'e eenyuun? Qabxiilee barnoota sirna nyaataa irraa argattan muraasa himuu dandeessuu?

7. Daa’imman hanqina nyaataatiin calalaman nyaata dabalataa argachuu irratti rakkooleen isin hubattan maaltu jira?
8. Hojjattootni ekisteenshinii fayyaa guyyaa hojii hundumaa keellaa fayyaatti argamanii tajaajila kennuu irratti yaadni isin qabdan maali?
9. Nyaanni dabalataa hawaasa keessatti ni gurgurama odeeffannoo jedhu qabduu? Yoo eeyyee ta'e eenyutu gurgura? Gosa nyaataa kamtu gurgurtaaf caalaatti argama? Maalif? Dukkaana/suuqiiwwan naannoo sanaa keessatti argachuun waanuma baramedhaa?
10. Akka hawaasa ganda keessaniitti bishaan dhugaatii eessaa argattu? rakkinni gama kanaan isin qunnamu maali?
11. Akka yaada keessaniitti tajaajila TSFP keessatti rakkoodha jettanii wanti isin hubattan maali? Komii bal’aa hawaasni kaasu jiraa?
12. Tajaajila TSFP fooyyessuuf yaadonni keessan maali?