BARRIER ANALYSIS AND COVERAGE ASSESSMENT OF IMAM PROGRAMME

FINAL REPORT | NUWAKOT DISTRICT, NEPAL | JUNE 2017

ACTION AGAINST HUNGER
ACTION CONTRE LA FAIM

unicef
for every child

Government of Nepal
Ministry of Health
Department of Health Services
District Public Health office
Nuwakot

Cover image: Manisha Katwal

BARRIER ANALYSIS AND COVERAGE ASSESSMENT OF IMAM PROGRAMME

FINAL REPORT
NUWAKOT DISTRICT, NEPAL
JUNE 2017

ACKNOWLEDGEMENT

Action Contre la Faim (ACF) | Action Against Hunger would like to thank all the stakeholders who directly or indirectly contributed in the success of the coverage assessment held in June 2017. Action Against Hunger would like to express its gratitude to:

- District Public Health Office, Nuwakot including Chief of DPHO, Mr. Basanta Adhikari, and Nutrition Focal Person, Mr. Janardan Silwal for their guidance, assistance and support at all stages of the assessment

- Enumerators of the assessment viz. Alita Poudel, Goma Neupane, Min Bahadur Nagarkoti, Pratikshya Baniya, Rabina Raut, Raja Ram Silwal, Sabina Pudasaini and Tanka Shrestha

- All the key informants viz. health workers, FCHVs, CNWs, CBOs, community leaders of the sampled VDCs interviewed during the various stages of the assessment

- All the communities especially mothers/caretakers of children 6-59 months who were interviewed in Nuwakot district for their cooperation

ASSESSMENT TEAM

S.N.	Name	Designation
1	Roshna Maharjan	Senior Programme Quality Assurance Officer
2	Sujay Nepali Bhattacharya	HoD: Nutrition and Health
3	Sailendra Bista	Senior Programme Officer
4	Manisha Katwal	Senior Programme Officer
5	Anamika Shahi	Technical officer
6	Bishnu Poudel	Technical officer
7	Jitendra Yadav	Technical officer
8	Ramesh Shrestha	Technical officer
9	Sanjay Chaudhary	Technical officer

LIST OF ABBREVIATIONS/ ACRONYMS

CBOs	Community Based Organization(s)
CNWs	Community Nutrition Worker(s)
DPHO	District Public Health Officer
FCHVs	Female Community Health Volunteer(s)
HMIS	Health Management Information System
HF	Health Facility
HWs	Health Worker(s)
I/NGOs	International/Non-Government Organization(s)
IMAM	Integrated Management of Acute Malnutrition
IP	Implementing Partner
LMIS	Logistic Management Information System
MAM	Moderate Acute Malnutrition
MGM	Mother's Group Meeting
MUAC	Mid upper Arm Circumference
OTCC	Outpatient Therapeutic Care Centre
RUSF	Ready to Use Supplementary Food
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SMART	Standardized Monitoring Assessment of Relief and Transitions
SQUEAC	Semi Quantitative Evaluation of Access and Coverage
TSFP	Targeted Supplementary Feeding Programme
UNICEF	United Nations Children's Fund
VDCs	Village Development Committee(s)
WHZ	Weight for Height Z-score

Government of Nepal
Ministry of Health
Department of Health Services
Central Regional Health Directorate
District Public Health Office
Nuwakot

Phone: 010-560255
Fax: 010-560238

Ref. No.:

FOREWORD

Nuwakot is a hilly district, which now falls under Province 3. Most of the areas are undeveloped due to its topography and fragile geography. Complex geographical terrain and limited road access are major challenges for beneficiaries to utilize the basic health services. In such scenario, it is essential to take wise decision or steps to ensure the issues of accessibility and coverage of health programmes in the district is efficiently addressed. In that regard, Barrier Analysis and Coverage Assessment of 'Integrated Management of Acute Malnutrition (IMAM) programme' following Semi Quantitative Evaluation of Access and Coverage (SQUEAC) methodology was conducted in the district under 'Post Disaster (Earthquake) Nutrition Recovery Programme'. The programme funded by UNICEF has been implemented by District Public Health Office (DPHO) with the technical support of ACTION CONTRE LA FAIM (ACF) | Action Against Hunger. The main objective of the assessment was to assess all the factors influencing access and coverage of IMAM programme in the district.

Almost a month long assessment was conducted in three stages. The assessment specifically delineated the factors that hindered the programme coverage as well as ascertain factors that supported programme coverage. During the assessment, both qualitative and quantitative data was collected to figure out the problems and the causes of those identified problems. The assessment team had done a great work in collecting information from various sources, methods and locations to analyze all the issues exhaustively including factors associated with demand side and service side.

The assessment was followed by an action plan design workshop where all the possible ways to improve the programme was discussed. The workshop was very fruitful in a sense that small but effective and doable actions were identified. The District Public Health Office appreciates that work done by the assessment team and wholeheartedly takes ownership of all the results and recommendations of the assessment.

Lastly, I would like to thank and congratulate ACTION CONTRE LA FAIM (ACF) | Action Against Hunger for collaborating with District Public Health Office in conducting such an exhaustive assessment of IMAM programme. The findings of the assessment will enable the IMAM programme in the district to further improve its coverage and access. I sincerely hope the assessment results will also be of importance to other districts where IMAM programme is being implemented.

.....

Basant Adhikari
Chief, District Public Health Office

CONTENTS

LIST OF TABLES

LIST OF FIGURES

EXECUTIVE SUMMARY

Barrier analysis and coverage assessment was conducted in June 2017 in Nuwakot district. Although it was planned in May 2017, it could not be carried out as scheduled due to election. The mobility was limited and in some cases restricted too. However, the preliminary activities like collection of all IMAM registers, distance from VDCs to OTCC, analysis and interpretation of available programme data was started from April 2017. The overall objective of the assessment was to evaluate the coverage of Integrated Management of Acute Malnutrition programme. The programme includes both treatment services for both Severe Acute Malnutrition (SAM) through Outpatient Therapeutic Care Centres (OTCC) and Moderate Acute Malnutrition (MAM) through Targeted Supplementary Feeding Programme (TSFP) sites for children 6-59 months as well as MAM treatment for Pregnant and Lactating Women (PLW). However, the scope of this assessment was limited to management of SAM only.

The IMAM programme in the district started in May 2015 but the assessment covered the quantitative information on SAM management from January to December 2016. Eight enumerators were trained in taking anthropometric measurement and oedema checking. The team was also trained in the methodology of the assessment like active-adaptive case finding, door-to-door sampling, administering the interview guides and conducting group discussions.

The case identification in Stage II and III was done using Mid-Upper Arm Circumference (MUAC) tape, checking bilateral pitting oedema on child's both feet and Weight for Height Z-score (WHZ). To speed up the assessment, WHZ was taken of those children who do not fall in SAM by MUAC. The entire district was divided into 6 clusters during Stage II based on the catchment areas of OTCCs.

A total of 23 barriers and 13 boosters were identified during the qualitative data collection of Stage I. The barriers ranged from geographical inaccessibility, social issues such as hesitant to visit HFs due to language barriers between the service seekers and service providers, belief in traditional faith healers and no decision-making power with the female counterpart. The barriers also include service side barriers such as less supportive supervision from the health facility for the community level activities, poor follow up of defaulters and limited health services in absence of community nutrition workers (CNWs). The boosters include mostly service side factors such as capacity building of all health workers in the district in IMAM, active involvement of FCHVs during screening.

In the Stage II, hypothesis formulated related to spatial distribution of SAM cases and the catchment of HF without IMAM service. The hypothesis was tested adopting small area survey and was confirmed. The hypothesis for this assessment was *coverage of the programme is high in villages near (< or = 2 hrs by walking distance or by means of transportation) the OTCC and low in villages far (>2 hrs by walking distance or by means of transportation) from the OTCC and in the catchment area of those health facilities which do not have treatment programme for SAM cases*.

The finding of stage III suggests that coverage of IMAM programme in the district is **33.7%** (23.2% - 46.0%) with the precision level of 12. There was considerable overlap between the prior and the likelihood meaning that there is no conflict of the information in prior and the likelihood. The width of prior and the likelihood is also equal meaning that there is reliability in setting up of the prior and the prior is accurate and moderately strong. The posterior is narrower than the prior meaning that the likelihood has reduced the uncertainty and the posterior estimate is accurate.

1. BACKGROUND

1.1 NUWAKOT DISTRICT: BRIEF INFORMATION

Nuwakot is one of the 75 districts of Nepal, which now falls under Province 3. Bidur municipality is district headquarter of the district which covers an area of 1,121 km^2. As per census 2011, the district has a total population of 2,77,471.

The name Nuwakot is composed of two words "Nawa" and "Kort" where Nawa means nine and Kort means sacred religious place at the top of hill. The district has 9 hills in which various deities are said to dwell overseeing and protecting Nuwakot. Hence, the district is often known as "city of nine hills".

Nuwakot is located in central hill region with very less plain land. Most of the areas are undeveloped due to its topography and fragile geography. Schools, colleges, hospitals and road infrastructure are well developed in the city areas. Two hydro power stations are currently in operation. Most of the people are dependent on agriculture, teaching, foreign economy, livestock farming, business, hotels, Agri Tourism, Eco Tourism and Khadya Bank etc.

Climate in Nuwakot depends on the altitude that ranges from tropical to nival. The alit tropical, which ranges from 300 to 1,000 meters to Alpine ranging from 4,000 to 5,000 metres.

Table 1: Snapshot of socio demographic characteristics

Demographic characteristic		Nuwakot	Nepal
Total Population		2,77,471	2,64,94,504
	Male	1,32,787	1,28,49,041
	Female	1,44,684	1,36,45,463
Sex ratio		91.78	94.2
Total number of households		59,215	54,27,302
Average household size		4.69	4.88
Literacy rate of 6 years and above		60.2	76
Male		68.5	57.8
Female		52.6	66.6
Population density		248	180
Caste/Ethnicity (top four)			
	1	Tamang (42.8)	Chhetri (16.6%)
	2	Brahman-Hill (19.0)	Brahmin-hill (12.2%)
	3	Chhetri (12.6)	Magar (7.1%)
	4	Newar (7.4)	Tharu (6.6%)
Religion			
	1	Hiinduism (57.77%)	Hinduism (81.34%)
	2	Buddhism (40.01%)	Buddhism (9.04%)
	3	Islam (0.13%)	Islam (4.38%)
	4	Kirat (0.15%)	Kirati (3.04%)
	5	Christianity (1.61%)	
	6	Prakrity (0.01%)	

Source: Population Monograph of Nepal, 2014; National Population and Housing Census 2011 (National Report)

2. INTRODUCTION

IMAM is based on the premise that management of acute malnutrition becomes a part of comprehensive yet integrated set of nutrition activities in Nepal. It entails management of acute malnutrition to become part of basic health service; is within the framework of a multi-sectoral approach aimed at confronting the determinants of under-nutrition targeting the 1000 days period, the critical period between pregnancy up to second birthday of a child.

The objective of IMAM is as follows:

- Reduce morbidity and mortality of children <5 years
- Rehabilitate to be able to sustain their recovery on discharge
- Prevent further deterioration
- Prevent acute malnutrition in 1000 days period
- Prevent micronutrient deficiency disorder among <5 years children

IMAM covers children of age group 0-59 months. The principles guiding the IMAM includes maximum coverage and access, timeliness of care, appropriate care and care as long as needed.

2.1 OUTPATIENT THERAPEUTIC CARE CENTRE (OTCC)

Outpatient Therapeutic Care Centre is the point of service for the IMAM programme which is present within a government health facility. The services provided by the centre includes nutritional assessment through anthropometric measurements and/or Mid-Upper Arm Circumference (MUAC), counselling mothers and caretakers on infant and young child feeding practice which includes breastfeeding, variety and frequency of meal, active feeding, care of sick child and regular follow-up visit to health facility, and Ready-to-Use Therapeutic Food (RUTF).

An IMAM focal person in the health facility is primarily entrusted with running the centre. However, all the public health personnel in the district are trained on IMAM, so that even in the absence of IMAM focal person, service is not interrupted. Technically, the programme supports the District Public Health Office to train government public health personnel in IMAM from district to community level, provides technical backstopping and on the job coaching to the government public health personnel through supportive supervision and monitoring. A total of 11 OTCCs have been established and functioning.

2.2 RECORDING AND REPORTING SYSTEM OF IMAM PROGRAMME

IMAM is government run programme. Hence, the recording and reporting is done as per the existing government health system. Screening data comes from Female Community Health Volunteers (FCHVs). These FCHVs report to their respective health facilities every month. OTCC registers are maintained at OTCCs. These OTCC registers are maintained at the concerned OTCC. OTCC cards given to each enrolled case in the programme. In every follow up visit of each case, both the OTCC cards and OTCC registers are updated.

2.3 PROTOCOLS FOR THE MANAGEMENT OF SAM CHILDREN

All the children age 6-59 months in the community are screened every month by FCHV. The identified cases are then referred to OTCCs if the child's MUAC is <115mm. At the OTCCs, these cases are re-assessed through weight for height Z-score and MUAC. The children are admitted only if the children meet the following criteria of admissions:

- 6 to 59 months and
- MUAC <115mm or W/H Z-score <-3SD or presence of bilateral pitting oedema +/++ and
- Appetite test pass and
- No medical complication

Children are admitted to OTCC if the child meets the above-mentioned criteria. Depending on the distance of beneficiary to OTCC, the admitted cases are called for weekly or two weekly follow up visits. Cases can be in the programme with minimum of 42 days stay and maximum of 90 days once enrolled. The cases are discharged from the programme as follows:

A. Cured

- MUAC >115 mm and should have been enrolled in the programme at least for 42 days
- Weight gain in two consecutive visits
- No signs of bilateral pitting oedema in two consecutive visits
- Child looks healthy and active

B. Defaulter

- Absent for three consecutive visits if weekly visit
- Absent for two consecutive visits if biweekly visits

C. Death

If a child dies during treatment then discharged as dead.

D. Non Recovered

If the child does not meet the discharge criteria within 90 days under IMAM treatment, the case is discharged as non-recovered.

E. Transfer Out

If the child is admitted in an OTCC, but due to various reasons, e.g. seasonal migration the child will continue treatment in a different OTCC. In such a case, the child is transferred out to the OTCC (a different one). The child is also discharged as transfer out if the child is transferred to stabilization centre/in-patient therapeutic care centre.

F. Medical Transfer

The child is referred for medical treatment.

2.4 OBJECTIVES OF ASSESSMENT

The overall objective of the asessment was to evaluate the coverage of IMAM programme on management of SAM cases in Nuwakot district of Nepal. The specific objectives of the assessment were:

- To assess the coverage of the IMAM programme in Nuwakot district
- To identify boosters and barriers affecting the programme
- To develop recommendations/action plan for improvement of IMAM programme

3. METHODOLOGY

Barrier analysis and coverage assessment was conducted in June 2017 following SQUEAC methodology developed by coverage monitoring network. SQUEAC methodology is used globally for barrier analysis and coverage assessment.

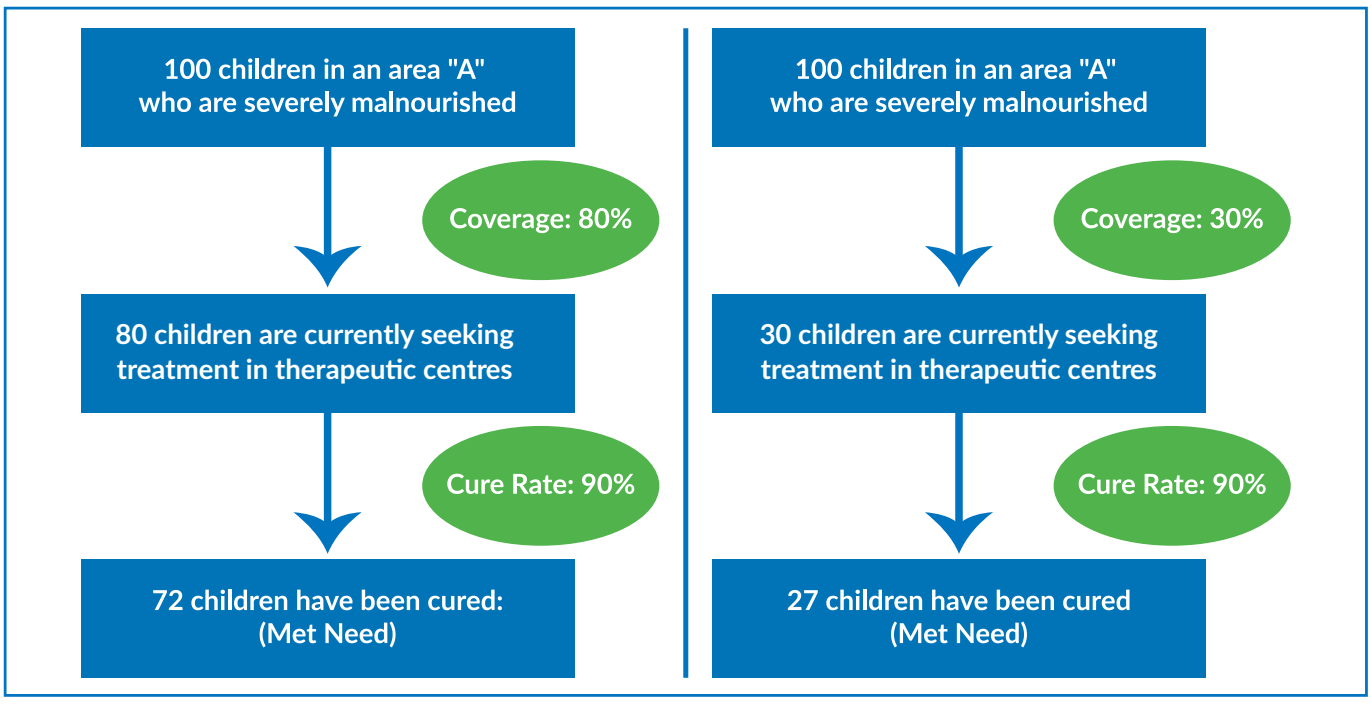
3.1 SEMI-QUANTITATIVE EVALUATION OF ACCESS AND COVERAGE (SQUEAC)

SQUEAC is a method that investigates and improves three aspects of Integrated Management of Acute Malnutrition (IMAM) programme, which includes effectiveness, coverage, and ability to meet need. It accumulates new and relevant information about coverage and factors influencing coverage. It also develops and test hypotheses about coverage and factors influencing coverage. It uses a mixture of quantitative (numerical) data collected from routine programme monitoring activities, small studies, small surveys, and small-area surveys, as well as qualitative data collected using informal group discussions and interviews with a variety of informants.

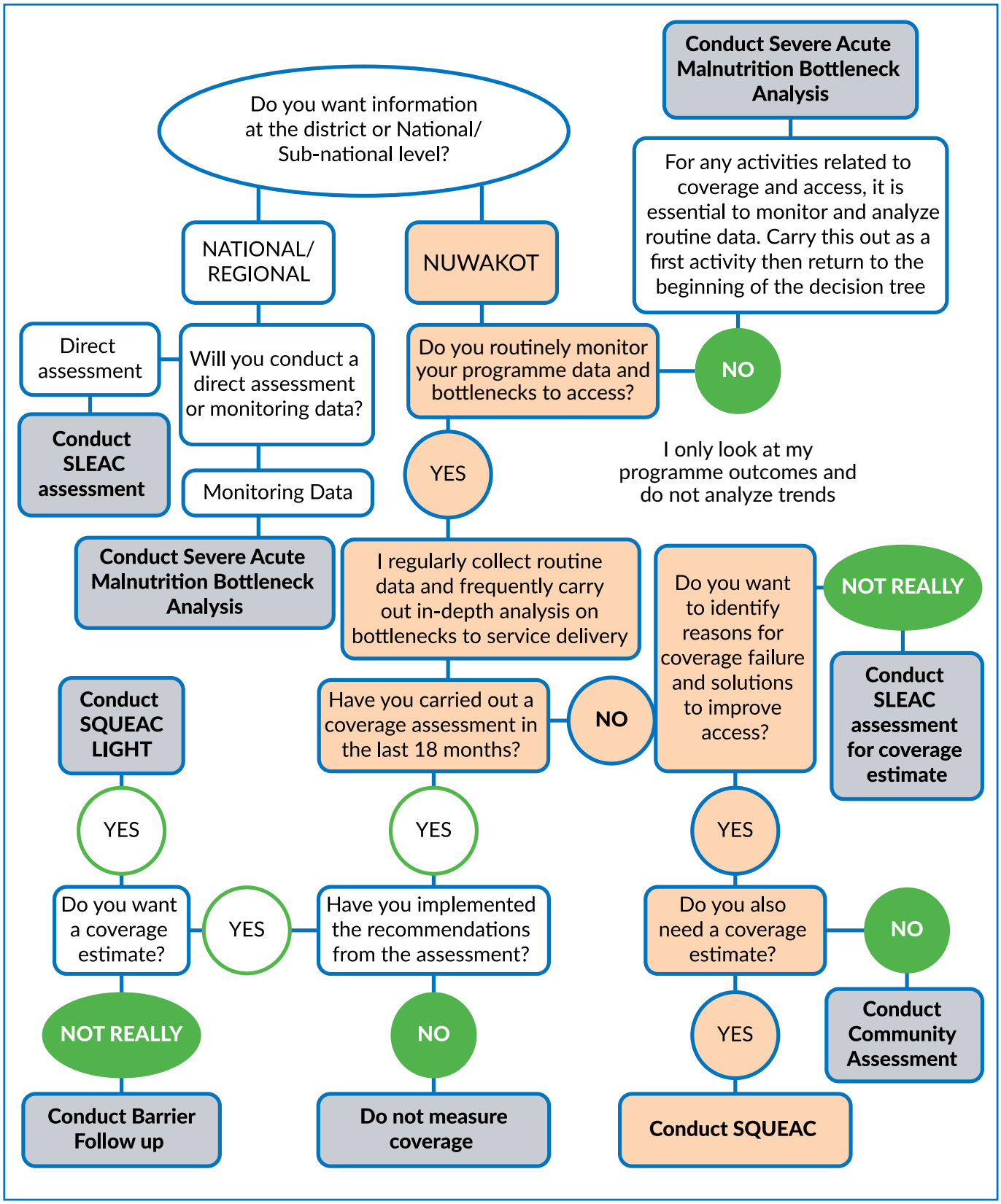
Coverage in context of IMAM programme is proportion of acutely malnourished individuals undergoing treatment in the programme with respect to total number of acutely malnourished individuals in a particular geographically defined area.

$$\frac{\textit{Number of SAM cases being treated}}{\textit{Number of SAM cases being treated and those NOT being treated (i.e.all SAM cases in the community)}}$$

However, the definition of coverage is not only limited to measurement of number of individuals who are in the programme and all those who needed to be in the programme. Programme coverage has wider scope, as highlighted in the figure below, including factors influencing coverage. It also looks into efficacy of the programme, measured by cured rate.



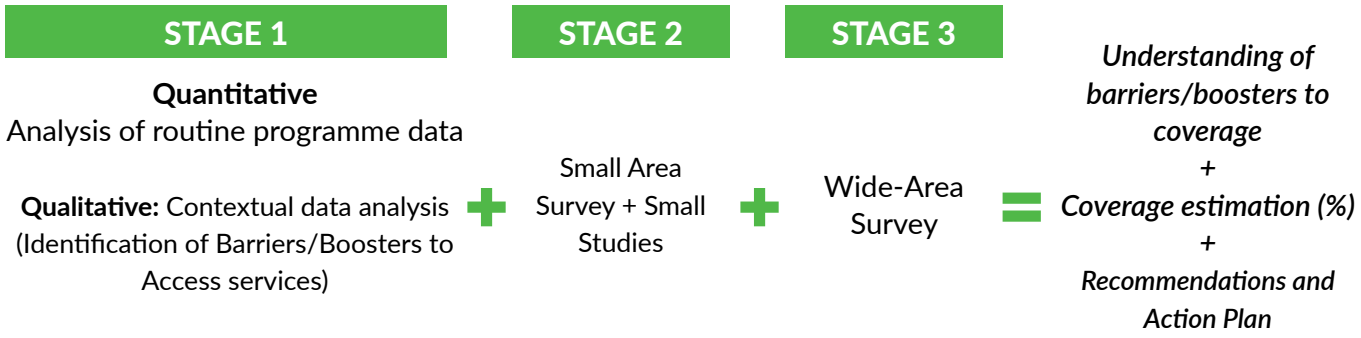
3.2 RATIONALE FOR SQUEAC BASED ON COVERAGE DECISION TREE DEVELOPED BY COVERAGE MONITORING NETWORK



(Source: http://www.coverage-monitoring.org/wp-content/uploads/2015/09/AAH-Coverage-Decision-Tree-Final.pdf)

3.3 SQUEAC PROCESS

The SQUEAC method uses a two-stage screening test model. **Stage 1** involves analysis of qualitative and quantitative information to identify barriers and boosters of IMAM programme, **Stage 2** confirms the location of areas of high and low coverage and the reasons for coverage failure identified in Stage 1 using small studies, small surveys, and small-area surveys. **Stage 3** provides an estimate of overall programme coverage using Bayesian techniques. This stage is undertaken only if it is appropriate and required.



3.4 ASSESSMENT TEAM AND TRAINING

Prior to the assessment conducted in the field, enumerators were hired. The training was conducted in two phase. For the first stage (i.e. qualitative data collection), five enumerators (2 females and 3 males) were enrolled for data collection along with supervisor. A day long training was conducted for qualitative data collection. During the training, enumerators were oriented about coverage assessment and its methodology. They were trained on administering the questionnaire. Demonstrations for taking interviews was done so that they can adopt it in the field. Sessions were focused on probing respondents so that maximum of the information can be extracted from them.

The team was divided into 5 teams; each team comprising of 3 enumerators. Each team consisted of one Technical Officer from Action Against Hunger as supervisor.

4. CHALLENGES AND LIMITATIONS

Some of the challenges and limitation faced during barrier analysis and coverage assessment are enlisted below:

- Since June – July is the closing month of government fiscal year, it was difficult to get time from government staff.
- The assessment started during monsoon. Even though it was planned to complete before the start of monsoon, it could not be conducted due to election. Monsoon is the pick season for agriculture and in Nuwakot most of the people in the rural areas depend on agriculture, most of the people were found to be away from the home. In many cases, during the data collection, many households were locked so couldn't meet mother and children. Returning to the same household was not possible because of dispersed settlement, difficult topography and inaccessible via roadways.
- The projection of number of children under five years as per HMIS was higher than the number of children found in few VDCs like Kakani located in the periphery of the capital city of Nepal, Kathmandu. The reason for this may be migration of people from those areas. Other VDCs like Samundratar, Rautbesi, Chaturale etc. also had less number of children. In some places, children enrolled in the programme were also missing.
- Interview scheduled for FCHVs had to be arranged either early in the morning or in the evening due to their busy schedule especially in farming. This resulted in difficulty in data collection.
- Even though IMAM programme has been implemented in the district since May 2015, the assessment was conducted compiling the data from January- December 2016. The data before 2016 was not captured in the assessment.
- It was found that the HMIS register was not maintained properly. For instance, the follow up visit of SAM child were missing, some cases were overstaying in the programme, and date of discharge was not filled. This led to discrepancy in the programme data and the actual registers maintained in OTCCs.

5. CONTEXT

5.1 OVERVIEW OF THE AREA AND POPULATION

Nuwakot district, situated in Central Hill region, is one of the seventy-five districts of Nepal. The hill region abuts the mountains and varies from 800 to 4,000 meters (2,625 to 13,123 ft.) in altitude with progression from subtropical climates below 1,200 meters (3,937 ft.) to alpine climates above 3,600 meters (11,811 ft.).

Population density is high in valleys but notably less above 2,000 meters (6,562 ft.) and very low above 2,500 meters (8,202 ft.) where snow occasionally falls in winter. The name, Nuwakot, is made up of two words 'nawa' and 'kort'. Nawa means nine in Nepali and 'kort' means sacred religious site at the top of hill. The district accordingly has nine hills over which various deities are said to dwell thus overseeing and protecting Nuwakot. This has led Nuwakot often being called "City of nine hills". The district, with Bidur as its district headquarters, covers an area of 1,121 km² and had a population of 277,471 in 2011. The district has approximately 29,265 children less than five years old as per HMIS target 2017/18. Nuwakot district is well known for religious, historical and tourism. Many places are of religious, historical importance. Nuwakot 7 storey old Palace, Nuwakot Palace and Bhairabi Temple are the most famous historical places of the district. Geopolitically, the district is administratively divided into 3 Electoral constituencies which consist, 13 former Illakas

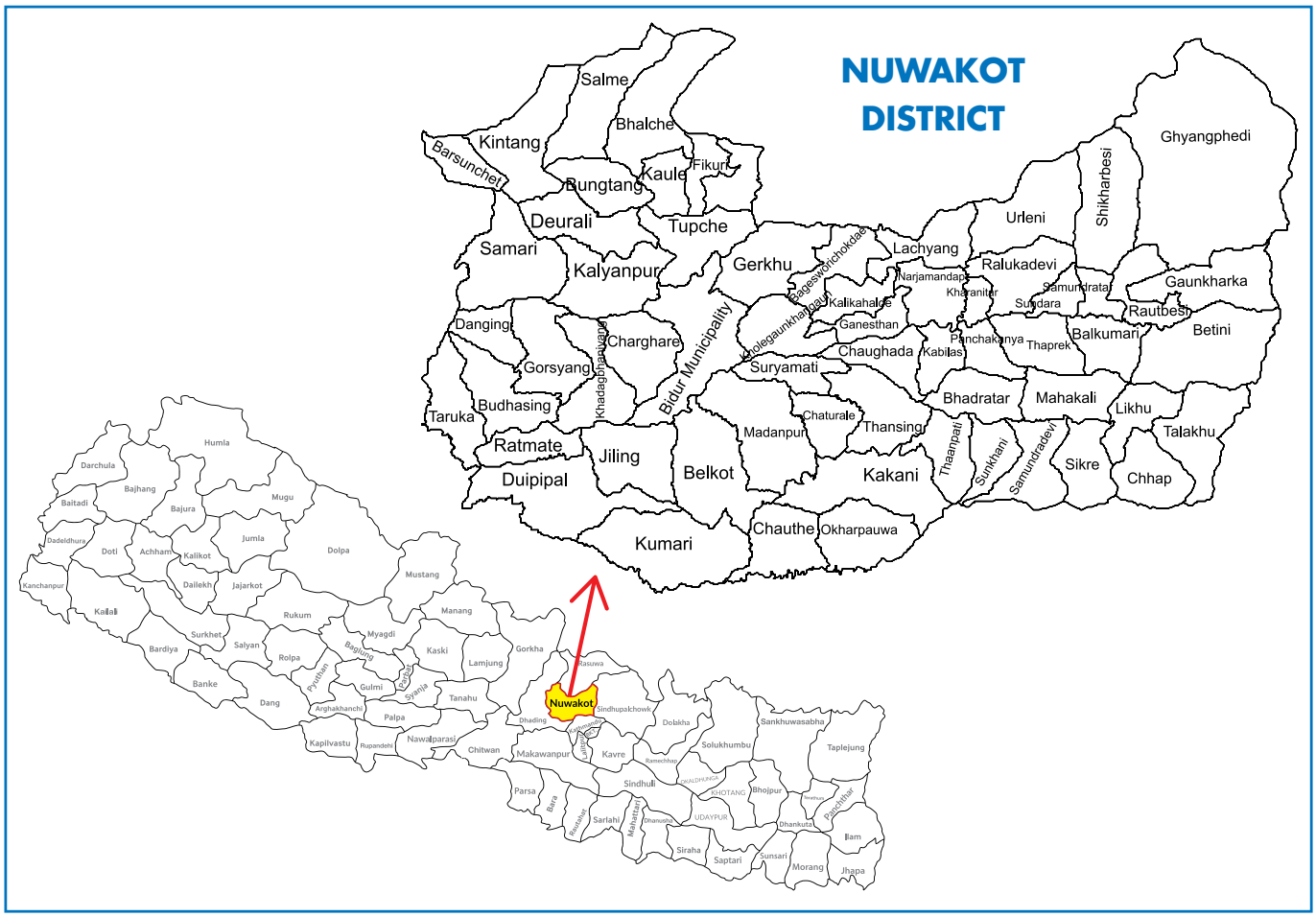


Figure 1: Map of Nuwakot district

with 61 VDCs and one municipality namely Bidur. Nuwakot is a hilly district of Nepal. It is located on the North-West of Kathmandu district. Although the district is located at the border of Kathmandu valley, many parts/VDCs of the district are still inaccessible by road and other development intervention.

Different ethnic castes (group) are found in Nuwakot. Majorities are Tamang (42.8%) and followed by Brahman/Chhetri (31.5%), Newar (7.4%), Rai (3.6%) and others (14.6%)[1]. There are altogether 499 educational institutions with 303 primary and pre pre-primary schools, 70 are lower secondary schools, 60 are secondary schools and 47 are higher secondary schools and 19 universities. Literacy rate of the district is 59.8% whereas female literacy rate is 52.4% and male literacy rate is 68%[2].

The Human Poverty Index Value for Nuwakot district is 35.7[3]. Major occupation in the district is agriculture. It has 112,100 (Ha) total lands out of which 35,995 (Ha) is forest land, 45,242 (Ha) cultivated land, 2405 (Ha) is non-cultivated land, 1352 (Ha) is snow land. Major agriculture production of this district is cereal crops (Paddy, Maize and millet).

5.2 DISTRICT HEALTH SYSTEM

At the district level, DPHO is responsible for implementing essential health care services (EHCS) and for monitoring activities and outputs of district hospitals, Primary Health Care Centres (PHCCs), Health Posts (HPs). The public service delivery outlets in the district include 1 government hospital, 3 PHCC, 64 HPs, 28 birthing centres, 5 rural health clinics, 4 urban health clinics, and 162 primary health care outreach clinics and 223 EPI outreach facilities in the district . Each level above HP is a referral point in a network from Health Post (HP) to primary health care centre (PHCC), from PHCC to district, zonal sub-regional and regional hospitals. The district has established 11 Outpatient Therapeutic Care Centres (OTCCs) for the provision of treatment to severely acutely malnourished children with support from UNICEF.

5.3 NUTRITION STATUS OF NUWAKOT DISTRICT

A nutrition survey known as SMART (Standardized Monitoring and Assessment of Relief and Transitions) was conducted in Nuwakot district in 26 May to 05 June 2016. SMART survey conducted showed that prevalence rate in Nuwakot district is at poor level [(i.e. 7.1% GAM (4.8-10.4 95% CI) and 1.8% SAM with a confidence interval (0.9-3.6 95% CI) and that the situation is in need of continued provision of treatment and prevention of acute malnutrition. Among the acutely malnourished children, 42.9% were stunted and 82.1% children were underweight. In addition, the district was classified as highly EQ affected district as a result of which most of the health system has been damaged and the district is in the process of recovery. Thus, this aggravating factor should be kept in mind as it can lead to further deterioration of the nutrition situation in the district.

The problem of chronic malnutrition and underweight in Nuwakot is at high level of severity 38.2% (32.9-43.9 95% CI) and 29.3% (24.0-35.2 95% CI) respectively. The trend calls for combined nutrition sensitive interventions targeting maternal nutrition, improved IYCF practices, promotion of good sanitation practices and access to safe water, healthy practices and appropriate use of health care services as well as strengthening household food security.

---

1 Population Monograph of Nepal, 2014; National Population and Housing Census 2011 (National Report)
2 National Population and Housing Census 2011(Village Development Committee/Municipality)Nuwakot
3 Nepal Human development report 2014
4 District Health Report, Nuwakot, 71/72

6. BARRIER ANALYSIS AND COVERAGE ASSESSMENT

6.1 QUANTITATIVE DATA COLLECTION AND ANALYSIS

6.1.1 Stage 1: Quantitative data analysis

Initially, quantitative information of the programme was gathered using the data collected and recorded by the programme. The data collected was validated by the programme with the registers maintained at OTCCs. After validating the programme data and data recorded in registers, it was found that there were few discrepancies in the information collected and the actual information recorded in the register. These information were rectified before further analysis. The quantitative information of the programme was collected from IMAM Register 2.6 maintained at all 11 OTCCs from January to December 2016.

6.1.2 Admissions over time

The graph below showed that significant number of cases were enrolled in the programme in between the month of April and May 2016. The enrolment dropped down steadily during the month of June and July, which is a bit contradictory to the general trend because epidemic of diarrhoea and other water borne diseases are prevalent during these months. This might be because of the monsoon season, resulting to blockage of roads and trials. Furthermore, the majority of the people of most of the parts of the districts is engaged in cultivation and hence the priority is given to the cultivation rather than taking care of the children. However, the enrolment peaked in August 2016, which might be because 2 days community level training done in July and August. The second day of the training was followed by the screening of the children that helped in identification of the cases and referring the identified cases to concerned OTCC. The enrolment dropped down from September onwards, this might be because of festive season. During the festival, most of the households have abundant food stock and hence less malnourished cases are reported.

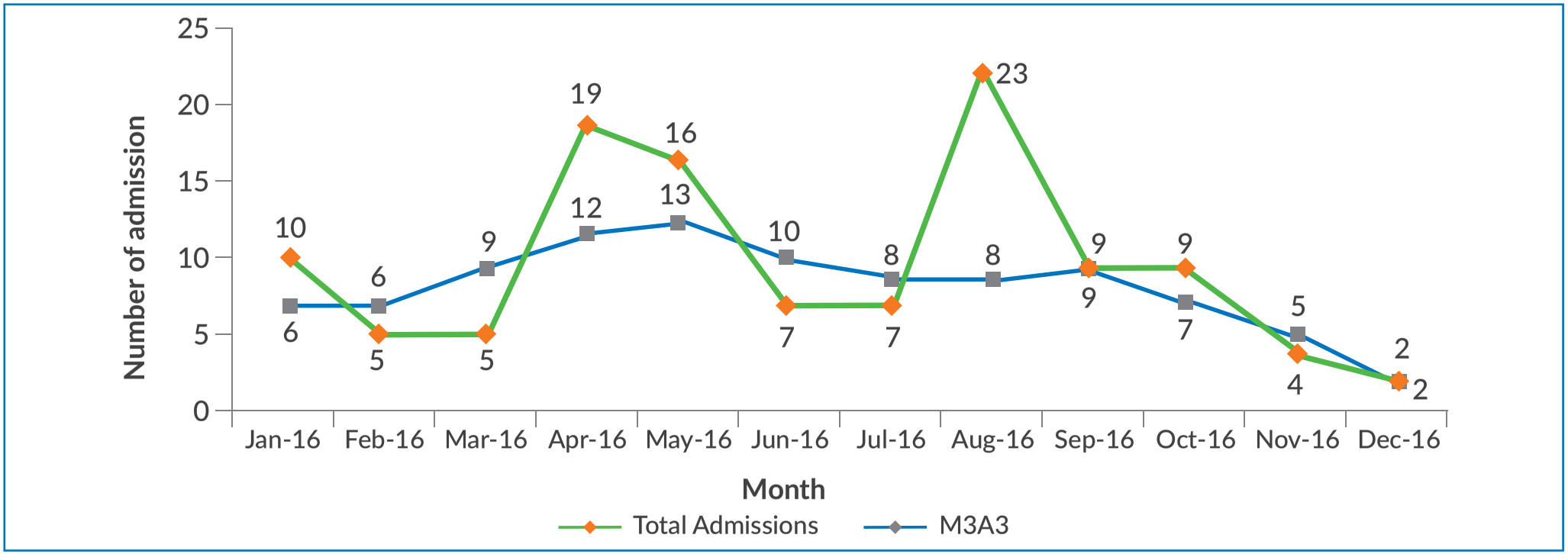


Figure 2: Admission over time

Description	January	February	March	April	May	June	July	August	September	October	November	December
Rainy season						Normal	High	High				
Temperature	Very cold	Normal cold		Very Hot	Very Hot	Normal	Normal	Normal			Normal Cold	Very Cold
Harvest time (main staple foods)			potato, Cauliflower, Cabbage Vegetable production, strawberry	Wheat Harvest		Rice cultivation Harvesting/ litchi, Mango	Rice cultivation	Maize Harvesting	Maize Harvesting	Potato, Cauliflower, Cabbage Vegetable production	Rice Harvesting	
Holidays and festivals										Dashain	Dipawali/ Tihar	
Pneumonia	High		Low				Moderate				High	
Diarrhoea						High						
Community level training												
Hygiene kit distribution												
Cookery kit distribution												

The figure shows the list of major events that take/took place from January to December 2016. Peak in admission in the month of August might be due to the community level training that started in the 3rd week of July and ended in 1st week of August. The community level training was followed by screening of 6-59 children. The identified cases during community level training might have been enrolled in August and hence peak observed in this month. The rapid fall seen starting from September might be due to cookery kit distribution, which was followed with MIYCN counselling to the mothers of golden 1000 days.

6.1.3 Admissions per health facility

The below graph showed that the number of the cases enrolled in OTCCs from January to December 2016. The graph shows that Trisuli hospital has the highest number of cases enrolled. The higher number of cases enrolled in this health facility might be because Trisuli hospital is the district hospital of the district with easy access via transport.

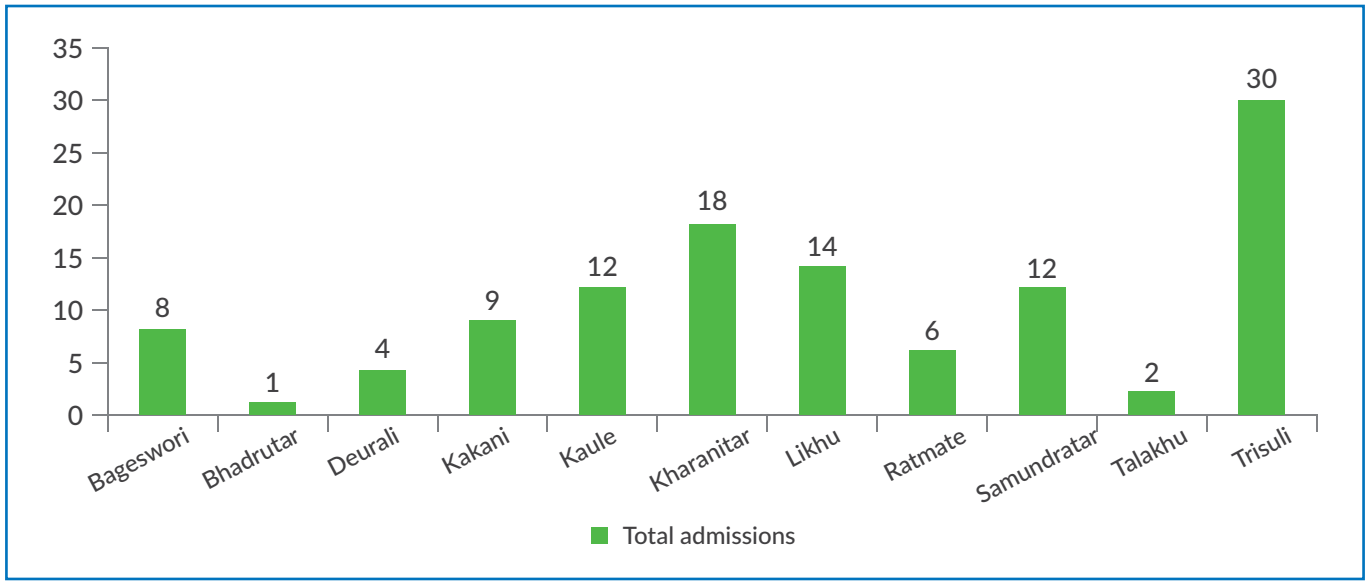


Figure 3: Total admission per health facility

6.1.4 Admissions on MUAC

The analysis of the registers also revealed a clear preference to MUAC criterion than WHZ criterion for admissions. As of total admissions, more than 70% of the cases were enrolled into the programme with MUAC measurement and there was no any case admitted by oedema. The graph below shows that the median MUAC on admission was 112 mm. There is no any clear cut offs for early admissions or late admissions. There were cases enrolled in the programme with MUAC less than median and some with more than median MUAC. Some cases were found to be enrolled in the programme when MUAC was 114 mm, which can be considered as very early detection of the cases. Most of the heaping of admission is seen at MUAC 110 mm. Even though median MUAC was found to be 112 mm but the cases with 98 mm, 99 mm to 114 mm MUAC reading were found to be enrolled in the programme. From the programme perspective, early detection of the cases and initiation of treatment at the early stage should be prioritized.

[5] http://www.spherehandbook.org/en/management-of-acute-malnutrition-and-micronutrient-deficiencies-standard-2-severe-acute-malnutrition/

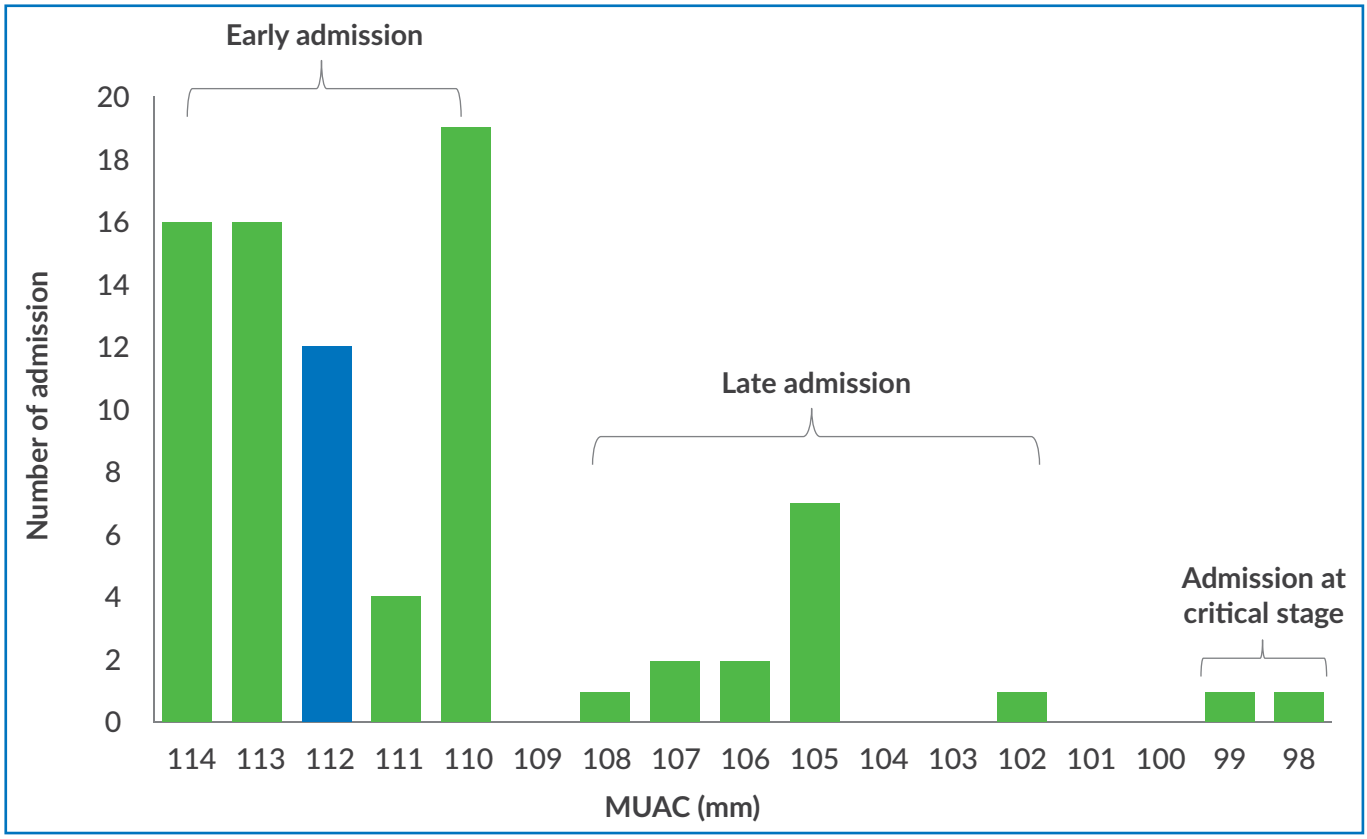


Figure 4: MUAC at admission

6.1.5 Type of discharge over time

In SAM management, the discharge outcomes include the children who are discharged as cured, default, death and non-recovered. As per the Sphere standard, a well performing OTCCs should have the cured rate of >75%, death rate <10% and defaulter rate <15% (Minimum standards in food security and nutrition,

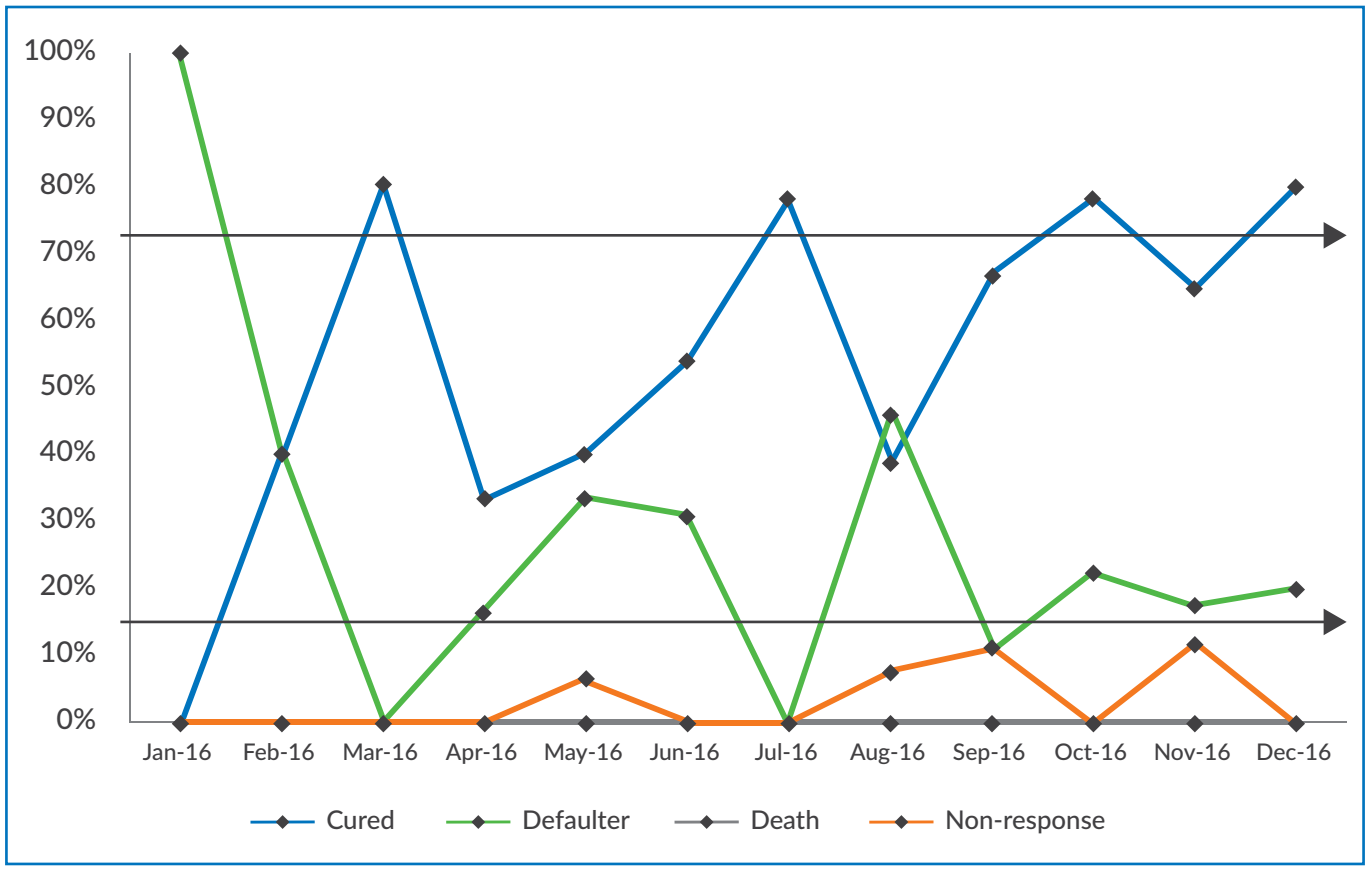


Figure 5: Discharges over time -all health centres

sphere Project[5]). However, while analysing the register, one of the notable issues that came across was detection of hidden defaulter. The time between the follow ups exceed 4 weeks, meaning they missed two consecutive follow up visits resulting in hidden defaulter. In some cases dates for follow up visits made by the beneficiaries was missing. This led in difficulty in tracking the defaulters on time. In some cases, there was no record of date of discharge and even missed the type of discharges made. In some instances, the cases seemed to continue the IMAM treatment even after crossing the length of stay. This suggests for refresher training to all the health workers focusing on maintaining proper recording in the registers.

6.1.6 Discharge outcomes per health centre

The standard treatment protocol on IMAM states that first follow-up visit after the enrolment should be weekly and then followed by routine follow-up visits in OTCCs can be either weekly or fortnightly depending on the ease and feasibility. However, while analysing the registers it was difficult to say whether the visit was weekly of fortnightly. Some beneficiary had follow-up visits of less than a week, while others had monthly follow up visits. The first follow up visits was not same across the health facilities ranging from one week to fifteen days to month after admission. Furthermore, there was inconsistency in the date of first follow up visit. For instance, the first follow visit and the date of admissions were recorded same while in some it was the date of first follow up visit rather than the date of admission. In some cases, the date of follow up was completely missing. Absence of date of follow up visit made it challenging to validate the compliance to treatment protocol.

The figure above showed that defaulter rate of the OTCCs in Kaule, Bageswori, Likhu and Kakani is comparatively higher. The geographic terrain of these VDCs is complicated with disperse settlement. The long distance between the OTCCs and beneficiaries' household may be the reason for high defaulter rate. The cured rate for Bhadrutar and Talakhu was apparently 100%. This is because in the OTCCs there were very less cases enrolled. Both OTCCs in Bhadrutar and Talakhu have difficult geographic terrain and the distance between the households within the same VDCs are too far to travel.

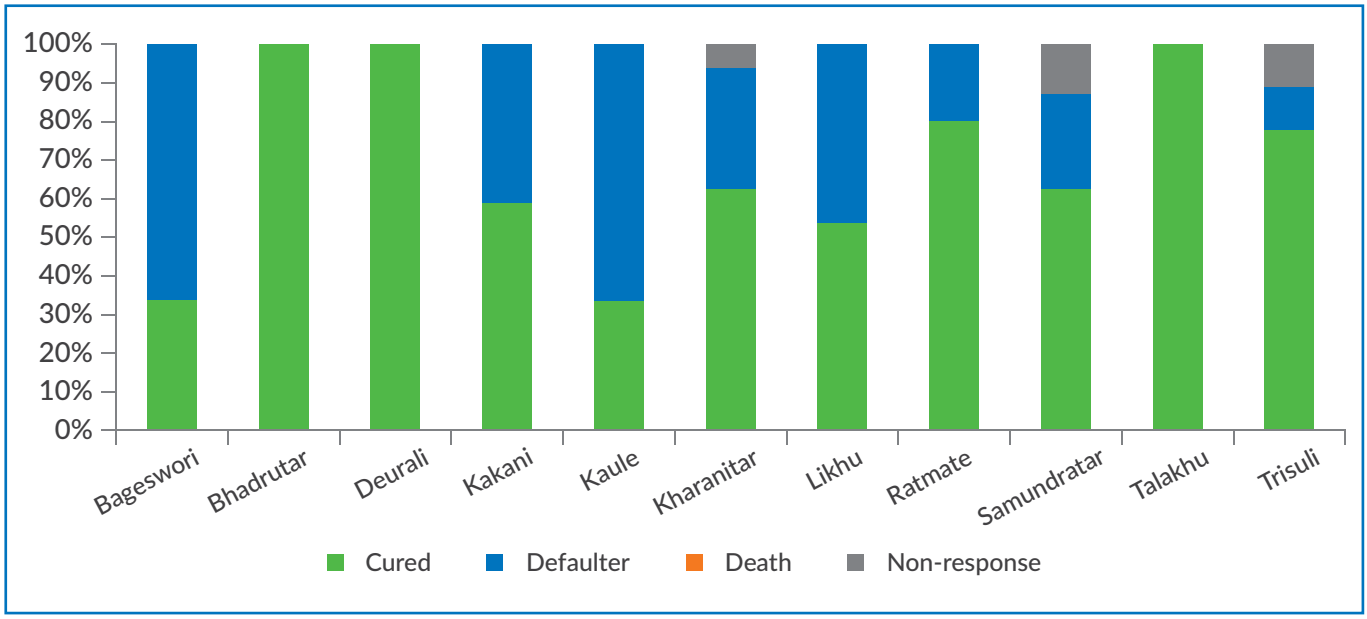


Figure 6: Discharges outcome per health facility

6.1.7 MUAC on discharge as default

The figure below showed that the cases defaulted at MUAC ranging from 105 to >=125 mm MUAC reading. This gives us the information that there is both early defaulters meaning that the cases stayed in the programme for very short period and defaulted when they are still at the critical stage. Similarly, there are cases who defaulted when their MUAC is improving and closed to meeting the discharge criteria. In both the cases, who defaulted at improving MUAC and who defaulted still having critical MUAC are likely

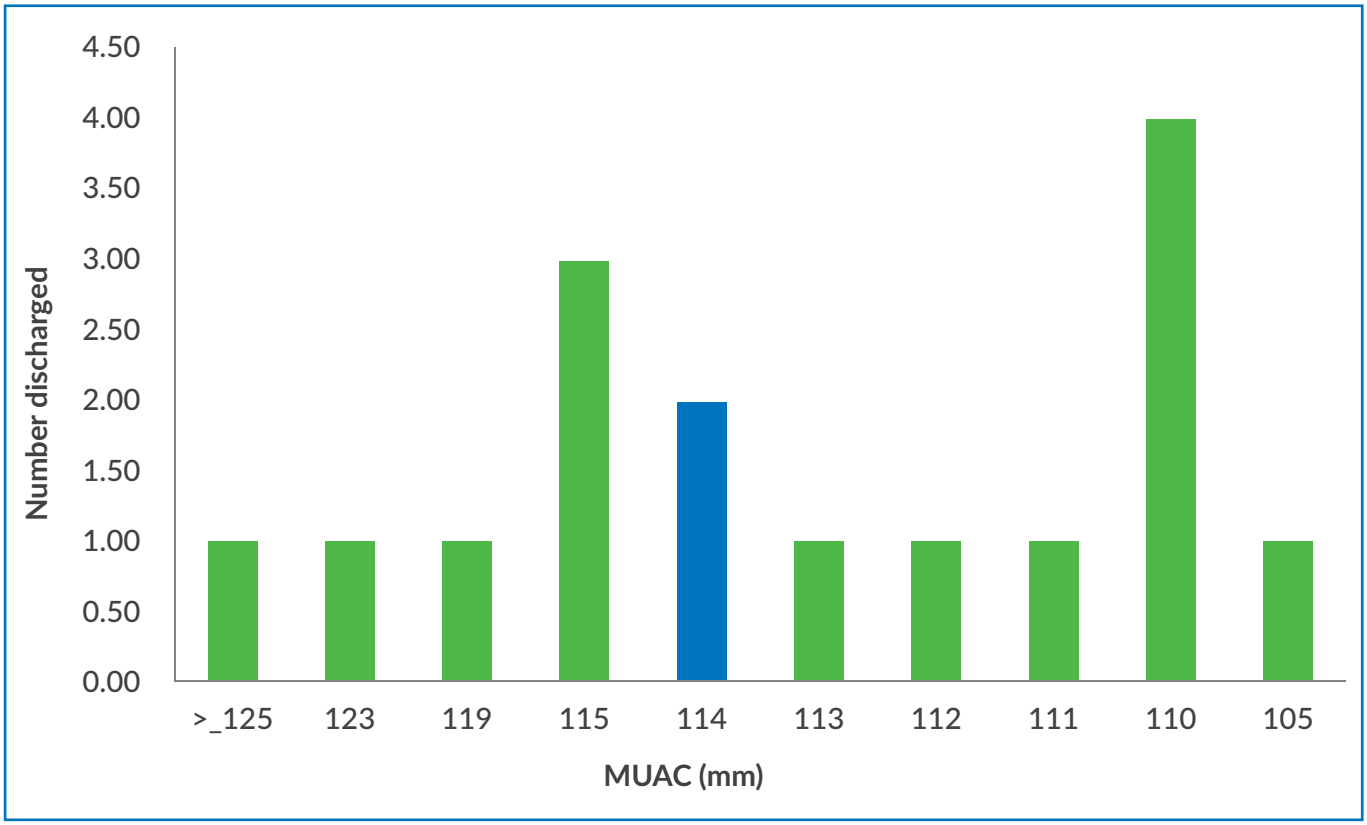


Figure 7: MUAC at discharge as defaulted

to worsen their conditions leading to more complications. The median MUAC for defaulting was shown at 114 mm. Similarly, it was also observed that there were some cases with MUAC greater than 115 mm.

6.1.8 Defaulting over time

The graph below showed the defaulting cases from January to December 2016. As from programme perspective, defaulter rate is the major issue for sustainability of the programme. The graph below showed the peak in the month of August this might be due to the monsoon rain. As during monsoon, in many parts of the districts, landslides occur and mobility of the people is minimal. The mothers and caretakers do not intend to take their children for seeking health services in such condition leading to higher defaulter rates.

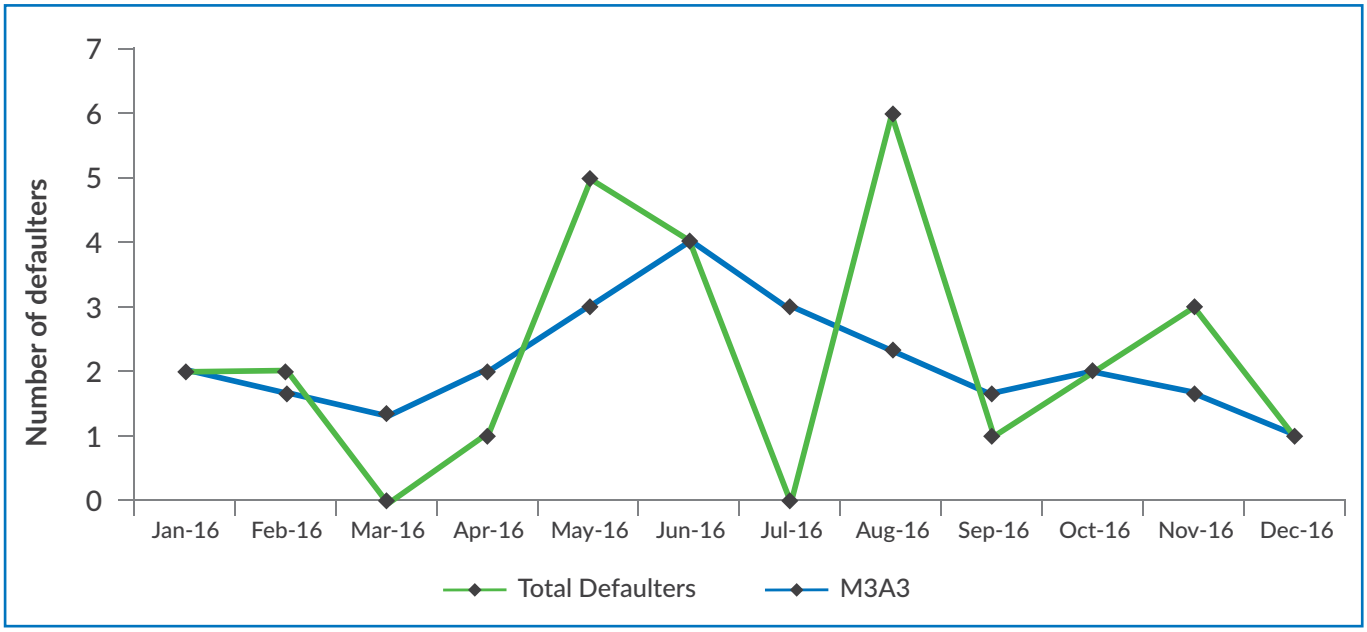


Figure 8: Defaulter over time

6.1.9 Time of default

The graph below showed that the defaulters heaped in the first and second week of enrolment. This means that the defaulters are still malnourished at the time of defaulting with the median MUAC of 114 mm resulting in likelihood to worsen condition of malnourished children due to incomplete treatment. The impact of defaulting of the child depends solely on the stage of defaulting. If the child defaults after receiving treatment up to 6 weeks, there is likelihood that the child gets recovered. However, if a child stays for <6 weeks and gets default, there is high likelihood of the children to be at risk of being malnourished or even worsened condition.

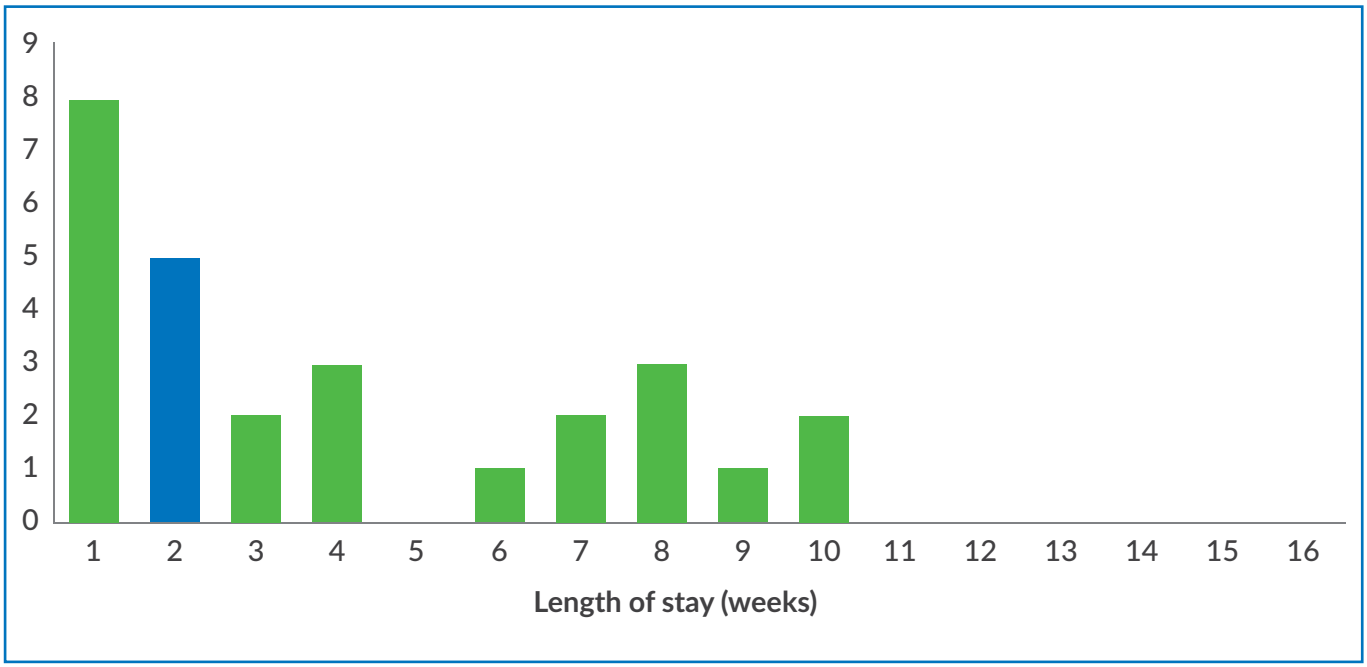


Figure 9: Weeks in programme before discharged as defaulter - all health centres

6.1.10 Length of stay of cured cases

From the graph below, it was observed that the median length of stay is 9 weeks. The IMAM guideline suggests that the minimum length of stay for a SAM child is 42 days, which is equivalent to 6 weeks, and maximum length of stay is 90 days, which is equivalent to 12 weeks. However, looking at the graph below, the cases have been discharged as cured without meeting the minimum length of stay criteria questioning on the compliance of the treatment. Similarly, significant number of the cases have overstayed in the programme i.e. beyond 90 days. This shows that there are still rooms for improving the programme. For improving the compliance of the treatment, the services or treatment should be done as per the IMAM guideline provided.

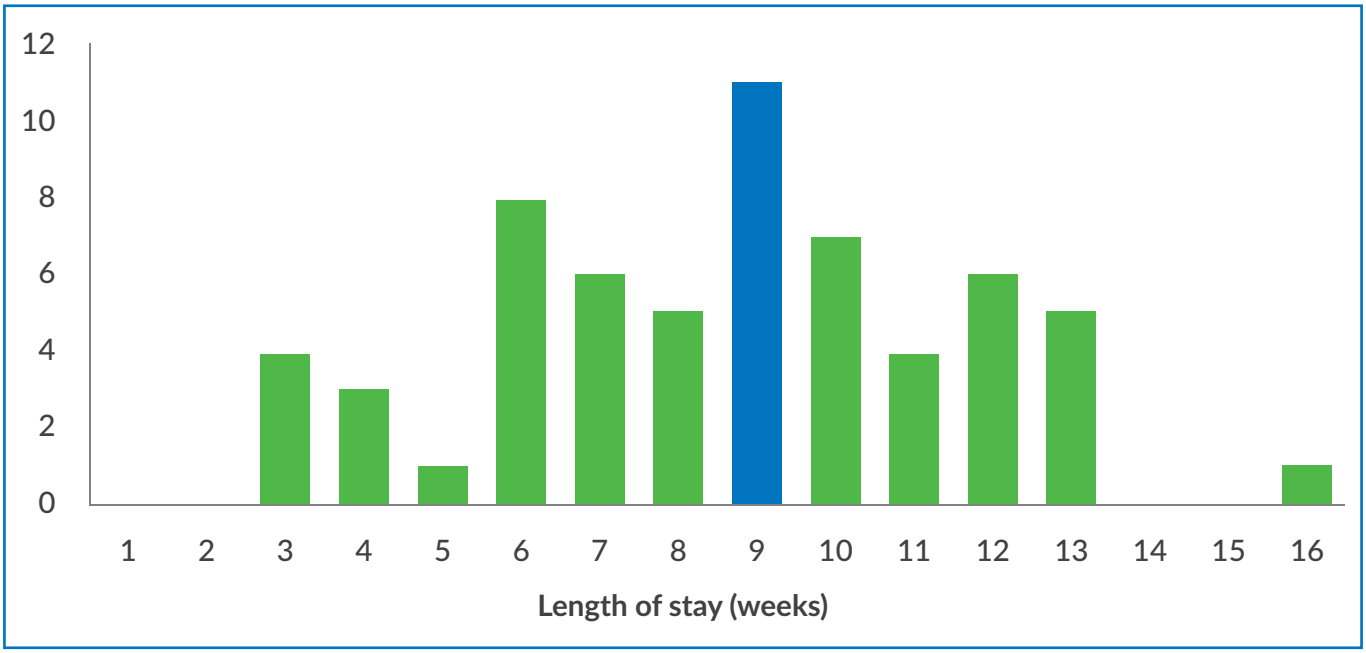


Figure 10: Weeks in programme before discharge cured

6.1.11 Admission and default by distance

The table below showed that the admission peaked from the beneficiaries coming from 1.5 to 2 hours distance by walking or by means of transportation. The table below showed that there are fewer number of children from the longer distance than those from the nearer distance.

Table 2: Admissions by distance

Distance	No. of ward	% of ward	No. of Admissions	% of Admissions
<=2 hrs	48	56%	73	62.93%
>2 hrs	38	44%	43	37.07%

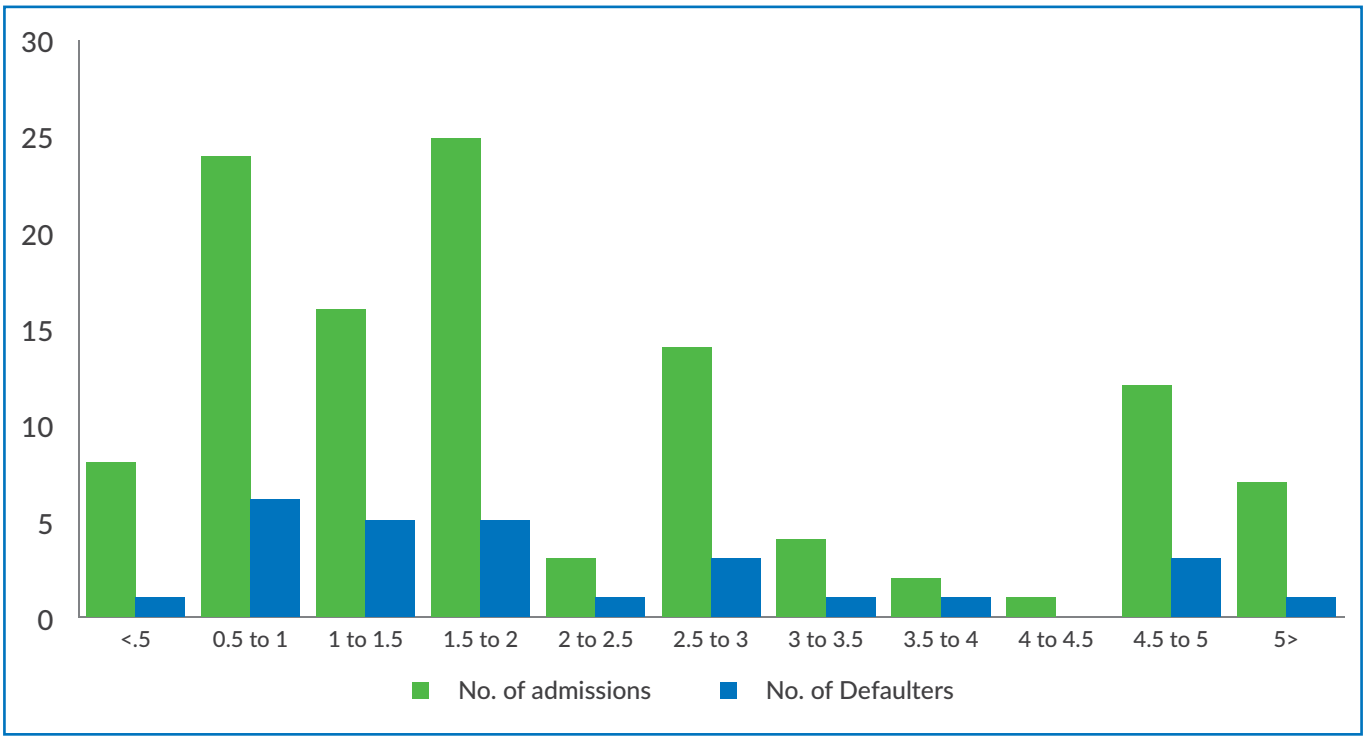


Figure 11: Admissions and defaulters by distance in hours

6.1.12 MUAC on discharge.

One of the discharge criteria in SAM management is MUAC > 115 mm. Looking at the graph, MUAC for discharge was 115 mm at lower limit and exceeding 125 mm at upper limit. The median MUAC during discharge was 120 mm MUAC reading. However, it was observed that majority of the cases were discharged at MUAC 115 mm. This shows that discharge criteria is not properly followed at OTCCs. It can also be said that supportive supervision done by various levels have been less effective and hence needs more supportive supervision at OTCC level.

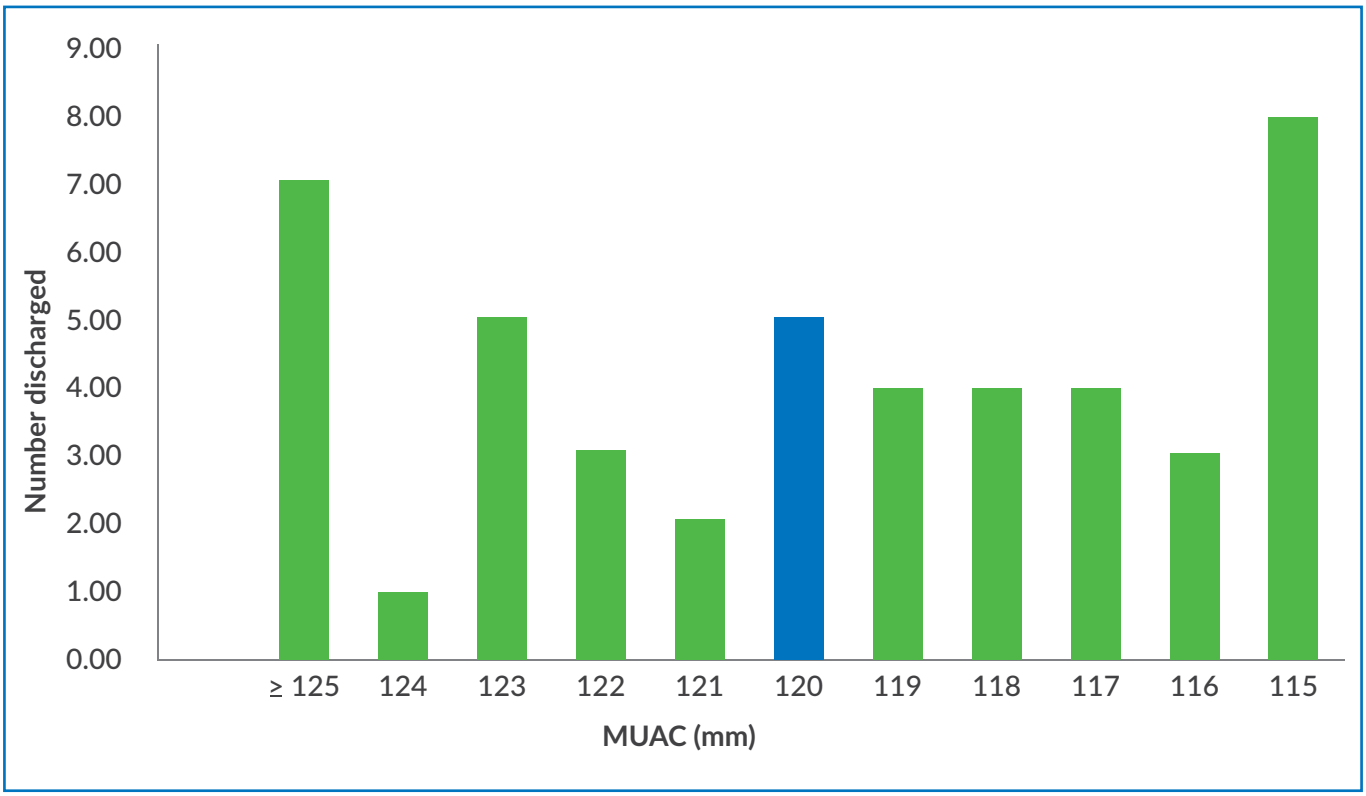


Figure 12: MUAC at discharge cured

Table 3: Performance Indicator from Jan to Dec 2016

Months	Cured	Defaulter	Death	Non Response
Jan	0%	100%	0%	0%
Feb	40%	40%	0%	0%
Mar	80%	0%	0%	0%
Apr	33%	17%	0%	0%
May	40%	33%	0%	7%
Jun	54%	31%	0%	0%
Jul	78%	0%	0%	0%
Aug	38%	46%	0%	8%
Sep	67%	11%	0%	11%
Oct	78%	22%	0%	0%
Nov	65%	18%	0%	12%
Dec	80%	20%	0%	0%
Jan to Dec	56%	25%	0%	5%

6.2 QUALITATIVE DATA COLLECTION AND ANALYSIS

The interview guides for collecting qualitative information was adapted from the interview guides from the coverage monitoring network. Qualitative information was collected from range of individuals including mothers/caretakers of under-five children, mothers/caretakers of malnourished children, representatives of community-based orgnizations, FCHVs, IMAM focal person, teachers, and health facility in charge and CNWs of partner organization. The qualitative information was collected from group discussion, in-depth interviews, semi structured interview as well as observations. The qualitative information helped to know the perception of the community and their sensitiveness on the issue of malnutrition and health seeking behaviour. Such information is particularly helpful in analysing the barriers and boosters of coverage of IMAM programme.

In the catchment area of an OTCC, a ward far and a ward near, wards with high and low admission, wards with high and low defaulter were visited. The assessment team visited 15 clusters/wards of 8 different OTCCs. The assessment was done considering two principles of SQUEAC, triangulation and sampling to redundancy. At the end of each day of data collection, discussion was done among the assessment team about the information generated from the interviews, group discussion and observations.

Table 4: Selected VDCs for qualitative information

S.N	Village Name	OTCCs
1	Rautbesi 04	Samundratar OTCC
2	Samundratar 02	Samundratar OTCC
3	Haldekalika 04	Bageswori OTCC
4	Narjamandap 02	Kharanitar OTCC
5	Kaule 06	Kaule OTCC
6	Fikuri 05	Kaule OTCC
7	Duipipal 01	Ratmate OTCC
8	Bhadrutar 02	Bhadrutar OTCC
9	Bidur 04	Bidur UHC
10	Charghare 05	Bidur UHC
11	Thanapati 02	Bhadrutar OTCC
12	Bhalche 07	Kaule OTCC
13	Gorshyang 08	Bidur UHC
14	Khadbhanjyang 04	Bidur UHC
15	Deurali 04	Deurali OTCC

Table 5: Barriers and boosters identified in Stage I and their description

S.N	Barriers	Explanation	Sources	Locations	Methods
1	Longer distance to OTCCs (geographic terrain)	Geographical distance has been one of the reason for high defaulters. It takes more than an hour to reach to OTCC on foot. There is no any means of transportation so have to walk. More over during rainy season, water level in the river increases and cannot cross the river. Most of the villages do not have access to transportation. So had to walk for longer hours for visiting OTCCs. There is also high probability of landslides during rainy season. Additionally mothers are reluctant to take their children to longer distance especially when their children are in severe condition.	I,M,$,Ω,ʘ, Ⓟ,©ϴ	RatHF,HK04, Rau4,Sam2, Fi5,Tha2	SSI,KII,GD
2	Negligence of caretaker on care of malnourished children	Even though mothers/caretakers are counselled on malnutrition. Mothers have the perception that malnutrition is not a disease. Due to this, they are reluctant for regular follow up visits. Mothers stop feeding RUTF when they think that their children have recovered due to which the children do not stay as per the protocol of IMAM. This lead to high probability of relapse and defaulter.	I,Ⓟ©	RatHF, KhaHF,BhaHF,B4,Bha7, KB4	SSI,KII,GD
3	Language barrier	Language has been one of the barriers in counselling the mothers of the cases. There is no two-way communication between caretakers and health workers. Due to this, they are hesitant to ask any queries. Not following the protocol for follow up visits, not feeding properly could be the result of the language barrier.	I,Ⓟʘ	RatHF,Sam2,Bha7	SSI,GD
4	Preference of traditional healer (esp. Rai community and where HF is far)	First contact point for health services is the traditional healers especially for the rural and ethnic and indigenous communities like, Rai, Tamangs. It hindered in early identification of the cases and timely enrolment in the programme.	M,$,ʘ	HK04,Kau6, Fi5,Sam2,Dr4	SSI
5	Taste of RUTF	SAM child refuse to consume RUTF. Since the children refuse to consume RUTF, most of the mothers are reluctant to take their children to OTCC for follow up visit, which leads to absentees and defaulter.	M,$,Ⓟ	HK04,KhaHF,Sam2	SSI
6	Unavailability of health workers at the health facility during the visit of case	When there is unavailability of the health workers during follow up visit, mothers/caretakers are reluctant to revisit the OTCC leading to defaulter case.	$	HK04	SSI
7	Less literate people	Minimal in understanding level of mothers and caretakers towards malnutrition.	ʘ	Kau6	SSI
8	Lack of awareness on care practices, sanitation, IYCF	Unable to realize the importance of care practices that contributes to minor illness and sanitation problem which further contribution to malnutrition. In addition to this, lack of awareness in IYCF depletion of nutritional status and hinders the progress of cases consuming RUTF.	ʘ,Ⓟ	Kau6, Fi5,RatHF,Dr4	ssI,KII

S.N	Barriers	Explanation	Sources	Locations	Methods
9	Turnover of trained HF staff	Turnover of trained over has been a problem in handling the cases as the new staff is unaware of correct procedures for the treatment. If partner staff is not present, there is high probability that cases are being returned without getting any treatment.	Ⓟ	Sam2,DrHF,Kau6	SSI
10	Sharing of RUTF with other children	It was found that there is sharing of RUTF among siblings especially when there are kids of similar ages. This leads to increase in length of stay as the child do not meet Reference Nutrient Intake (RNI).	Ⓟ⊙M	Sam2,Rau4	SSI
11	Limited supervision and monitoring	There has been limited supervision and monitoring from higher level. If there has been visits, it would have increased the ownership and provided guidance to the health facility staff.	Ⓟ⊙	Sam2,Dr4	SSI
12	Workload of caretaker/mothers, less time for child	Household chores are the responsibility of female (mothers). Additionally, workload increases during cultivation and harvesting time. Due to this, they cannot afford their time in taking care of the children. It contributes in increasing defaulters.	⊙©	Fi5,B4,KB4, DrHF	SSI
13	IMAM services limited only to OTCC	VDCs with OTCCs have strong awareness regarding IMAM whereas communities from the VDCs without OTCCs are unaware regarding IMAM.	Ⓟ$Θ	BhaHF,Tha2	SSI
14	Side effects of RUTF (Diarrhoea, Vomiting)	Mothers are reluctant to feed RUTF due to the side effects seen among their children. In addition, the children do not prefer to consume RUTF once they experience vomiting and diarrhoea. This lead to non-recovery and defaults.	Ⓟ⊙Ω	BhaHF,B4,KB4	ssi
15	Misconception of community regarding RUTF	Community have misconception that RUTF has been distributed free of cost as it is being experimented in the rural communities. This might have discouraged mothers for not visiting the OTCCs.	$Ⓟ	BhaHf,Gor8	SSI
16	Poor economic condition	Due to poor economic condition, parents of the children are busy in daily wages labour activities. Hence, they do not have time for taking care of their children. Also in some cases, even though children come to HF for the first visit, in most cases they do not visit for second visits and so on, as they cannot afford the transportation cost. Apart from this, they cannot afford to nutritious food for their children, even though they are aware that their children requires nutritious food for the overall growth and development.	⊙Θ©	Fi5, Tha2,Rau4,B4	SSI,GD
17	Lack of ownership by HWs	Usually in absence of CNWs, the cases are returned empty handed. Though health workers have been trained, they rely on CNWs for providing IMAM services.	©	B4	SSI
18	Lack of decision making power among mother	Since the decision making power lies on husband or in law, the mothers cannot take their children to the OTCCs.	©	B4	SSI

S.N	Barriers	Explanation	Sources	Locations	Methods
19	Weak coordination between OTCC and ITC	There is hesitant for referring cases to ITC and vice versa.	Ⓟ	Sam2	SSI
20	Inappropriate practice of feeding RUTF	The inappropriate practice of feeding RUTF like mixing RUTF with water, milk and also feeding RUTF as well as other food lead to low dose of RUTF (RNI) and hence lead to longer length of stay. It can also contribute increasing non-recovery rate.	Ώ,Ⓞ	KB4,B4	SSI
21	Improper MUAC measurement and reading by FCHVs	Some FCHVs still have difficulty in taking measurement. This lead to high number of wrong admissions.	Ⓟ©	KhaHF, Dr4	SSI, Obs
22	Visiting a medical shop for treatment	Preference of community people to seek treatment from medical stores/pharmacy still exist. This may lead to minimal visit to health facility.	Ⓞ©	HK4,B4	SSI
23	Improper maintenance of records and delay in reporting by FCHVs	Delay in reporting by FCHVs delayed the enrolment of identified cases and tracing the cases to be followed for home visits.	Ⓞ,Ⓟ	Dui1, DrHF	SSI

S.N	Booster	Explanation	Sources	Locations	Methods
1	Capacity building of FCHVs/health workers	Health workers as well as FCHVs are trained on IMAM programme. The training capacitate them on management of the cases. The training also helped them to motivate them. Furthermore, it also helps them to own the programme.	Ⓞ,Ⓟ	Dui1, KhaHf,HK04, Rau4, Sam2, Kau6,C5,KB4	SSI
2	Discussion of regarding IMAM programme in mothers group meeting	Since during mother's group meeting, the mothers are counselled on care practices of children. The mothers are updated on IMAM programme. This has also been a platform to find out the hidden cases and trace default cases.	Ⓞ,M,©	Dui1, HK04, Rau4, Sam2, Kau6, c5,Bha7	SSI
3	Monthly screening	Monthly screening is one of the major activity. This has helped to reach maximum of the cases and to track the cases to be followed up. It also helped to track the progress of the cases that has been enrolled in the programme.	Ⓞ,M,	Dui1, HK04, Fi5, Kau6,c5,Bha7,KB4	SSI
4	Integration of screening in PHC/ORC	The integration of screening during PHC /ORC has helped to identify the cases and build the ownership of the programme by the health workers.	$Ⓞ℗	NM2, Rau4, Fi5,KB4	SSI

S.N	Booster	Explanation	Sources	Locations	Methods
5	Self motivation for regular follow ups by mothers	The mothers are motivated to know the progress of the child who is being enrolled in the programme. Seeing their children's progress, they are motivated for follow up visits. This has also helped in creating awareness about the programme by mothers themselves.	ʘ	NM2,c5	SSI
6	Presence of CNW in field	Presence of CNW in OTCCs have helped to provide services when health workers are on leave. It also helped on job site coaching for new staff. It also helped in supporting active case finding.	ʘ,℗	KhaHF, Sam2, Kau6	SSI
7	Awareness of IMAM programme among community	IMAM programme has reached in capacity building of various community based fora. This has helped to raise awareness among the community. This has helped in strengthening referral mechanism.	Ώ,M	Rau4, Sam2,B4,KB4	SSI,Obs
8	Supportive HWs, teacher, other INGO's representative	Health workers are positive towards IMAM programme. It helped to coordinate between supporting organization and the health facility (OTCC). This has helped in intervening in different platforms. For e.g. nutrition and health cluster meeting.	Ώ,ʘ,©	Rau4, Kau6	SSI
9	Strong coordination and communication among HFs and FCHVs	Strengthen the referral mechanism, tracking defaulter, validate recording and reporting.	ʘ,©	Kau6,KB4	SSI
10	Effective follow up visits protocol (2 weekly)	Since many of the villages are far from OTCCs, two weekly visits have been effective. Moreover, it is also effective to monitor the progress of the cases.	ʘ	BhaHF,	SSI
11	Active involvement of FCHVs in IMAM programme	Regular screening by FCHVs, helped in defaulter tracking, regular home visits and sensitization of mothers.	ʘ,Ɵ,$	BhaHF,Tha2,Gor8	SSI,GD
12	Strong community mobilization activities	Strong community mobilization activities has helped in identification of new cases, defaulter tracking sensitization of the community people.	Ɵ©	BhaHF,Tha2,C5	SSI
13	Timely supply of RUTF and nutritional commodities and proper stock maintenance	Maintained stock level of commodities at health facility. Due to adequate level of stock at health facility, the beneficiaries coming for the treatment did not have to return empty hand and come back only for commodity again from the far off places. This build some kind of motivation to come for next follow up visit.	℗	BhaHF,Tha2,C5	SSI

Table 6: Quantitative data source with symbol

S.N	Source	Symbol
1	Mother or carer of malnourished children who are enrolled in the programme	Ώ
2	Mother or carer of malnourished children not covered in IMAM programme	Φ
3	Mother or carer of malnourished children who defaulted from IMAM programme	$
4	IMAM focal person in health facility in the district	℗
5	Female Community Health Volunteer	ʘ
6	Nutrition focal person	@
7	Representative of a community based organization	©
8	Community leader, community	ϴ
9	Teacher	T
10	Mother of cured child	M
11	Health Facility In-charge	I

Table 7: Quantitative data collection methods with symbol/acronym

S.N	Method	Symbol
1	Semi-structured Interview	SSI
2	Group Discussion	GD
3	Focus Group Discussion	FGD
4	In depth Interview	IDI
5	Case study	CS
6	Informal Interviews	IF
7	Observation	Obs

6.3 STAGE II

6.3.1 Hypothesis formulation and testing

Prior to conducting Stage II, enumerators were trained on methodology to be used for data collection. The training emphasized on nutritional assessment of the target beneficiaries using both MUAC tape as well as anthropometric equipments. The training also focused on case finding through active adaptive methodology. Apart from the technical sessions, they were also trained on questionnaires for covered and uncovered cases. For case finding, assessment was done using both MUAC and anthropometric equipments. However, anthropometric equipments (i.e. Weighing scale, Height/Length board) were used to measure the children who did not fall under SAM by MUAC.

Stage II was conducted to test one or more factors identified during quantitative analysis of programmatic data and findings of the qualitative information collection in order to determine whether our beliefs about coverage was accurate. The process involved setting up of hypothesis related to one or more factors, which are measurable and quantified and have influence on coverage. The locations for testing hypothesis was purposively selected.

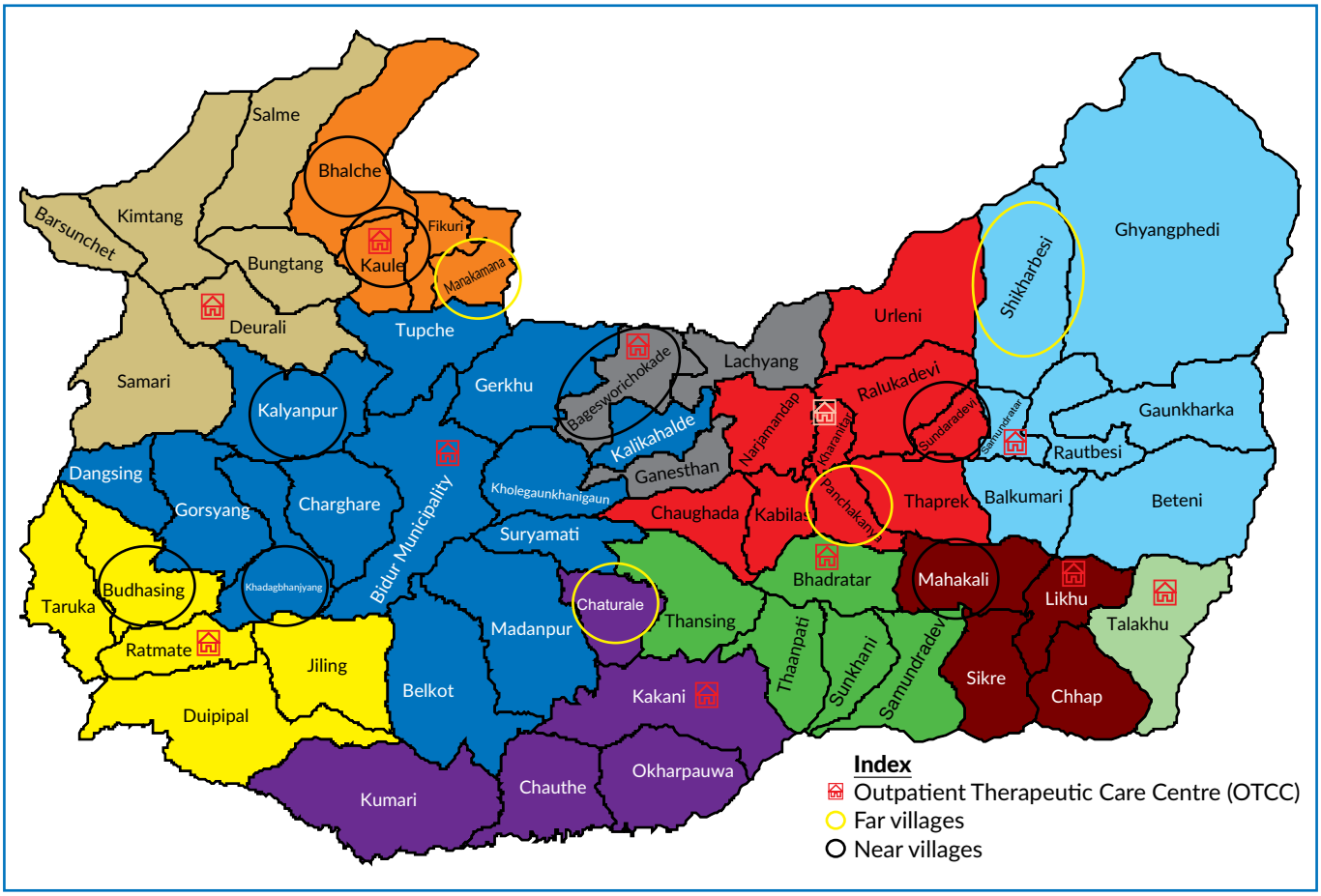


Figure 13: Map showing selected clusters for Stage II

Table 8: Selected wards/clusters for hypothesis testing

S.N	Village	Catchment OTCC	Distance from OTCC walking hours
1	Bageswori 4	Bageswori	15
2	Kalyanpur 5	Bidur	90
3	Buddhasin 1	Ratmate	80
4	Kaule 5	Kaule	60
5	Panchakanya 5	Kharanitar	150
6	Chaturale 7	Kakani	180
7	Shikharbesi 4	Samundratar	150
8	Manakamana 5	Kaule	180
9	Bhalche 8	Bhalche	80
10	Mahakali 1	Bhadrutar	30
11	Khadgabhanjyang 6	Bidur	
12	Sundaradevi 4	Kharanitar	60

Assessment team developed a hypothesis that stated, *"coverage of the programme is high in villages near the OTCC and low in villages far from the OTCC and in the catchment area of those health facilities which does not have SAM treatment programme"*. Here, the distance was defined as near if it takes 2 hours or less by walking or by any other transportation means and far if it takes more than 2 hours by foot or by any transportation means to reach the OTCC to seek service delivery.

Altogether, 4 villages near to the OTCC (which is 2 hours or less), 4 villages far from the OTCC (which is >2 hours) and other 4 villages/wards that were in the catchment area of health facilities, which do not have SAM treatment programme was sampled for hypothesis testing. Assessment targeted three categories of children which included SAM children in the programme (covered), SAM children not in the programme (uncovered) and SAM children recovering in the programme i.e. who are not SAM on the day of data collection but under treatment. In total, the assessment team found two cases in near distance, 4 cases in far distance and 1 case in the catchment of health facilities where there was no SAM management services. The findings revealed that villages far from the OTCC and in the area catchment area of health facility without OTCC had low coverage confirming the hypothesis.

Hypothesis 1 : Villages near (2 hours or less than 2 hrs walking distance) to OTCC has high coverage

Hypothesis 2: Villages far (>2 hours walking distance) to OTCC and catchment area of HF without OTCC has low coverage

Table 9: Result for Hypothesis 1

Total no. of cases found (n)	2
No. of covered case	1
No. of uncovered case	1
Coverage standard	50%
Decision rule (D1)	n*(P/100)
Decision rule (D1)	2*50/100
Decision rule (D1)	1
Result	Out of total cases found, more than 1 case should be covered case. Since, 1 is not more than 1, hypothesis 1 is not confirmed. Meaning villages near to OTCC do not necessarily have high coverage.

Hypothesis 2: Village far (>2 hours walking distance) to OTCC and catchment area of HF without OTCC have low coverage

Table 10: Result for Hypothesis 2

Total no. of cases found (n)	5
No. of covered case	0
No. of uncovered case	5
Coverage standard	50%
Decision rule (D1)	(n*P)/100
Decision rule (D1)	(5*50)/100
Decision rule (D1)	2.5
Result	Out of total cases found, more than 2 case should be uncovered case. Since 5 is more than 2.5, hypothesis 2 is confirmed. Meaning villages far from OTCCs and villages without OTCCs have low coverage.

6.4 PRIOR BUILDING

Based on the qualitative and quantitative information collected by the assessment team, a belief about the programme coverage has been estimated, which is termed as a **prior**. Prior means something based on prior information i.e. the analysis of existing data and information in this case. Based on the simple scoring

of barriers and boosters, weighting of barriers and boosters and histogram prior has been generated. The table below provides a glimpse of simple scoring and weighting of boosters and barriers. The positive and negative factors were scored on a scale of 1 to 4 based on how much they contributed to SAM programme coverage.

Table 11: Rating of result of boosters and barriers

Positive Factors (Boosters)	Weighting		Negative Factors (Barriers)	Weighting	
	Simple	Weighted		Simple	Weighted
Trained FCHVs and health workers	4	4	Longer distance to OTCC (geographic terrain)	4	3
Discussion of regarding IMAM programme in mothers group meeting	4	2	Negligence of caretaker on care of malnourished children	4	3
Monthly screening by FCHVs	4	2.5	Language barrier	4	1
Integration of screening in ORC/PHC	4	1	Preference of traditional healer (esp. Rai, Tamang community and where HF is far)	4	2
Self motivation for regular follow ups	4	2	Taste of RUTF	4	1
Presence of CNW in field	4	3.5	Unavailability of health workers at the health facility during the visit of case	4	1
Awareness of IMAM programme among community	4	3	Less literate people	4	2
Supportive HWs, teacher, other INGOs	4	3	Poor care practices, sanitation, IYCF	4	3
Strong coordination and communication among HFs and FCHVs	4	3.5	Turnover of trained HF staff	4	2
Effective follow up visits protocol (2 weekly)	4	3	Sharing of RUTF with other children	4	1
Active involvement of FCHVs in IMAM programme	4	4	Limited monitoring and supervision	4	2
Strong community mobilization activities	4	1.5	Workload of caretaker/mothers, less time for child	4	3
Timely supply of RUTF and nutritional commodities and proper stock maintenance	4	4	IMAM services limited only to OTCC	4	3
			Side effects of RUTF (Diarrhoea, vomiting)	4	1.5
			Misconception of community regarding RUTF	4	1
			Poor economic condition	4	2
			Lack of ownership by HWs/ rely on CNW	4	2
			Lack of decision making power among mother	4	1.5
			Weak coordination between OTCC and ITC (response from ITC)	4	3.5
			Inappropriate practice of feeding RUTF	4	3

Positive Factors (Boosters)	Weighting		Negative Factors (Barriers)	Weighting	
	Simple	Weighted		Simple	Weighted
			Improper MUAC measurement and reading by FCHVs	4	1.5
			Improper recording and delay in reporting by FCHVs	4	1.5
			Visiting a medical shop for treatment	4	2
	52	37		92	46.5
	52	37		8	53.5

Weighted scores

The level of impact of the booster or barrier on programme coverage as well as the number of source and methods confirming them attributed to the final scores. A factor confirmed by fewer sources and with a lower impact was deemed to be of low significance and scored low while those factors confirmed by several sources and with a high potential impact were given a high score.

The total sum of the boosters added to the lowest possible coverage (0 + 37) was equal to **37%**. The total sum of the barriers subtracted from the highest possible coverage (100–46.5) was equal to **53.5%**. Hence, the prior mode calculated from the weighted boosters and barriers was {(37%+53.5%) /2} **45.3%.**

Simple scores

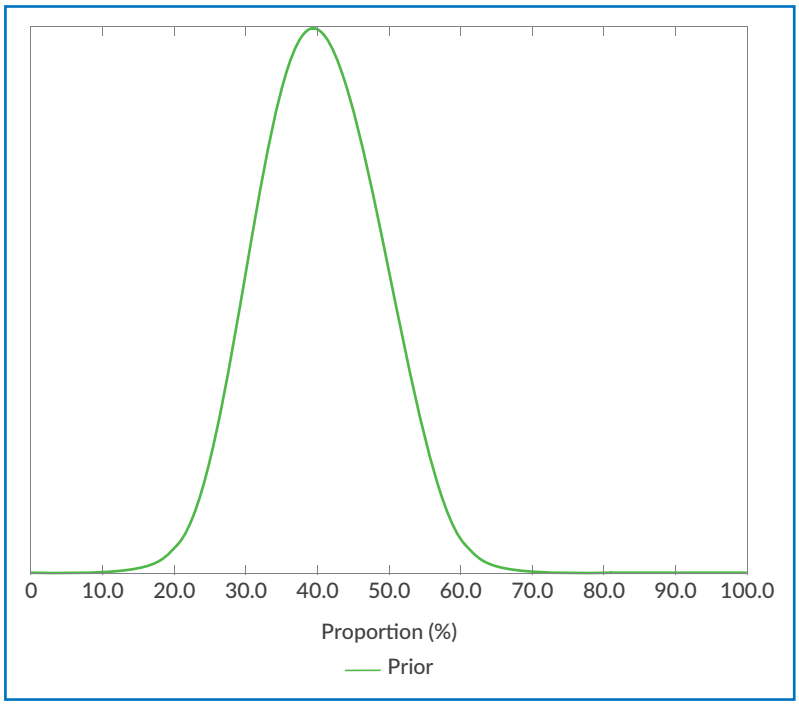
Based on the assumption that all the listed barriers and boosters have the same level of impact they were given the same maximum score of 4. The total sum of the simple boosters added to the lowest possible coverage (0 + 52) is equal to **52%**. The total sum of the simple barriers was subtracted from the highest possible coverage (100 – 92) was equal to **8%**. Hence, the prior mode from the simple boosters and barriers was {(52% +8%)/2} =30%.

Histogram belief

The prior mode from the histogram represents the belief of the programme team. The programme team believed that the coverage of the programme was 44%.

6.4.1 Prior plot

The Bayes SQUEAC estimate calculator version 3.01 produced a plot of the prior mode. The plot considered a high uncertainty of ±25% since this is the first coverage assessment done in the district. The prior mode derived from the summation of weighted, simple score and histogram values {(30+45.3+44)/3)} which was 39.8%.



6.5 STAGE III: WIDE AREA SURVEY

6.5.1 Sample size calculation

Minimum sample size for SAM cases was calculated using Bayes technique. This technique used parameters; prior mode of 40%, a prior α = 13.4, prior β = 20.1 and a precision of 12%. A SAM sample of **32 cases** was calculated using the Bayes technique.

6.5.2 Number of village required to obtain the sample size

An appropriate village sample size was calculated based on the following considerations; n (SAM cases, sample size of 32 children), an average village size of 495, the percentage of children under- five 10% and a SAM prevalence by MUAC of 1.8%.[6] A total of 37 villages was calculated using the formula shown below

$$n\ villages = \frac{n}{average\ villages\ population \times \frac{\%\ population\ of\ 6 - 59m}{100} \times \frac{Prevalence}{100\%}}$$

Systematic random sampling was used to sample 37 wards. A list of villages was taken from census 2011 and numbering was done from 1 to 560. The sampling interval used was 14. The first village was selected doing the lottery from 1 to 14 and then after the other villages were selected with an interval of 14 until a total of 37 villages were selected. Hence, the team needed to visit 37 villages to find out 32 cases.

6.5.2 Data collection

A total of four teams each comprising of 2 enumerators (1 measurer and 1 enumerator) and a supervisor were involved in the data collection during wide area survey. Four teams consisting of a supervisor were involved in the data collection in total of 37 wards.

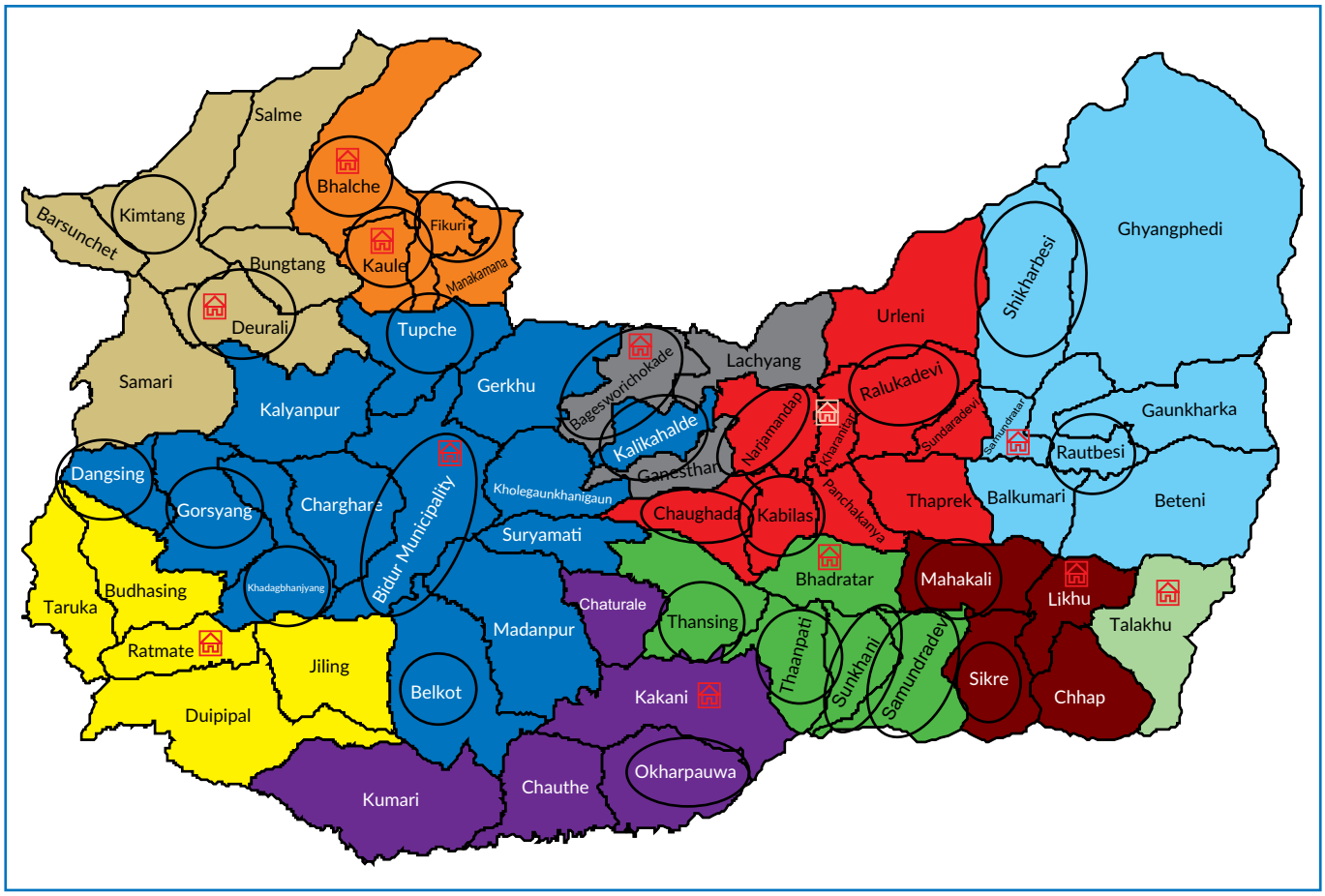


Figure 14: Map showing selected clusters in Stage III

[6] SMART SURVEY REPORT, Nuwakot May-June 2016

Data was collected using MUAC and anthropometric equipments. Data collection was done following active adaptive case finding. All the uncovered cases found during the data collection were referred to the nearest OTCC with a referral slip. Mothers of both the covered and uncovered cases were interviewed to ascertain the reasons for being covered and non-covered. A standard questionnaire was administered for interviewing mothers or caretakers.

Table 12 : Clusters selected for wide area survey

S.N	Village	S.N	Village	S.N	Village
1	Sunkhani 4	14	Okharpauwa 8	27	Gorsyang 8
2	Sunkhani 5	15	Shikharbesi 1	28	Khadgabhanjyang 4
3	Sikre 5	16	Shikharbesi 2	29	Fikuri 5
4	Sikre 7	17	Kabilas 8	30	Fikuri 7
5	Samundradevi 4	18	Bageswori 1	31	Kaule 3
6	Samundradevi 5	19	Thanapati 9	32	Bhalche 1
7	Likhu 8	20	Chaughada 8	33	Thansing 6
8	Likhu 9	21	Haldekalika 4	34	Deurali 4
9	Mahakali 5	22	Narjamandap2	35	Bidur 6
10	Ralukadevi 5	23	Tupche 4	36	Kimtang4
11	Chaturale 2	24	Dipipal 2	37	Dansing 5
12	Rautbesi 1	25	Gekhu 1		
13	Rautbesi 2	26	Belkot 7		

6.5.3 Coverage estimations

The single coverage estimator was used for estimating the coverage of OTCC. The estimates of the coverage was done using covered cases, recovering cases in the programme and recovering cases not in the programme. The following formula was used to estimate the coverage:

$$Single\ Coverage = \frac{Cin + Rin}{Cin + Cout + Rin + Rout}$$

Where C_{in}= Ccovered cases, R_{in}= Recovering cases, C_{out}= Uncovered cases and R out= Recovering cases not in programme.

C_{in}, C_{out}, R_{in} were collected during the wide área survey and Rout was calculated using the formula below:

$$Rout \cong \frac{1}{3} \text{ x } (Rin \text{ x } \frac{Cin + Cout + 1}{Cin + 1} - Rin)$$

Table 13: The result of wide area survey is presented in the table below.

Type of cases	No. of cases
SAM covered cases C_{in}	5
Recovered cases R_{in}	3
Uncovered cases C_{out}	21
Total no. of cases	29

As given in the table, the assessment team found 21 uncovered cases. The main reasons for not being enrolled in the programme is given below:

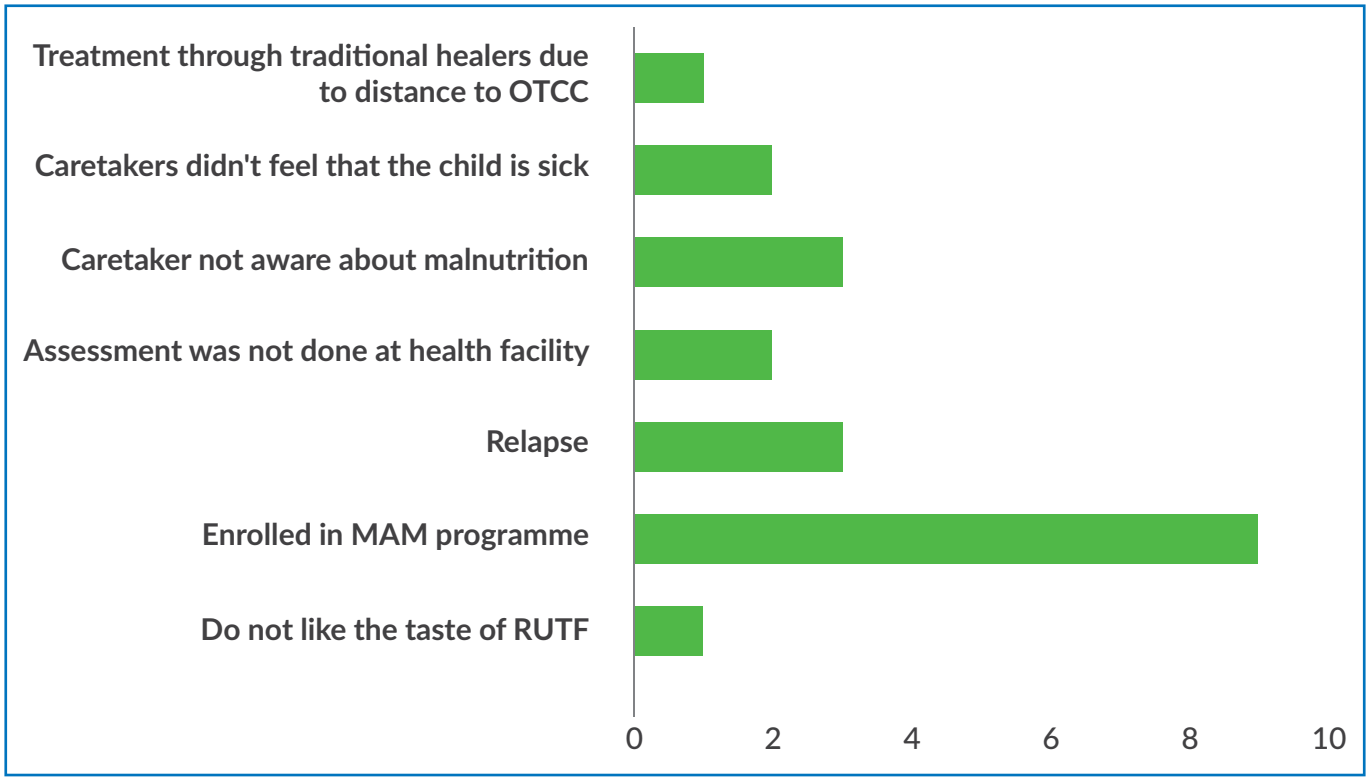


Figure 15: Reasons for not attending in OTCC (n=21)

The three relapse cases found during the assessment indicates poor compliance of the programme by caretaker possibly because of lack of time to take care of the child after the child is discharged from the programme. Similarly, 9 cases were found to be SAM but enrolled in TSFP sites and receiving RUSF. This indicates either poor programme compliance by the caregiver, possibly because caregiver has not been feeding RUSF as per the protocol or it could be because at the time of admission of the child in the TSFP sites, the child was not assessed by z-score as all these nine cases were SAM by z-score but MAM by MUAC measurement. There were two cases identified as uncovered who stated that nutritional assessment of the child was not done by MUAC and/or by weight for height in the health facility (OTCC). This could be because at the time of their visit in the OTCC, the IMAM focal person was not present or any other staff did not attend the cases.

During the wide area survey, 29 cases were identified in 37 villages. Among 29 cases C_{in} =5, C_{out} = 21 and R_{in} =3. Using Bayes calculator, the conjugate analysis was done with the prior parameters for prior estimate of 39.8%:

33.7% (95% CI: 23.2 %-46.0%) z=0.97, p=0.333

The p-value for the final conjugate analysis was 0.33 indicating that the final estimate is valid and can be reported, as there is no conflict between the prior and the likelihood.

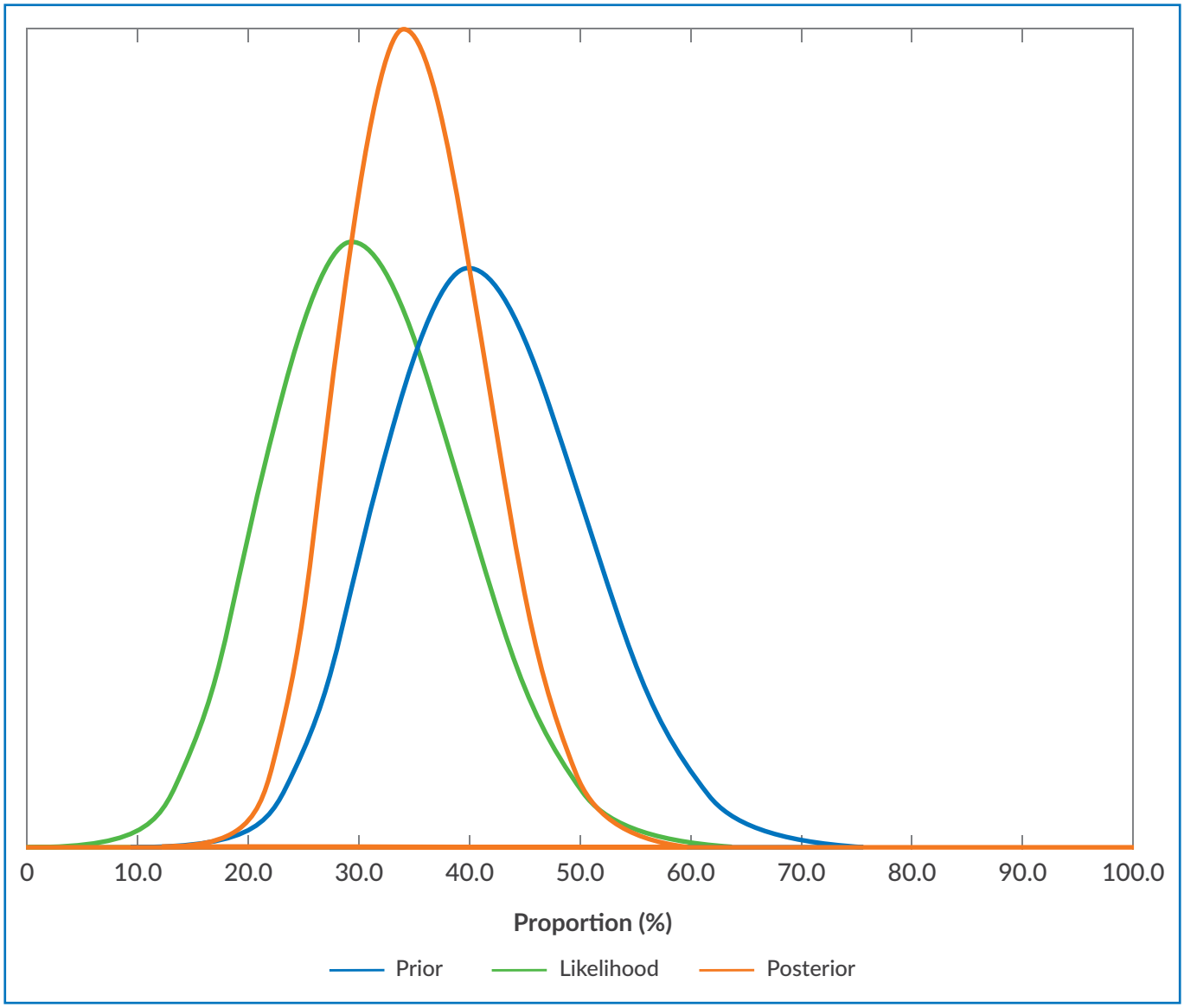


Figure 16: Graphic representation of prior, likelihood and posterior

The above figure shows that there was considerable overlap between the prior and the likelihood meaning that there was no conflict of the information in prior and the likelihood. The width of prior and the likelihood was equal meaning that there is reliability setting up of the prior and the prior is accurate and moderately strong. The posterior was narrower than the prior meaning that the likelihood has reduced the uncertainty and the posterior estimate is accurate.

7. DISCUSSION AND CONCLUSION

The official records, i.e., the registers placed in each OTCC showed that in between January to December 2016, a total of 116 SAM children aged 6 to 59 months has been enrolled in the programme in the district. As per SMART survey conducted in May- June 2016, an estimate for SAM prevalence is 1.8% (0.9-3.6 95% CI) by WHZ was found. Looking at the quantitative data, one of the major issues with the IMAM programme was retention of the children enrolled in the programme. Majority of the cases defaulted in first two weeks. Those cases who exited from the programme not completing the course of treatment are more likely to worsen their condition.

Coverage ranged from 23.2% to 46.0%. Even though the suggested sample size was 32 cases, we were able to find only 29 cases and the coverage estimate was done based on 29 cases. Among the 29 cases, 21 cases were found to be uncovered cases hence attributed in low coverage estimates. Looking at the coverage estimate plot, the prior and the likelihood do not conflict with one another. Hence, chances of any bias affecting the coverage estimate were likely to be minimal. Further the coverage estimate plot also showed that posterior distribution is narrower than the prior which means that likelihood could add very less information to the posterior.

During wide area survey, the most of uncovered cases (9 out of 21) were receiving treatment from TSFP sites for MAM treatment. However, these cases were found to be SAM by weight for height z-score at the time of wide area survey. Up on further investigation, all the 9 cases have been identified as MAM by MUAC and hence have been receiving treatment for the same. Weight for height z-score was not used as TSFP sites do not have height board for the measurement. Hence, the cases were enrolled in MAM as per MUAC measurement. This suggests that assessment by MUAC only should not be considered for identification of the cases. Both MUAC and weight for height should be used at the health facility level for early identification of cases so that none of the cases is left SAM behind from the appropriate treatment.

Similarly, the other issues of the programme was the retention of the cases in the programme. During the assessment, it was found that there were a number of hidden defaulters in the programme. The gap between two follow-up visits was greater than the standard practice. The common factors attributed to this was the distance between OTCC and the beneficiaries' household and also engagement of caregivers in other work like, agriculture, doing household chores and in some cases, community's deep rooted belief in traditional healers like lama, gurus etc.

During the assessment, some of FCHVs had problem identifying the midpoint of the upper arm circumference and taking correct reading. Similarly, the recording and reporting maintained at OTCC were not up to the mark. This calls for intensified supportive supervision at various level. Meanwhile, the quantitative data analysis in Stage I revealed that the case admission peaked in between April to August 2016 when intensive screening activities were done such as during community level training, the month after mass campaign and hence resulted in high case admissions. This indicates that identification and enrolment peaks when there are some activities like mass campaign and distribution programme like hygiene kit distribution, cookery kit distribution etc .

8. RECOMMENDATIONS AND ACTION PLAN

After completion of the assessment, a half day meeting was held between DPHO, supervisors of health facilities, Technical Officers and Programme Officers of Action Against Hunger on 28 Aug 2017. During this meeting, findings of the assessment was presented and devised the recommendations and actions to increase the coverage of IMAM programme in Nuwakot district.

Some of the recommendation that came up during the action plan development are as follows:

1. Expansion of OTCCs: Establish at least one OTCC in each municipal or rural municipal catchment area
2. Timely refresher training on IMAM to FCHVs and health workers to inform them regarding updated protocols and guidelines and to reinforce the key messages
3. Increase supportive supervision and monitoring at various levels to identify gaps and devise the solution to fulfil those gaps that might hinder the coverage and access of the programme
4. Establishment of nutrition corner at health facility
5. Promotion of IMAM programme through visibility materials
6. Sharing of experiences of mothers of enrolled cases during mother's group meetings to motivate other mothers
7. Demonstration of feeding practices to the children during mothers group meetings

Table 14: Recommendation and Action Plan

	Recommendation	Action	Responsibility	Frequency
Recording /Reporting	Improve standard of recording in IMAM register in OTCC (HMIS 2.6)	Increase supportive supervision visit to the health facility. Prior to SSM visit, make a list of the indicators and focus in those indicators which seriously have problems.	DPHO/Implementing Partner/ Donor	As per need
Capacity building	Increasing the number of admissions based on WHZ	Conduct a session on z score in a gathering of IMAM focal person organized by the DPHO.	DPHO/Implementing Partner/ Donor	As per need
		Provide on the job coaching to the health personnel during supportive supervision and monitoring visits.	Technical officers	As per need
	Involve the traditional healers in the programme	Orient the traditional healers regarding IMAM programme so that they can divert the suspicious cases to the OTCC.	DPHO/Implementing Partner/ Donor	As per need
Defaulter tracking	Follow up the defaulter cases specially in health facilities	Prepare a list of children who defaulted during the supportive supervision and monitoring visit along with contact numbers and mobilize community nutrition workers and FCHVs for follow up visit of such cases.	Technical officers	As per need
Outreach Services	Integration of MUAC screening during ORC/PHC visits	Request DPHO to add screening activities primarily based on WHZ in the respective PHC/ORC; Participate in the meeting of health facility operations and management committee of those health facility due to be organized under the PHC/ORC strengthening activities; Provide height boards and salter scale to the PHC/ORC	DPHO/Implementing Partner/ Donor	As per need
	Mobile services	Set a protocol of conducting outreach services. Outreach service will help in identification of the cases hence maximize the coverage.	DPHO/Implementing Partner/ Donor	As per need
Supply and logistic	Timely and adequate supply of RUTF	All RUTF should be transported following LMIS system of the government and should ensure none of the OTCC centres are out of stock. Calculation of stock should be based on the caseload of the particular OTCC.	DPHO/Implementing Partner/ Donor	As per need
Communication	Design the communication or visibility materials	Develop the visibility materials which are more pictorial and can be understood by lay man and place them in strategic places. Ensure that the messages are in local lanaguages.	Health units of municipal and rural municipal level /Implementing Partner/ Donor	As per need
Strategy	Develop a plan to implement the programme as per new government structures	Develop a strategy of implementing the programme through municipal and rural municipal level. Orient the chief of municipal and rural municipal level.	Implementing Partner/ Donor	

9. ANNEXES

ANNEX 9.1: VILLAGE SCREENING RESULTS FROM STAGE III

Village	Related OTCC	SAM found	SAM covered	SAM recovered	SAM uncovered
Sunkhani 4	Bhadrutar	0	0	0	0
Sunkhani 5	Bhadrutar	0	0	0	0
Sikre 5	Bhadrutar	1	0	0	1
Sikre 7	Bhadrutar	0	0	0	0
Samundradevi 4	Bhadrutar	0	0	0	0
Samundradevi 5	Bhadrutar	0	0	0	0
Likhu 8	Likhu	1	0	0	1
Likhu 9	Likhu	1	0	0	1
Mahakali 5	Likhu	0	0	0	0
Ralukadevi 5	Kharanitar	0	0	0	0
Chaturale 2	Kakani	1	0	0	1
Rautbesi 1	Samudratar	1	0	0	1
Rautbesi 2	Samudratar	0	0	0	0
Okharpauwa 8	Kakani	1	0	0	1
Shikharbesi 1	Samudratar	0	0	0	0
Shikharbesi 2	Samudratar	0	0	0	0
Kabilas 8	Kharanitar	2	0	1	1
Bageswori 1	Bageswori	0	0	0	0
Thanapati 9	Bhadrutar	2	2	0	0

Village	Related OTCC	SAM found	SAM covered	SAM recovered	SAM uncovered
Chaughada 8	Kharanitar	0	0	0	0
Haldekalika 4	Kharanitar	1	0	0	1
Narjamandap2	Kharanitar	2	0	0	2
Tupche 4	Bidur	1	0	0	1
Dipipal 2	Ratmate	0	0	0	0
Gekhu 1	Bidur	1	0	0	1
Belkot 7	Bidur	4	2	0	2
Gorsyang 8	Bidur	1	0	0	1
Khadgabhan-jyang 4	Bidur	0	0	0	0
Fikuri 5	Kaule	0	0	0	0
Fikuri 7	Kaule	2	0	0	2
Kaule 3	Kaule	0	0	0	0
Bhalche 1	Kaule	0	0	0	0
Thansing 6	Bhadrutar	1	0	0	1
Deurali 4	Deurali	2	0	1	1
Bidur 6	Bidur	1	0	1	0
Kimtang4	Deurali	1	1	0	0
Dansing 5	Bidur	2	0	0	2
Total		**29**	**5**	**3**	**21**

ANNEX 9.2: QUESTIONNAIRE USED DURING STAGE-I OF BARRIER ANALYSIS AND COVERAGE ASSESSMENT

Interview Guide: Care taker of malnourished children who are enrolled in the programme in Nepali and English

कोड
Code

अन्तर्वार्ता निर्देशिका: आइमाम कार्यक्रम अन्तर्गत उपचार प्राप्त गरिरहेका बालबालिकाको हेरचाह गर्ने व्यक्ति					
Interview Guide: Care taker of Malnourished children who are enrolled in the programme					
अन्तर्वार्ता दिने व्यक्तिको नाम				मिति (ग/म/सा)	
Name of Interviewee				Date (dd/mm/yy)	
बहिरंग उपचार सेवा केन्द्र (जस अन्तर्गत सेवा प्राप्त गरिएको हो)				अन्तर्वार्ता लिने व्यक्तिको नाम	
Name of the OTCC				Name of Interviewer	
गा.वि.स		वडा नम्बर		टिम	
VDC		Ward		Team	

उपचार सम्बन्धी जानकारी					
Treatment related Information					
तपाइँको बच्चा पहिलो पटक आइमाम कार्यक्रममा भर्ना भएको हो ?	हो		होइन		
Is this the first time that your child has been enrolled in IMAM programme?	Yes		No		
आइमाम कार्यक्रम अन्तर्गत उपचार सुरू गरेको कति समय भयो ? Since when have you been in the programme?					
तपाइँले आफ्नो बच्चामा केही फरक पाउनु भएको छ ? छ भने के फरक पाउनु भएको छ ? Have you noticed a difference in the condition of your child? If yes what are those differences					
तपाइँको बच्चा कति पटक आइमाम कार्यक्रममा भर्ना भएको छ ? How many times has your child been enrolled in IMAM programme?			चोटी Times		
(यदि एकपटक भन्दा बढी बच्चा कार्यक्रममा भर्ना भएको छ भने निम्न प्रश्न सोध्ने) तपाइँको बच्चा कार्यक्रममा पुन: भर्ना हुनुको कारण के हो ? (To be asked only if the child has been admitted into the programme more than once)Why has your child returned to the programme?					
तपाइँका अरू कुनै बच्चा आइमाम कार्यक्रममा भर्ना भएका छन् ?	छ		छैन		
Do you have other children enrolled in CMAM programme?	Yes		No		

स्वास्थ्य संस्थामा उपचार गराउन सघाउ पुऱ्याउने तत्वहरु	
Factors triggering the start of treatment	
तपाइँले आइमाम कार्यक्रम बारे कसरी थाहा पाउनु भयो ? How did you hear about IMAM programme?	
तपाइँले स्वास्थ्य संस्था जाने निर्णय किन लिनु भयो ? Why did you decide to go to the health facility?	
तपाइँलाई कहिले लाग्यो की तपाइँको बच्चा बिरामी छ /सन्चो छैन ? तपाइँले कस्ता लक्षण एवम् समस्या देख्नुभयो ? कस्तो समस्याको देखापरेपछि तपाइँ स्वास्थ्य संस्था जानु भएको थियो ? When did you notice that your child is ill? What symptoms and problems did you notice? What sort of health problems triggered you to get to the health facility?	
के तपाइँलाई स्वास्थ्य संस्था जान कसैले उत्साहित गरेको थियो ? यदि थियो भने कसले गरेको थियो ? अतः उक्त व्यक्तिले तपाइँलाई उपचारको सिलसिलामा हौसला प्रदान गरिरहन्छ ? यदि त्यस्तो छ भने किन ? Did someone encourage you to go to the health facility? If yes who did? Does the person encourage you to continue the treatment? Why?	
उपचार लिन जाने व्यवहारमा सहज/ प्रभाव पार्ने कारणहारु	
Factors facilitating/influencing treatment seeking behavior	
उपचारमा लानु अघि बच्चा कति समयसम्म बिरामी थियो ? अनि यो अवस्थालाई कसरी लिनु भएको थियो ? साथै बच्चालाई यस्तो भएपछि आफन्त, साथी एवम् छिमेकीहरूबाट कस्तो सल्लाह पाउनु भयो ? How much time prior to start of treatment was the child sick? And how did you perceive that condition? Further under such circumstances what sort of suggestions did you receive from your relatives, friends and neighbours?	
तपाइँको बच्चा बिरामी हुनुको मुख्य कारणहरु के के हुन् जस्तो लाग्छ ? What do you think are the reasons for your child falling sick?	
तपाइँलाई बच्चाले सहि समयमा उपचार पायो भन्ने लाग्छ की लाग्दैन ? यदि ढिलो भएको लाग्छ भने के कारणले समयमा उपचारलाई लान सकिएन ? अथवा समयमै लागेको जस्तो लाग्छ भने के कारणले समयमा उपचारलाई लान सकियो ? Do you think that you child received treatment on time? If you think that you were late to start the treatment what were the reasons? Or else if you think you were able to start the treatment on time what were the reasons?	
यहाँ यस्तो अवस्थालाई जनाउन कुन शब्दको प्रयोग गरिन्छ ? बच्चालाई यस्तो हुँदा खासगरी के गर्ने गरिन्छ What word is used to describe the condition? What is practiced under those circumstances?	
उपचारको क्रममा परिवारका सदस्यहरूको कस्तो साथ पाउनु भएको छ ? What's the support been like from your family members?	
तपाइँ कति चोटी RUTF लिन स्वास्थ्य संस्था जानु भैसक्यो ? यहाँदेखि स्वास्थ्य संस्था जना कतिको गाह्रो छ ? हिंडेर पुग्नुहुन्छ की गाडीमा ? अनि कति समय लाग्छ गएर घर फर्किन ? तपाइँसँग अरू कोहि जानु हुन्छकी एक्लै जानु हुन्छ ? How many times have you been to the health facility to receive RUTF? How difficult is it to get to the health facility? Do you walk or take a vehicle to get there? Does someone go with you to the health facility?	

(यदि अरू पनि बच्चाहरु छन् भने) तपाइँ उपचारलाई जानु भएको बेला बच्चाहरूलाई कस्ले हेरिदिन्छ ? Who takes care of your children while you go to visit the health facility for treatment?	
तपाइँलाई के कुराले गर्दा उपचारलाई निरन्तरता दिन उत्साहित गरिरहेको छ ? What inspires you to continue the treatment?	
तपाइँले आफ्नो बच्चालाई यसरी उपचार गराई राखेको कुरालाई लिएर छरछिमेक र समाजबाट कस्तो प्रतिक्रिया पाउनु भएको छ ? What sort of reactions are you getting from your neighbours and society members?	
स्वास्थ्य संस्थामा उपचार गर्न जाने निर्णय कसले लिएको हो ? घरमा सामान्यतया महत्वपूर्ण विषयहरूमा कसरी निर्णय लिइने गरिन्छ ? Who took the decision of going to the health facility for treatment? How do you get to make a decision on important issues at your home?	
सामान्यतया तपाइँको बच्चा/बच्चाहरुको हेरचाह गर्न परिवारका सदस्यहरूबाट कस्तो साथ पाउनु हुन्छ ? Generally what sort of support do you receive from your family members in context of taking care of your children?	
आफ्नो र बच्चाको स्वास्थ्य बारे सल्लाह लिनु परेमा धेरै जसो कोसँग सल्लाह लिनु पर्छ ? Whose advice do you seek when it comes to your own and child's health related matters?	
सेवाको गुणस्तर	
Quality of service	
तपाइँ स्वास्थ्य संस्थामा जाँदा स्वास्थ्य कर्मीहरू उपलब्ध हुन्छन् ? यदि छैनन् भने, किन नभेटेको होला ? Do you get to meet the health workers when you get to the health facility? If not, do you know the reason?	
स्वास्थ्यकर्मीहरूले तपाइँको बच्चालाई के भएको हो र उक्त उपचार किन दिएको हो भन्ने बारे के भने ? What have the health workers told you about the child's condition and the treatment?	
RUTF को प्रयोग कसरी गर्ने भन्ने बारे स्वास्थ्य कर्मीहरूले के भन्नु भएको छ ? What have the health workers told you about the use of RUTF?	
हरेको चोटी स्वास्थ्य संस्थामा जाँदा तपाइँसँग कुरा गर्न स्वास्थ्य कर्मीले कतिको समय दिन्छन् ? उहाँहरूको तपाइँप्रतिको व्यवहार कस्तो पाउनु भएको छ ? उहाँहरूबाट उपचारका क्रममा कस्तो सहयोग पाउनु भएको छ ? How much time does the health worker give you during consultation? How has their behavior with you? What sort of help have you received from them?	
स्वास्थ्यकर्मीसँग सल्लाहको क्रममा तपाइँले RUTF प्रयोग भन्दा बाहेक अरू केहि कुरामा सल्लाह प्राप्त गर्नु भएको छ ? Have you received any other advice besides use of RUTF?	
स्वास्थ्य संस्था कुन दिन जाने तपाइँलाई कसरी थाहा हुन्छ ? के स्वास्थ्यकर्मीले र तपाइँ मिलेर मिति तोक्ने गर्नु भएको छ ? How do you know which day you need to visit the health facility? Do you and the health workers get together to set the date?	
तपाइँले स्वास्थ्य संस्थादेखि RUTF के मा बोकेर ल्याउनु हुन्छ ? How do you carry the RUTF from the health facility to your home?	

(यदि अरू पनि बच्चाहरु छन् भने) तपाइँले RUTF तपाइँका अन्य बच्चाहरूलाई पनि दिनु हुन्छ ? (If there are other siblings in the house)Do you give the RUTF to your other children as well?	दिन्छु Yes		दिन्न No		
आइमाम कार्यक्रमको लागि पृष्ठपोषण					
Feedback to IMAM programme					
आइमाम कार्यक्रमको बारे तपाइँको के धारणा छ ? र किन ? What do you think about IMAM programme and why?					
यस कार्यक्रममा कुनै परिवर्तन गर्ने अधिकार तपाइँलाई दिईयो भने के परिवर्तन गर्न चाहनुहुन्छ ? If you were given the right to make changes in the programme what changes would you make?					
के तपाइँ यस्तो अवस्थामा रहेका अन्य बच्चाहरूका आमा बुवालाई स्वास्थ्य संस्थामा गई जचाउन आग्रह गर्नुहुन्छ ? आग्रह गर्नुहुन्छ भने किन ? यदि आग्रह गर्नु हुन्न भने किन ? Will you recommend parents of children in similar condition to go visit the health facility ? If yes Why? If not why?					

Interview Guide: Care taker of Malnourished children not covered in IMAM programme

कोड
Code

अन्तर्वार्ता निर्देशिका: आइमाम कार्यक्रम अन्तर्गत उपचार नलिएका बालबालिकाको हेरचाह गर्ने व्यक्ति					
Interview Guide: Care taker of Malnourished children not covered in IMAM programme					
अन्तर्वार्ता दिने व्यक्तिको नाम Name of Interviewee				मिति (ग/म/सा) Date (dd/mm/yy)	
बहिरंग उपचार सेवा केन्द्र (जस अन्तर्गत सेवा प्राप्त गरिएको हो) Name of the OTCC				अन्तर्वार्ता लिने व्यक्तिको नाम Name of Interviewer	
गा.वि.स VDC		वडा नम्बर Ward		टिम Team	
बच्चाको अवस्था बारे हेरचाह गर्ने व्यक्तिको धारणा					
Perception of the caretaker on the present condition of the child					
तपाइँको बच्चाको स्वास्थ्य कस्तो छ ? के तपाइँलाई लाग्छ तपाइँको बच्चा बिरामी छ ? How is your child's health? Do you think that you child is ill?	लाग्छ Yes		लाग्दैन No		

तपाईंले तपाईंको बच्चामा कुनै स्वास्थ्य सम्बन्धी समस्या देख्नु भएको छ ? Have you noticed any of the health related problem in your child?	वान्ता हुने Vomiting		ज्वरो Fever		कुनै विषयमा चासो नभएको Apathy	
	तौल घटेको Weight Loss		भोक नभएको Loss of appetite		छालामा घाउ Skin Lesions	
	शरीर सुन्निएको Swelling		कपाल झर्ने Hair loss		झाडापखाला Diarrhea	
	अन्य कुनै समस्या Other					
तपाईंलाई तपाईंको बच्चामा यस किसिमका स्वास्थ्य सम्बन्धी समस्याहरु किन देखा परेको जस्तो लाग्छ ? What do you think are the reasons for this condition?						

उपचार लिन जाने व्यवहारमा सहज/ प्रभाव पार्ने कारणहरू Factors influencing treatment seeking behavior				
तपाईंले यस्ता स्वास्थ्य समस्याको उपचारको लागि केही गर्दै हुनुहुन्छ वा के गर्ने सोचमा हुनुहुन्छ ? यदि छ भने के गर्दै हुनुहुन्छ वा के गर्ने सोचमा हुनुहुन्छ ? (यदि स्वास्थ्य संस्थामा लाने सोची राख्नु भएको छ भने अहिलेसम्म स्वास्थ्य संस्था किन नजानु भएको होला भनेर सोध्ने तर यदि स्वास्थ्य संस्थामा जाने बारे उहाँले सोच्नु भएको छैन भने यस पछाडिको प्रश्न सोध्ने) Have you taken measures to treat this condition or intend to treat this condition? What measures have you taken to treat this condition or how do you intend to treat this condition? (If taking to health facility is one of the intended actions then ask for the reasons behind not being able to do so until this time but if it not one of the intended actions then ask the following question)				
तपाईंलाई आफ्नो बच्चालाई स्वास्थ्य संस्थामा लगेर उपचार गराउनु राम्रो उपाय हुन्छ भन्ने लाग्छ ? यदि हो भने किन अथवा होइन भने किन ? Do you think it would be a good idea to take your child to the health facility for treatment? If it is a good idea then why is it a good one or else if it is not then why?				
यहाँ यस्तो अवस्थालाई जनाउन कुन शब्दको प्रयोग गरिन्छ ? बच्चालाई यस्तो हुँदा सामान्यतया के गर्ने गरिन्छ ? तपाईंको बच्चा कहिले कहिले बिसन्चो हुन्छ ? र सामान्यतया बच्चा बिरामी हुँदा के गर्ने गरिन्छ ? What word is used to describe the condition (Malnutrition)? What is practiced under those circumstances? How often does your fall sick? and what actions are taken when a child falls sick ?				
तपाईंको बच्चा बिरामी हुनुको मुख्य कारणहरु के के हुन् जस्तो लाग्छ? What do you think are the reasons for your child falling sick?				
तपाईं कहाँ आएर महिला स्वास्थ्य स्वयं सेविकाले यस विषयमा कुरा गर्नु भएको छ वा तपाईं यस विषयमा कुरा गर्न स्वयं सेविकाका जानु भएको छ ? Has the female community health volunteer come visit you on this issue or have you been to see her with regards to this condition?	छ Yes		छैन No	

सामान्यतया कुनै पनि उपचार गर्न जाने निर्णय कसले लिने गरेको छ ? घरमा सामान्यतया महत्वपूर्ण विषयहरूमा कसरी निर्णय लिइने गरिन्छ ? Generally who takes the decision to go ahead with any treatment related issues? In your home how do you get to deciding on important issues?					
सामान्यतया तपाइँको बच्चा/बच्चाहरुको हेरचाह गर्न परिवारका सदस्यहरूबाट कस्तो साथ पाउनु हुन्छ ? Generally what sort of support do you receive from your family members in context of taking care of your children?					
तपाइँको घरदेखि स्वास्थ्य संस्था कति टाढा छ ? यदि तपाइँलाई स्वास्थ्य संस्था जानु परेमा कसरी जानु हुन्छ ? How far is the health facility from your place? If you have to get there how do you do it?					
तपाइँलाई शिघ्र कुपोषित बालबालिकाको उपचारको लागि ल्याइएको नेपाल सरकारको स्वास्थ्य कार्यक्रम बारे केही थाहा छ ? तपाइँले आफ्नो परिवार, आफन्तजन वा साथी भाइ वा छरछिमेकले यस बारे कुरा गरेको सुन्नु भएको छ ? Do you have any knowledge of government health programme dedicated to the treatment of severely malnourished children (IMAM programme)? Have you any of your family members, relatives or friends and neighbours talk about it?					
तपाइँ स्वास्थ्य संस्था कहिले जानु भएको छ ? तपाइँ अन्तिम पटक स्वास्थ्य संस्था ? Have you ever visited the health facility? When was the last time that you visited the health facility?					
आफ्नो र बच्चाको स्वास्थ्य बारे सल्लाह लिनु परेमा धेरै जसो कोसँग सल्लाह लिनु पर्छ ? Whose advice do you seek when it comes to your own and child's health related matters?					
तपाइँलाई कसैले बच्चाको विषयलाई लिएर स्वास्थ्य संस्था जानु भनेर सल्लाह दिनु भएको छ ? यदि छ भने कसले ? Have you ever been recommended by others to visit the health facility in context of your child?					
आइमाम कार्यक्रमको लागि पृष्ठपोषण Feedback to IMAM programme					
यदि हामीले तपाइँको बच्चालाई स्वास्थ्य संस्थामा लगेर उपचार गरे निको हुन्छ भन्यौ भने के तपाइँ आफ्नो बच्चालाई स्वास्थ्य संस्था लैजान इच्छुक हुनुहुन्छ ? If we say that treatment in the health facility will enable your child to become healthy soon, Would you be interested to visit the health facility?	छु Yes		छैन No		
तपाइँ कस्तो वातावरण भयो भने आफ्नो बच्चालाई स्वास्थ्य संस्थामा लगेर उपचार गराउन जान सक्नु हुन्छ ? Under what condition can you go ahead with the treatment in the health facility?					

Interview Guide: Care taker of malnourished children who defaulted from IMAM programme

कोड
Code

अन्तर्वार्ता निर्देशिका: आइमाम कार्यक्रम अन्तर्गत उपचार लिएर बीचैमा छोडेका बालबालिकाको हेरचाह गर्ने व्यक्ति								
Interview Guide: Care taker of Malnourished children who defaulted from IMAM programme								
अन्तर्वार्ता दिने व्यक्तिको नाम						मिति (ग/म/सा)		
Name of Interviewee						Date (dd/mm/yy)		
बहिरंग उपचार सेवा केन्द्र (जस अन्तर्गत सेवा प्राप्त गरिएको हो)						अन्तर्वार्ता लिने व्यक्तिको नाम		
Name of the OTCC						Name of Interviewer		
गा.वि.स			वडा नम्बर			टिम		
VDC			Ward			Team		
बच्चाको अवस्था बारे हेरचाह गर्ने व्यक्तिको धारणा								
Perception of the caretaker on the present condition of the child								
तपाइँको बच्चाको स्वास्थ्य कस्तो छ ? के तपाइँलाई लाग्छ, तपाइँको बच्चा पूर्ण रूपमा स्वस्थ भइसक्यो ?	लाग्छ		लाग्दैन					
How is your child's health? Do you think that your child is completely healthy now?	Yes		No					
तपाइँले तपाइँको बच्चाको उपचारलाई निरन्तर नदिएपछि कुनै स्वास्थ्य सम्बन्धी समस्या देख्नु भएको छ ? Have you found any of the health related problems in your child after discontinuing with the treatment?	वान्ता हुने Vomiting		कुनै विषयमा चासो नभएको Apathy		कपाल झर्ने Hair loss		अन्य कुनै समस्या Other	
	तौल घटेको Weight Loss		भोक नभएको Loss of appetite		झाडापखाला Diarrhea			
	ज्वरो Fever		शरीर सुन्निएको Swelling		छालामा घाउ Skin Lesions			
(यदि कुनै समस्या देखा परेको भए) के तपाइँलाई लाग्छ, उपचारलाई निरन्तरता नदिएको कारणले तपाइँको बच्चामा यस किसिमका स्वास्थ्य सम्बन्धी समस्याहरु देखा परेको हो ? (if any health problems have been observed) Do you think that discontinuing with the treatment is the reason behind these health problems?								

उपचार लिन जाने व्यबहारमा असर अथवा प्रभाव पार्ने कारण	
Factors influencing treatment seeking behavior	
तपाइँले अहिले उपचारको लागि के गर्दै हुनु हुन्छ वा के गर्ने सोचमा हुनुहुन्छ ? तपाइँ उपचारलाई कसरी अगाडि लैजाने सोच्नु भएको छ ? (यदि स्वास्थ्य संस्थामा फेरि लाने सोच्नु भएको छ भने स्वास्थ्य संस्थामा अहिलेसम्म किन नजानु भएको होला भनेर सोध्ने तर यदि स्वास्थ्य संस्था जाने बारे सोच्नु भएको छैन भने यस पछाडिको प्रश्न सोध्ने) Now what measures have you taken to treat this condition or intend to treat this condition? What measures have you taken to treat this condition or how do you intend to treat this condition? (If you thinking of going to health facility again then why have you not gone until this time but if it is not one of the intended actions then ask the following question)	
तपाइँलाई आफ्नो बच्चालाई स्वास्थ्य संस्थामा लगेर उपचार गराउनु राम्रो उपाय हो भन्ने लाग्छ ? यदि लाग्छ भने किन र लाग्दैन भने किन ? Do you think it would be a good idea to take your child to the health facility for treatment? If it is a good idea then why is it a good one or else if it is not then why?	
यहाँ यस्तो अवस्थालाई (कुपोषण) कसरी भनिन्छ अथवा कसरी जनाइन्छ ? बच्चालाई यस्तो हुँदा सामान्यतया के गर्ने गरिन्छ ? तपाइँको बच्चा कतिको बिरामी पर्छ ? र सामान्यतया बच्चा बिरामी हुँदा के गर्ने गरिन्छ ? What word is used to describe the condition (Malnutrition)? What is practiced under those circumstances? How often does your fall sick? and what actions are taken when a child falls sick ?	
तपाइँको बच्चा बिरामी हुनुको मुख्य कारणहरु के के हुन् जस्तो लाग्छ ? What do you think are the reasons for your child falling sick?	
तपाइँ कहाँ आएर महिला स्वास्थ्य स्वयं सेविकाले यस विषयमा कुरा गर्नु भएको छ वा तपाइँ यस विषयमा कुरा गर्न स्वयं सेविकाका जानु भएको छ ? Has the female community health volunteer come visit you on this issue or have you been to see her with regards to this condition?	
सामान्यतया कुनै पनि उपचार गर्न जाने निर्णय कसले लिने गरेको छ ? घरमा सामान्यतया महत्वपूर्ण विषयहरूमा कसरी निर्णय लिइने गरिन्छ ? Generally who takes the decision to go ahead with any treatment related issues? In your home how do you get to deciding on important issues?	
सामान्यतया तपाइँले बच्चारबच्चाहरुको हेरचाह गर्न परिवारका सदस्यहरूबाट कस्तो साथ पाउनु हुन्छ ? Generally what sort of support do you receive from your family members in context of taking care of your children?	
तपाइँको घरदेखि स्वास्थ्य संस्था कति टाढा छ ? यदि तपाइँ स्वास्थ्य संस्था जानु परेमा कसरी जानु हुन्छ ? How far is the health facility from your place? If you have to get there how do you do it?	
केही समयको उपचारमा तपाइँले आफ्नो बच्चामा केही फरक पाउनु भएको थियो ? छ भने के फरक पाउनु भएको थियो ? Did you notice a difference in the condition of your child during the time of treatment? If yes what difference did you observe?	
आफ्नो र बच्चाको स्वास्थ्य बारे सल्लाह लिनु परेमा धेरै जसो कोसँग सल्लाह लिनु पर्छ ? Whose advice do you seek when it comes to your own and child's health related matters?	
तपाइँलाई कसैले बच्चाको विषयलाई लिएर स्वास्थ्य संस्था जानु भनेर सल्लाह दिनु भएको छ ? यदि छ भने कसले ? Were you recommended by others to visit the health facility in context of your child? If so who did?	
तपाइँले कहिले सोच्नु भयो कि आफ्नो बच्चाको उपचार अब स्वास्थ्य संस्थामा निरन्तरता नदिने भनेर ? के कसैले तपाइँलाई निरूत्साहित गरेको थियो ? When did you think that you are no more continuing with the treatment? Did someone discourage you?	

आइमाम कार्यक्रमलाई पृष्ठपोषण				
Feedback to IMAM programme				
यदि हामीले तपाइँको बच्चालाई स्वास्थ्य संस्थामा लगेर उपचार गरे निको हुन्छ भन्यौं भने के तपाइँ आफ्नो बच्चालाई स्वास्थ्य संस्था लैजान इच्छुक हुनुहुन्छ ? If we say that treatment in the health facility will enable your child to become healthy soon, Would you be interested to visit the health facility?	छु Yes		छैन No	
अब कस्तो अवस्था सिर्जना भयो भने तपाइँ स्वास्थ्य संस्थामा लगेर बच्चालाई उपचार गराउन सक्नु हुन्छ ? Now under what circumstances will you be able to continue the treatment?				
यस कार्यक्रममा कुनै परिवर्तन गर्ने अधिकार तपाइँलाई दिईयो भने के परिवर्तन गर्न चाहनुहुन्छ ? If you were given the right to make changes in the programme what changes would you make?				

Interview Guide: IMAM focal person in health facility

कोड Code

अन्तर्वार्ता निर्देशिका आइमाम कार्येक्रम हेर्ने स्वास्थ्यकर्मी			
Interview Guide: IMAM focal person in health facility in Nuwakot district			
अन्तर्वार्ता दिने व्यक्तिको नाम Name of Interviewee		मिति (ग/म/सा) Date (dd/mm/yy)	
बहिरंग उपचार सेवा केन्द्र Name of the OTCC		अन्तर्वार्ता लिने व्यक्तिको नाम Name of Interviewer	
गा.वि.स VDC	वडा नम्बर Ward	टिम Team	

क्षमता विकास	
Capacity Building	
स्वास्थ्य संस्थामा तपाइँहरु मध्ये कति जना IMAM को तालिम प्राप्त गर्नु भएको छ ? के यो तालिम बिरामीको उपचार गर्न पर्याप्त छ ? How many of you are trained in IMAM in this health facility? Is it enough to handle the case load?	
तपाइँलाई तालिमले शिघ्र कुपोषित बच्चाको उपचार राम्ररी गर्न मद्दत पुऱ्याएको छ ? यदि छ भने कसरी ? (जस्तै Z स्कोर तालिकाको प्रयोग, मापनहरु गर्न इत्यादि) Has the training enabled you to handle SAM cases appropriately? If so how (Such as use of Z score table, taking measurements etc.)	
तपाइँलाई यदि बिरामीको उपचार गर्न कुनै दुविधा भयो के गर्नु हुन्छ ? What do you do in case of any confusion in case management?	

तपाइँ आफू IMAM कार्यक्रमको focal point भएको नाताले, तपाइँले कार्यक्रम व्यवस्थापन राम्ररी गर्न सक्नु भएको जस्तो लाग्छ ? Do you think as an IMAM focal person you have been able to handle the programme better?	
आइमाम कार्यक्रमको गुणस्तर Quality of IMAM programme	
तपाइँको स्वास्थ्य संस्थामा कहाँबाट धेरै प्रेषण हुने गरेको छ ? र किन ? What kind of referral is most frequent in your health facility? Why?	
तपाइँको स्वास्थ्य संस्थामा defaulter को अवस्था कस्तो छ ? यदि defaulter छन् भने के कारणले गर्दा defaulter भएका होलान् ? defaulter हरूलाई कसरी फलो अप गर्ने गर्नु भएको छ ? अर्के गा.वि.स.बाट तपाइँको स्वास्थ्य संस्थामा उपचार गर्न आउने बच्चाको हकमा कसरी फलो अप गर्ने गर्नु भएको छ ? What is the situation of defaulter in your health facility? If there are then what could be the reasons for defaulting? What do you do to follow-up on the children who default from the programme? How do you follow-up on children from different VDC who has come your health facility for treatment?	
निको भएर डिस्चार्ज हुने बालबालिकाको हकमा के कारणले गर्दा उनीहरू पूर्ण रूपमा उपचार प्राप्त गर्न सक्षम भएका होलान् ? निको भएर डिस्चार्ज हुने बच्चाहरू defaulter बच्चाहरुको परिप्रेक्ष्यमा कसरी फरक हुन्छन् ? In context of children who get discharged as cured, what do you think are prime reasons for them to be able to do so? How do they differ in context to children who default?	
नियमित सेवाको क्रममा कुनै चुनौतिहरूको सामना गर्नु परेको छ ? यदि छन् भने के हुन् र ती चुनौतिहरूको निराकरणको लागि कस्ता कदम चल्नु भएको छ ? Have you come across any challenges during your day to day service delivery? If yes what are they and what measures have you take to mitigate those challenges?	
तपाइँ नियमित रूपमा स्क्रीनिंग कार्यक्रमहरु संचालन गर्नु हुन्छ ? बाल विकास केन्द्रहरूमा पनि मुआक नाप्ने र रेफरल हुने कुरालाई कसरी लिनु हुन्छ ? Do you regularly organize screening programme? What do you think about the idea of screening and referral by early childhood development center facilitators?	
डिस्चार्ज र भर्नाका आधारहरूमा तपाइँलाई कुनै दुविधा छ ? यदि छन् भने ती के हुन् ? Do you have any confusion with regards to the discharge and admission criteria? If yes what are they?	
के तपाइँहरूले ITCC/ stabilization सेन्टरमा रेफर गरेका बच्चाहरु भर्ना भएका छन् ? कुनै यस्तो घटना छ जब तपाइँहरूले रेफर गरेको बच्चालाई भर्ना गरिएन ? यदि छ भने किन त्यस्तो भएको होला ? समस्टिगत रूपमा ITCC / OTCC बीचको रेफरलको अवस्था कस्तो छ ? Have the children referred from your health facility to inpatient therapeutic care center/stabilization center been successfully admitted in ITCC? Are there instances when child was not admitted? Then what was the reason? Overall what is the scenario of referral to and from ITCC?	
के तपाइँलाई लाग्छ, तपाइँ सम्पूर्ण शिघ्र कुपोषित बच्चाहरु कार्यक्रममा ल्याउन सफल हुनु भएको छ ? यदि छ भने किन र छैन भने किन ? Do you think you have been able bring all the SAM children into the programme? If yes why? if not why?	
समुदायलाई कुपोषण बारे जागरूक तुल्याउन के कदम चाल्नु भएको छ ? जागरणको यस्तो प्रक्रियामा कसलाई बढी लक्षित गर्नु हुन्छ ? What steps have you taken to sensitize the community on Malnutrition? Who has been the target of the sensitization process?	
तपाइँ सरोकारवालार अन्य सरकारी संस्था र साझेदार संस्था हरुसँग कसरी समन्वय गरिरहनु भएको छ ? के उनीहरू सहकार्य गरिरहेका छन् ? How are you coordinating with various stakeholders/government agencies and partner agencies in the sensitization process? Have they been cooperative?	
हामीले जति पनि जागरणका प्रयासहरू गर्दैछौ के यो प्रयाप्त छ ? यदि पर्याप्त छ भने किन र छैन भने किन ? Do you think the sensitization efforts are sufficient? If yes why? If not why?	

आपूर्ति व्यवस्थापन					
Logistics Management					
RUTF को नियमित उपलब्धता IMAM कार्यक्रमको निरन्तरताको लागि एकदम महत्वपूर्ण छ, यसै सन्दर्भमा तपाइँले RUTF कसरी नियमित रूपमा उपलब्ध गराई राख्नु भएको छ ? Regular availability of RUTF is critical to sustainability of IMAM. So in this context how have you ensured that required amount of RUTF is always available in health facility?					
विशेषगरी बर्षातको समयमा सामानहरू जिल्ला सदरमुकामदेखि ल्याउन चुनौतिपूर्ण हुने गर्छ, यस्तो समयमा आपूर्ति व्यवस्थापन कसरी गर्ने गर्नु भएको छ ? Especially during rainy season transfer of logistics from district headquarters becomes very challenging. So how do you manage the logistics for the programme during this period?					
के यी सबै सामानहरू उपलब्ध छन् ? Are these materials available?					
मुआक टेप	छ		छैन		
MUAC tape	Yes		No		
तौल लिने सामग्री	छ		छैन		
Weighing scale	Yes		No		
उचाई र लम्बाई नाप्ने बोर्ड	छ		छैन		
Height board	Yes		No		
Z- स्कोर तालिका	छ		छैन		
Z - score table	Yes		No		
राष्ट्रिय मेडिकल प्रोटोकल	छ		छैन		
National medical protocol	Yes		No		
IMAM फ्लिप चार्ट	छ		छैन		
IMAM flipchart	Yes		No		
RUTF भण्डारण गर्ने बाकस	छ		छैन		
Tin trunk to store RUTF	Yes		No		
Amoxicillin DT / Syrup (tablet / bottle)	छ		छैन		
	Yes		No		
भिटामिन ए क्याप्सुल	छ		छैन		
Vitamin 'A' capsule	Yes		No		
जुकाको औषधी	छ		छैन		
Albendazole	Yes		No		

रेकर्डिङ र रिपोर्टिंग फारमहरु	
Recording and Reporting forms	
IMAM कार्यक्रम अन्तर्गतको रेकर्डिङ र रिपोर्टिंगको अवस्था कस्तो छ ? यी फारमहरु भर्न कुनै समस्या छ ? तपाइँले जिल्ला जनस्वास्थ्य कार्यालयमा नियमित रिपोर्टिंग गर्ने गर्नु भएको छ ? (FCHV register -HMIS 4.2 FCHV report collection form -HMIS 9.1) How has your recording and reporting of the IMAM programme been? Do you have any problems filling up the form? Have you been regularly reporting it to the district public health office? (IMAM OTC Register -HMIS 2.6/Monthly Reporting Sheets -HMIS 9.1 and 9.3)	
महिला स्वास्थ्य स्वयंसेविकाले स्वास्थ्य संस्थामा गर्ने रिपोर्टिंगको अवस्था कस्तो छ ? यस सम्बन्धी कुनै चुनौतिहरु छन् ? यदि छन् भने यो चुनौतिहरूको सामना गर्न के कस्ता कदमहरु चाल्नुभएको छ ? What is the situation of reporting to the health facility from female community health volunteers? Are there any challenges in that context? If there are any challenges what measures have you taken to mitigate them?	
समुदाय बारे जानकारी	
Community profile	
तपाइँ काम गर्ने समुदायको मुख्य चुनौतिहरु के के हुन् ? What are the main challenges of the community you work in?	
तपाइँको समुदायमा सबैभन्दा बढी लाग्ने बालबालिका सम्बन्धी रोग कुन हो ? यो कुन महिनामा बढी लाग्ने गर्छ ? What are most frequent childhood diseases in the community where you work? In which month are they more prevalent?	
समुदायका मानिसले कुपोषणलाई इंकित गर्न कुन शब्दको प्रयोग गर्छन् ? कुपोषणलाई समुदायमा कसरी लिइने गरिन्छ ? तपाइँलाई लाग्छ समुदायले यस्तो अवस्थाको बच्चालाई हेलाको दृष्टिकोणले हेर्छन् ? What are the local terms used by the community to depict malnutrition? How is the condition perceived by the community? Do you think there is any stigma surrounding this health condition?	
समुदयमा कुपोषणका मुख्य कारणहरु के के हुन् ? What are the main causes of malnutrition in the community?	
समुदायमा कस्ता व्यक्तिहरूले अरू मानिसका बानी बेहोरामा प्रभाव पर्न सक्छन् ? तपाइँलाई के लाग्छ की एउटा घरधुरीमा आमाको स्वास्थ्य सम्बन्धी बानी बेहोरा र उपचार अपनाउने सम्बन्धी निर्णयलाई कसले बढी प्रभाव पर्न सक्छ ? Who are people in the community who can influence community's treatment seeking behavior? Who do you are the key people in a household who influence mother's health behavior and treatment seeking decisions?	
तपाइँको समुदायका मानिसहरू धामी झाक्री वा झार फुक गर्ने मानिसका जान्छन् ? तपाइँलाई यस सम्बन्धी कुनै जानकारी छ ? Do people in your community go to traditional healers? Do you have any information on this context	
आइमाम कार्यक्रमको लागि पृष्ठपोषण	
Feedback to IMAM programme	
IMAM कर्यक्रमका सबल र दुर्बल पक्षहरु के के हुन् ? What do you think are the strengths and weakness of the IMAM programme?	
कार्यक्रममा अझै सुधार ल्याउन के कुरा परिवर्तन वा बदल्न चाहनुहुन्छ ? What would you like to change or add in the programme to improve further?	
कार्यक्रम अन्तर्गतको सेवा लिन कुनै बाधा छ (भाषा,संस्कृतिक, धार्मिक इत्यादि) Do you think there are any barriers (Language, cultural, religious etc.) for people to use the service of the programme?	

Interview Guide: Female Community Health Volunteer

कोड
Code

अन्तर्वार्ता निर्देशिका: महिला स्वास्थ्य स्वयं सेविका			
Interview Guide: Female Community Health Volunteer			
अन्तर्वार्ता लिने व्यक्तिको नाम Name of Interviewee		मिति (ग/म/सा) Date (dd/mm/yy)	
बहिरंग उपचार सेवा केन्द्र Name of the OTCC		अन्तर्वार्ता दिने व्यक्तिको नाम Name of Interviewer	
गा.वि.स VDC	व.डा. नम्बर Ward	टिम Team	

क्षमता विकास	
Capacity Building	
के तपाइँले IMAM को तालिम प्राप्त गर्नु भएको छ ? यदि छ भने के यो तालिमले तपाइँलाई कुपोषणका संकेत र लक्षणहरू पहिचान गर्न र पाखुराको नाप लिन अझ बढी सक्षम बनेको जस्तो लाग्छ ? Are you trained in IMAM? If yes, do you think it has boosted your skills on taking measurements and identifying signs and symptoms of malnutrition?	
कुनै दुविधा उत्पन्न भए के गर्नु हुन्छ ? What do you do in case of any confusion?	
आइमाम कार्यक्रमको गुणस्तर	
Quality of IMAM programme	
तपाइँलाई लाग्छ की तपाइँले सम्पूर्ण शिघ्र कुपोषित बच्चाहरु कार्यक्रममा ल्याउन सफल हुनु भएको छ ? यदि छ भने किन र छैन भने किन ? Do you think you have been able to bring all the SAM children into the programme? If yes why? if not why?	
समुदायलाई कुपोषण बारे जागरूक बनाउन के कदम चाल्नु भएको छ ? जागरणको यस्तो प्रक्रियाले कसलाई बढी लक्षित गर्छ ? What steps have you taken to sensitize the community on malnutrition? Who has been the target of the sensitization process?	
के तपाइँले अन्य समुदायस्तरका संस्थाहरूसँग समन्वय गरेर समुदायलाई जागरूक बनाउने कार्यक्रमहरु संचालन गर्न सक्नु भएको छ ? यदि गर्नु भएको छ भने कसरी ? Have you been able to coordinate with other community level organizations for sensitization on nutrition related issues? If yes how?	
हामीले जति पनि जागरणका प्रयासहरू गर्दैछौ ? के यो पर्याप्त छ ? यदि छ भने किन र छैन भने किन ? Do you think the sensitization efforts are sufficient? If yes why? If not why?	

के तपाइँ कहाँ मानिसहरु कुपोषणको लक्षण भएका बालबालिका लिएर आउछन् ? यदि आउछन् भने हेरचाह गर्ने व्यक्तिलाई कसरी स्वास्थ संस्थासम्म उपचार गर्न जान विश्वस्त तुल्याउनु हुन्छ ? Do people bring their child to you who are showing symptoms of malnutrition? If yes how do you convince the caretakers to visit the health facility?	
कार्यक्रममा भर्ना भएका बच्चाहरूको फलोअपको लागि वा defaulter हरूको फलोअप लागि स्वास्थ्य संस्थाले तपाइँसँग समन्वय गर्छ ? तपाइँले फलोअपको लागि आफ्नो तर्फबाट के गर्नु भएको छ ? Does the health facility coordinate with you in context of following up with child enrolled in IMAM programme or those who defaulted? What initiations have you taken to follow-up?	
के तपाइँ आफुले स्वास्थ्य संस्थामा प्रेषण गर्नु भएका बालबालिकाको फलोअप गर्ने गर्नु भएको छ ? तपाइँको वडामा कुनै त्यस्तो बच्चा छ जो स्क्रीनिंग गर्दा कुपोषणमा परेता पनि अहिलेसम्म स्वास्थ्य संस्था गएको छैन ? यदि छ भने अहिलेसम्म किन उपचार गर्न नगएको होला ? तपाइँले त्यस्तो अवस्थामा उक्त बच्चाको परिवारलाई स्वास्थ्य संस्थामा जान कसरी राजी गर्नुहुन्छ ? Do you follow-up on the children who you have been referred to the health facility after being screened as SAM? Do you know any child in your ward that has been screened as malnourished and yet has not visited the healthy? If such case exists why has the child not been taken for treatment and what measures have you taken to persuade the family?	
के तपाइँले नियमित रूपमा बच्चाहरूको मुआक मापनको कार्यक्रम राख्नु हुन्छ ? यदि गर्नु हुन्छ भने कसरी गर्नु हुन्छ ? अनि तपाइँले स्वास्थ्य संस्थामा सोध्नु भएको छ की मैले प्रेषण गरेका मध्ये कति बच्चा भर्ना भए वा उनीहरूका घर गएर फेरि हेर्नु भएको छ ? Do you regularly organize screening programme? If yes how do you do it? Have you asked how many children have been accepted by the health facilities or have you visited the children's house to inquire?	
अनि परामर्श प्रदान गर्दा कस्ता सन्देशहरूमा बढी जोड दिनु हुन्छ ? What sort of messages do you focus on while counselling to caretakers of SAM children?	
तपाइँको समुदयमा कुपोषणका मुख्य कारणहरु के के होलान् ? What do you think are the reasons for malnutrition in your area?	

आपूर्ति व्यवस्थापन

Logistics Management

के यी सबै सामानहरू उपलब्ध छन् ?						यी मध्ये कुनै पनि समान उपलब्ध नभए किन नभएको होला ?
मुआक टेप	छ		छैन			
MUAC tape	Yes		No			
IMAM फिलप चार्ट	छ		छैन			
IMAM flipchart	Yes		No			

रेकर्डिङ र रिपोर्टिंग फारमहरु	
Recording and reporting formats	
IMAM कार्यक्रम अन्तर्गतको रेकर्डिङ र रिपोर्टिंगको अवस्था कस्तो छ ? यी फारमहरु भर्न कुनै समस्या छ ? तपाइँले जिल्ला जनस्वास्थ्य कार्यालयमा नियमित रिपोर्टिंग गर्ने गर्नु भएको छ (FCHV register -HMIS 4.2 FCHV report collection form -HMIS 9.1) How has your recording and reporting of the IMAM programme been? Do you have any problems filling up the form? Have you been regularly reporting it to the district public health office?(FCHV register -HMIS 4.2 FCHV report collection form -HMIS 9.1)	
समुदाय बारे जानकारी	
Community profile	
तपाइँ काम गर्ने समुदायको मुख्य चुनौतीहरु के के हुन् ? What are the main challenges of the community you work in?	
तपाइँको समुदायमा सबैभन्दा बढी लाग्ने बालबालिका सम्बन्धी रोग कुन हो ? यो कुन महिनामा बढी लाग्ने गर्छ ? What are most frequent childhood diseases in the community where you work? In which month are they more prevalent?	
समुदायका मानिसले कुपोषणलाई इंकित गर्न कुन शब्दको प्रयोग गर्छन् ? कुपोषणलाई समुदायमा कसरी लिइने गरिन्छ ? तपाइँलाई लाग्छ समुदायले यस्तो अवस्थाको बच्चालाई हेलाको दृष्टिकोणले हेर्छन् ? What are the local terms used by the community to depict malnutrition? How is the condition perceived by the community? Do you think there is any stigma surrounding this health condition?	
यदि बच्चालाई स्वास्थ्य संस्था प्रेषण गर्नु परेमा परिवारको कुन सदस्यसँग कुरा गर्नु हुन्छ ? Which family member do you talk to if a child needs to be referred to health facility?	
तपाइँको सल्लाह पछि कसले निर्णय लिन्छ ? Who makes the decision following your recommendation?	
समुदायमा कुपोषणका मुख्य कारणहरु के के हुन् ? What are the main causes of malnutrition in the community?	
समुदायमा कस्तो व्यक्तिहरूले अरू मानिसका बानी बेहोरा प्रभाव पर्न सक्छन् ? तपाइँलाई के लाग्छ की एउटा घरधुरीमा आमाको स्वास्थ्य सम्बन्धी बानी बेहोरा र उपचार अपनाउने सम्बन्धी निर्णयलाई कसले बढी प्रभाव पर्न सक्छ ? Who are people in the community who can influence community's treatment seeking behavior? Who do you are the key people in a household who influence mother's health behavior and treatment seeking decisions?	
तपाइँका समुदायका मानिसहरू धामी झाक्री वा झार फुक गर्ने मानिसका जान्छन् ? यदि जाने चलन छ भने किन जान्छन् होला ? Do people in your community go to traditional healers? If they do why do they go there?	
बच्चा बिरामी परेको बेला स्थानीय औषधि पसलमा जाने चलन कस्तो छ ? के तपाइँलाई मानिसहरू स्वास्थ्य संस्था नजाने कारण यो पनि एउटा हो जस्तो लाग्छ ? Do people visit the local pharmacy to obtain medicines when there child is sick? Do you think that is one of the reasons that could prevent them from visiting the health facility?	

आइमाम कार्यक्रमलाई पृष्ठपोषण	
Feedback to IMAM programme	
IMAM कार्यक्रमका सबल र दुर्बल पक्षहरु के के हुन् ? What do you think are the strengths and weakness of the IMAM programme?	
कार्यक्रममा अझै सुधार ल्याउन के कुरा परिवर्तन वा बदल्न चाहनुहुन्छ ? What would you like to change or add in the programme to improve further?	
कार्यक्रम अन्तर्गतको सेवा लिन कुनै बाधा छ (भाषा, संस्कृतिक, धार्मिक इत्यादि) Do you think there are any barriers (Language, cultural, religious etc.) for people to use the service of the programme?	

Interview Guide: Representative of a community based organization

कोड
Code

अन्तर्वार्ता निर्देशिका: समुदयमा आधारित भएर कम गर्ने संस्थाका प्रतिनिधि			
Interview Guide: Representative of a community based organization			
अन्तर्वार्ता दिने व्यक्तिको नाम		मिति (ग/म/सा)	
Name of Interviewee		Date (dd/mm/yy)	
संस्थाको नाम		अन्तर्वार्ता लिने व्यक्तिको नाम	
Institution		Name of Interviewer	
पद			
Position			
संस्थागत पृष्ठभूमि			
Organizational background			
समुदायमा तपाईको संस्थाको भूमिका के हो? What is the role of your organization in the community?			
समुदायमा तपाईको संस्थाको भूमिका के हो? Which are VDCs that your organization is working in and since when have you been working in this sector?			
समुदाय बारे जानकारी			
Community profile			
तपाई काम गर्ने समुदायमा जातजतिहरुको कस्तो समिश्रण छ? के यस किसिमको समिश्रणले तपाईको कमलाई कुनै प्रभाव पार्छ? प्रभाव पार्छ भने कसरी प्रभाव परिरहेको छ? What is the ethnic composition of the community where you work? Does it influence your work methods? If so how?			

तपाई काम गर्ने समुदायमा कुन कुन भाषा बोलिन्छ? के भाषाको कारणले कार्यक्रममा कुनै अवरोध उत्पन्न भएको छ? यदी हो भने कसरी ? Which languages are spoken in the community where you work? Do they represent a linguistic barrier? If yes then how?	
के समुदयमा धर्मको कारणले मानिसको व्यवहारमा प्रभाव पर्ने गरेको छ? यदि छ भने कसरी? Does religion have an impact on people's health behavior in the community? Explain.	
तपाई काम गर्ने समुदायमा सामाजिक(आर्थिक भिन्नता कस्तो छ? यस किसिमको समीकरणले के समुदायमा मानिसहरू बीचको सम्बन्धलाई प्रभाव परेको छ? Are there important socioeconomic differences among people in the community where you work? Do they influence internal community relationships? If yes, how?	
तपाई काम गर्ने समुदायका मानिसहरूको आयको मुख्य स्रोत के हो? What are main sources of income for people living in the community where you work?	
तपाई काम गर्ने समुदाको संरचना कस्तो छ? उक्त समुदायका प्रभावशाली व्यतित्वहरु कोको छन्? समुदायमा निर्णयहरु कसरी संचार हुने गरेको छ? How the community is where you work organized? Who are the influential people in the community? How are decisions communicated?	
समुदायमा औपचारिक र अनौपचारिक संचारका माध्यमहरु कस्तो छ? कुन माध्यम बढी प्रभावकारी छ र किन? What (formal & informal) channels of communication are available in the community where you work? Which are most efficient? Why?	
सामजिक परिचालनको लागि कस्तो विधि अपनाउनु भएको छ? समाजलाई जागरूक र सुसुचित बनाउने कार्य हरूमा धेरै जसो कसलाई लक्षित गर्नु हुन्छ र किन? What is your approach of community mobilization? Who do you target during sensitization efforts and why?	
तपाइको अनुभवको आधारमा घरधुरिहरूमा निर्णय गर्ने अधिकारको प्रत्यायोजन कसरी भएको पाउनु हुन्छ? आमा र बच्चाको स्वास्थ्य सम्बन्धी बिषयमा कसको प्रभाव बढी हुन्छ? Based on your experience can you tell us a bit on how in the household the decision making power is distributed? Who is the most influential figures in terms of women's and child's issues?	
आइमाम कार्यक्रमलाई पृष्ठपोषण	
Feedback to IMAM programme	
तपाईलाई IMAM कार्यक्रमबारे थाहा छ? Do you know about IMAM programme?	छ ☐ Yes ☐ छैन ☐ No ☐
यदी थाहा छ भने मात्रै निम्न प्रश्नहरु सोध्ने (If yes then ask the following questions)	
IMAM कार्यक्रमका सबल र दुर्बल पक्षहरु के के हुन्? What do you think are the strengths and weakness of the IMAM programme?	
कार्यक्रममा अझै सुधार ल्याउन के कुरा परिवर्तन वा बदल्न चाहनुहुन्छ? What would you like to change or add in the programme to improve further?	
समुदायले IMAM कार्यक्रमलाई कसरी लिइरहेको छ? How does the community perceive IMAM programme?	

Interview Guide: Community member or leader

कोड
Code

अन्तर्वार्ता निर्देशिका: समुदयका सदस्य वा नेत्तृत्वदायी भूमिकामा रहेका व्यक्ति			
Interview Guide: Community member or leader			
अन्तर्वार्ता दिने व्यक्तिको नाम		मिति (ग/म/सा)	
Name of Interviewee		Date (dd/mm/yy)	
संस्थाको नाम		अन्तर्वार्ता लिने व्यक्तिको नाम	
Institution		Name of Interviewer	
पद			
Position			

समुदायमा कुपोषण सम्बन्धी जानकारी
Malnutrition related information in the community
समुदायका मानिसले कुपोषणलाई इंकित गर्न कुन शब्दको प्रयोग गर्छन? कुपोषणलाई समुदायमा कसरी लिइने गरिन्छ? तपाईलाई लाग्छ समुदायले यस्तो अवस्थाको बच्चालाई हेलाको दृष्टिकोणले हेर्छन्? What are the local terms used by the community to depict malnutrition? How is the condition perceived by the community? Do you think there is any stigma surrounding this health condition?
कुपोषणको उपचार गर्ने कार्यक्रमको बारेमा सुन्नु भएको छ? Are you aware of a programme which treats malnutrition?
कार्यक्रम सम्बन्धी सेवा प्रदान गर्ने ठाउँ तपाइको गाउँ भन्दा कति टाढा छ (घण्टामा)? यो दुरी कत्तिको टाढा हो? How far is the programme site from the village? Distance in time (Hours) and Perception of the distance (far or close)
समुदायले कुपोषित आमा र बच्चालाई कसरी हेरेका हुन्छन् ? How does the community perceive the mothers and the families of the malnourished children?
मुआक टेप देखाएर सोध्ने की उहाले यो टेप देख्नु भएको छ की छैन? देख्नु भएको छ भने कहाँ र कोसँग? कहिले देख्नुभएको छ केको लागि प्रयोग भईरहेको थियो? गाउँमा को-को यस्ता व्यक्ति छन् जसले येस टेपको प्रयोग गर्नु हुन्छ ? यदी छन् भने कहिले कहिले उहाँहरूले घर घर गई बच्चाहरूको पाखुरा नाप्नु हुन्छ? Show the MUAC tape and ask if they have seen it? Where did you see it and with who? When did you see it (MUAC) and what was it being used for? Are there people in this village who use this (MUAC) on your children? If yes, how often do visit the houses and screen the children?
कार्यक्रम अन्तर्गत सेवा लिरहेको कोही बच्चा चिन्नु हुन्छ ? Do you know any malnourished children in the programme?
तपाई यस्तो कोही कुपोषित बच्चा चिन्नु हुन्छ जो कार्यक्रम अन्तर्गत छैन? कारण के होला? Do you know any malnourished children NOT in the programme? What are the reasons?

तपाईले यस्तो कोही बच्चा चिन्नु भएको छ जसले कार्यक्रम बिचैमा छोड्यो? कारण के होला? Do you know of any children who were left the programme in the middle of the treatment (defaulting children)? What are the reasons?
तपाई यस्तो कोही बच्चा चिन्नु हुन्छ जो कार्यक्रममा भर्ना गरिएन? किन? Do you know of children who have been rejected from the programme? Why?
समुदायमा कसैले स्वास्थ्य शिक्षा प्रदान गर्छ? कसले प्रदान गर्छ र कति कतिको अन्तरालमा? Does anyone provide health education in the village? Who provides it and how often do they talk about it?
समुदायमा कुपोषण सम्बन्धी उपचार उपलब्ध छ भनेर खबर गर्ने उपयुक्त व्यक्ति को हुन सक्छ ? उहाँले सूचना कसरी प्रवाह गर्नु हुन्छ? Who would be the most appropriate people to inform the community of nutrition treatment? How can they disseminate the information (method used)?
आइमाम कार्यक्रमलाई पृष्ठपोषण
Feedback to IMAM programme
कार्यक्रममा अझै सुधार ल्याउन के कुरा परिवर्तन वा बदल्न चाहनुहुन्छ ? What would you like to change or add in the programme to improve further?

ANNEX 9.3: QUESTIONNAIRE USED DURING STAGE II AND III OF SQUEAC

QUESTIONNAIRE FOR COVERED SAM CASES

Date: _____ Name of Child: _____

District : _____ MUAC: _____

Village : _____ Odemea? (+, ++, +++): _____

Height: _____ Weight: _____

Name of Carer : _____ Sex: _____

Enumerator/Supervisor name : _____ Age: _____

Proof Proof that child is in the programme (e.g. packet of RUTF/OTC Registration Card/explanation):

_____ _____ _____

1. How did you first know that your child was malnourished?

_____

_____

_____

_____

_____

2. How did you hear about the programme?

_____

_____

_____

_____

_____

3. Did you treat your child before coming to the health facility/OTC?

□ Yes ; How?

_____

Why did you then go to the health facility/OTC?

_____

_____

_____

_____

_____

4. Do you know any other malnourished children in the community?

_____

_____

_____

_____

_____

_____

QUESTIONNAIRE FOR NON COVERED SAM CASES

Date: _____ Name of Child: _____

District : _____ MUAC: _____

Village : _____ Odemea? (+, ++, +++): _____

Height: _____ Weight: _____

Name of Carer : _____ Sex: _____

Enumerator/Supervisor name : _____ Age: _____

Proof that child is in the programme (e.g. packet of RUTF/OTP Card/explanation):

_____ _____ _____

1. Do you think your child is sick ?

□ Yes; which illness is your child suffering from ? □ No → STOP

_____

2. Do you think your child is malnourished?

□ Yes □ No → STOP

_____

3. Do you know where you can take your child to be treated (for malnutrition)?

□ Yes ; what is the name of the programme/where is it? □ No → STOP

_____

4. Why have you not taken your child to the Health Facility?

_____

_____

_____

_____

_____

_____

5. Has your child previously received treatment from the OTC or SFP or TFU? (circle appropriate)

□ Yes ; why are they no longer in the programme ? □ No → STOP

_____ _____

□ 1. Defaulter; when ? _____

□ 2. Discharged cured ; when ? _____ why ? _____ _____

□ 4. Other reasons : _____ □ 3. Discharged non-cured ; when ? _____

_____

Thank the carer and provide with a referral slip.

Any additional comments/observations :

ANNEX 9.4: DAILY DATA COLLECTION FORM IN STAGE II AND STAGE III

Date:	
Enumerator team:	
Village:	
Distance from nearest OTC site hours:	
FCHV present (yes or no?)	

	COUNT OF:	TALLY
	NUMBER OF HOUSEHOLDS VISITED:	
	CASES SCREENED:	
	HOUSEHOLDS REFUSING ENTRY:	
SAM CASES	COVERED	
	UNCOVERED	
	RECOVERING CASE (>115mm MUAC in SAM programme)	

ANNEX 9.5: PARTICIPANTS OF COVERAGE ASSESSMENT

S.N.	Pariticipants	Designation	Organization	Contact no.
1	Basanta Adhikari	Chief of District Public Health Office	DPHO, Nuwakot	9851173934
2	Janardan Silwal	Nutrition Focal Person	DPHO, Nuwakot	9851206348
3	Pramila Devkota	Nutrition Officer	UNICEF, Nuwakot	9802065958
4	Sujay Nepali Bhattacharya	Head of Department: Nutrition & Health	Action Against Hunger	9801187510
5	Sailendra Bista	Sr. Programme Officer	Action Against Hunger	9801241741
6	Manisha Katwal	Sr. Programme Officer	Action Against Hunger	9801187513
7	Roshna Maharjan	Core team	Action Against Hunger	9801241738
8	Anamika Shahi	Core team	Action Against Hunger	9861168932
9	Bishnu Poudel	Core team	Action Against Hunger	9849494358
10	Ramesh Shrestha	Core team	Action Against Hunger	9843697989
11	Sanjay Chaudhary	Core team	Action Against Hunger	9801527959
12	Jitendra Yadav	Core team	Action Against Hunger	9844111400
13	Tanka Shrestha	Enumerator	Action Against Hunger	9844309794
14	Sabina Pudasaini	Enumerator	Action Against Hunger	9849962704
15	Pratikshya Baniya	Enumerator	Action Against Hunger	9841016540
16	Raja Ram Silwal	Enumerator	Action Against Hunger	9843241763
17	Min Bahadur Nagarkoti	Enumerator	Action Against Hunger	9849451915
18	Alita Poudel	Enumerator	Action Against Hunger	9849115298
19	Goma Neupane	Enumerator	Action Against Hunger	9840139257
20	Rabina Raut	Enumerator	Action Against Hunger	9843638788


ACTION
AGAINST
HUNGER
ACTION
CONTRE
LA FAIM