SEMI-QUANTITATIVE EVALUATION OF ACCESS AND COVERAGE (SQUEAC)

FINAL REPORT | MAKAWANPUR DISTRICT, NEPAL
FEBRUARY, 2017

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SABAL

Government of Nepal
Ministry of Health
Department of Health Services
District Public Health Office
Makawanpur

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Cover Picture: A woman from Makawanpur district being interviewed on coverage and access to IMAM program in her locality.

Picture by: Shankar Bista

ACKNOWLEDGEMENTS

Sustainable Action for Resilience and Food Security (Sabal) project would like to thank all the parties and individuals, who were involved either directly or indirectly in the success of the Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) assessment held in Makawanpur district in February 2017. Sabal project extends it gratitude to:

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- All the key informants interviewed during the various stages of the assessment.

- All the communities residing in the Makawanpur district for providing consent and taking part in the assessment.

ACRONYMS

ACF	Action Contre La Faim
ARI	Acute Respiratory Infection
BBQ	Barrier Booster Questions
CMAM	Community based Management of Acute Malnutrition
CNW	Community Nutrition Worker
DAG	Disadvantaged Group
DPHO	District Public health office
ECD	Early Childhood Development
EHCS	Essential Health Care Services
EPI	Expanded Program on Immunization
FANTA	Food and Nutrition Technical Assistance
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
HMIS	Health Management Information System
HP	Health Post
IMAM	Integrated Management of Acute Malnutrition
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
ITCC	Inpatient Therapeutic Care Center
IYCF	Infant and Young Child Feeding
LQAS	Lot Quality Assurance Sampling
MAM	Moderate Acute Malnutrition
MCH	Maternal and Child health
MSNP	Multi Sectoral Nutrition Plan
MUAC	Mid-Upper Arm Circumference
NGO	Non-Government Organization
NHSP-II	Nepal Health Sector Program-II
ORC	Out Reach Clinic
OTCC	Outpatient Therapeutic Care Center
PHCC	Primary Health Care Center
RUTF	Ready-to-use Therapeutic Food
Sabal	Sustainable Action for Resilience and Food Security
SAM	Severe Acute Malnutrition
SLEAC	Simplified Lot Quality Assurance Sampling Evaluation of Access and Coverage
SMART	Standardized Monitoring and Assessment of Relief and Transitions
SQUEAC	Semi Quantitative Evaluation of Access and Coverage
SSI	Semi- Structured Interview
TSFP	Targeted Supplementary Feeding Program
UNICEF	United Nation Children's Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
UNWFP	United Nation World Food Program
WHZ	Weight-for-Height Z-score

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Foreword

Makwanpur is a hilly district situated in the central hills. Difficult geographical terrain and poor road access comes as a challenge to utilization of basic health services. In this context it is important to make informed decision to ensure that we efficiently address the issues of accessibility and coverage of health programs in the district. In that regard, Semi Quantitative Evaluation of Access and Coverage (SQUEAC) assessment was conducted by Sustainable Action for Resilience and Food Security (Sabal), a USAID funded program, in collaboration and supervision of District Public Health Office (DPHO), Makwanpur. The main objective of the study was to assess all the factors influencing the access and coverage of Integrated Management of Acute Malnutrition (IMAM) program in the district.

I am delighted to know that it is only second occasion that SQUEAC assessment has been conducted in Nepal following the first one in Saptari district in 2013. The assessment also estimated the coverage of IMAM program in the district. A month long assessment was held in three stages. The assessment specifically outlined the factors which undermined program coverage as well as ascertain factors that support program coverage. During the assessment qualitative and quantitative data was collected to outline the problem as well probe the cause of those problems. The assessment team did a wonderful job of collecting information from various sources, methods and location to analyze all the issues exhaustively including factors associated with demand side and service side. The assessment also presented us with an opportunity to screen approximately twelve hundred children throughout the district.

The assessment was followed by an action plan design workshop where all relevant stakeholders had an opportunity to share their views on way forward. The workshop was fruitful to develop very specific and doable activities with a set timeline. The District Public Health Office wholeheartedly takes ownership of all the results and recommendations of the assessment.

In the end I would like to thank and congratulate the Sabal project as well as Action Against Hunger | Action Contre La Faim (ACF) –the technical lead, for collaborating with District Public Health Office in conducting such an exhaustive assessment of the IMAM program. The results of the assessment will enable the IMAM program 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 program is being conducted.

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EXECUTIVE SUMMARY

BACKGROUND

Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) assessment was held in Makawanpur district in February 2017. The overall objective of the survey was to evaluate the access and coverage of Integrated Management of Acute Malnutrition program (IMAM) in Makwanpur district focusing on management of severe acute malnutrition (SAM) cases. Although IMAM program is not limited to management of severe acute malnutrition. The project deals with only SAM management. Hence, the assessment is limited to only SAM management. The assessment covered quantitative information on SAM case management from January to December 2016.

APPROACH

SQUEAC is a multi-stage (three stage) and two-pronged (qualitative and quantitative) assessment technique therefore the enumerators received one-day training at the beginning of each stage. The project trained nine enumerators in taking MUAC measurement, edema checking, active- adaptive case finding, door-to-door sampling, administering the interview guides and conducting group discussions. Mid-Upper Arm Circumference (MUAC) tape and presence of bilateral pitting edema was taken as two methods for case identification. The assessment covered entire district by subdividing into 15 sections based on the catchment areas of outpatient therapeutic care centers (OTCC), point of service of IMAM program. The assessment team used active-adaptive case finding and door-to-door sampling to locate cases.

FINDINGS

Qualitative assessment, which involved interviews and discussion with all relevant stakeholder, identified 22 barriers and 14 boosters of the program triangulated by methods, sources and location. The barriers ranged from geographical inaccessibility and economic unaffordability to social issues such as language barriers between the service seekers and provider, gender bias towards female child, belief in traditional faith healers. 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 or no health service to beneficiaries when IMAM focal person is absent. The boosters include mostly service side factors such as capacity building of all health workers in the district in IMAM, active screening of children at various health events, well equipped OTCC among others.

Quantitative assessment involved analysis of treatment record from enrollment to discharge of each child admitted into the program. Project activities involving MUAC screening influenced admission peaks more than seasonality. The assessment observed non-compliance to treatment protocol with respect to gap between follow-up and there timings which means there are hidden defaulters in the program. While defaulting is a major issue, majority of defaulters defaulted in the first week of enrollment worsening acute malnutrition. More than three-fourth of the SAM admissions were limited to children residing at a distance of less than 10 kilometers from the point of service. It suggests that distance does play a role in case admission. The assessment did proceed to stage 3 i.e. the final stage to obtain a coverage estimate figure. However, due to lack of sufficient sample to make valid assumption of the coverage the assessment was unable to come up with coverage estimates for IMAM program. The assessment suggests that while it would be important to reduce barriers to access the more challenging part is to retain the enrolled children.

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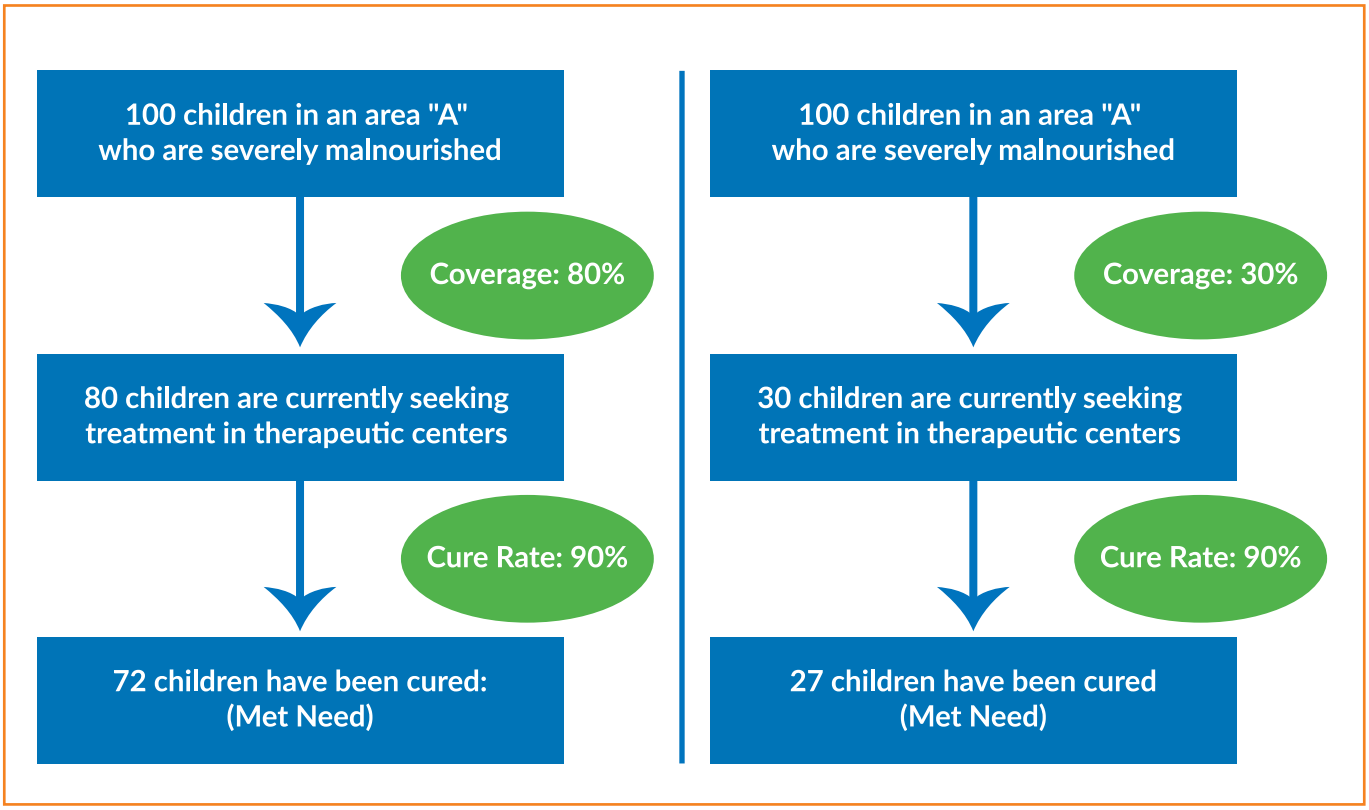
1 SEMI-QUANTITATIVE EVALUATION OF ACCESS AND COVERAGE (SQUEAC)

SQUEAC is a coverage assessment method that investigates and improves three aspects of Integrated Management of Acute Malnutrition (IMAM) program, 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 tests hypotheses about coverage and factors influencing coverage. As the name highlights it is semi-quantitative, using a mixture of quantitative (numerical) data collected from routine program 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 key informants.

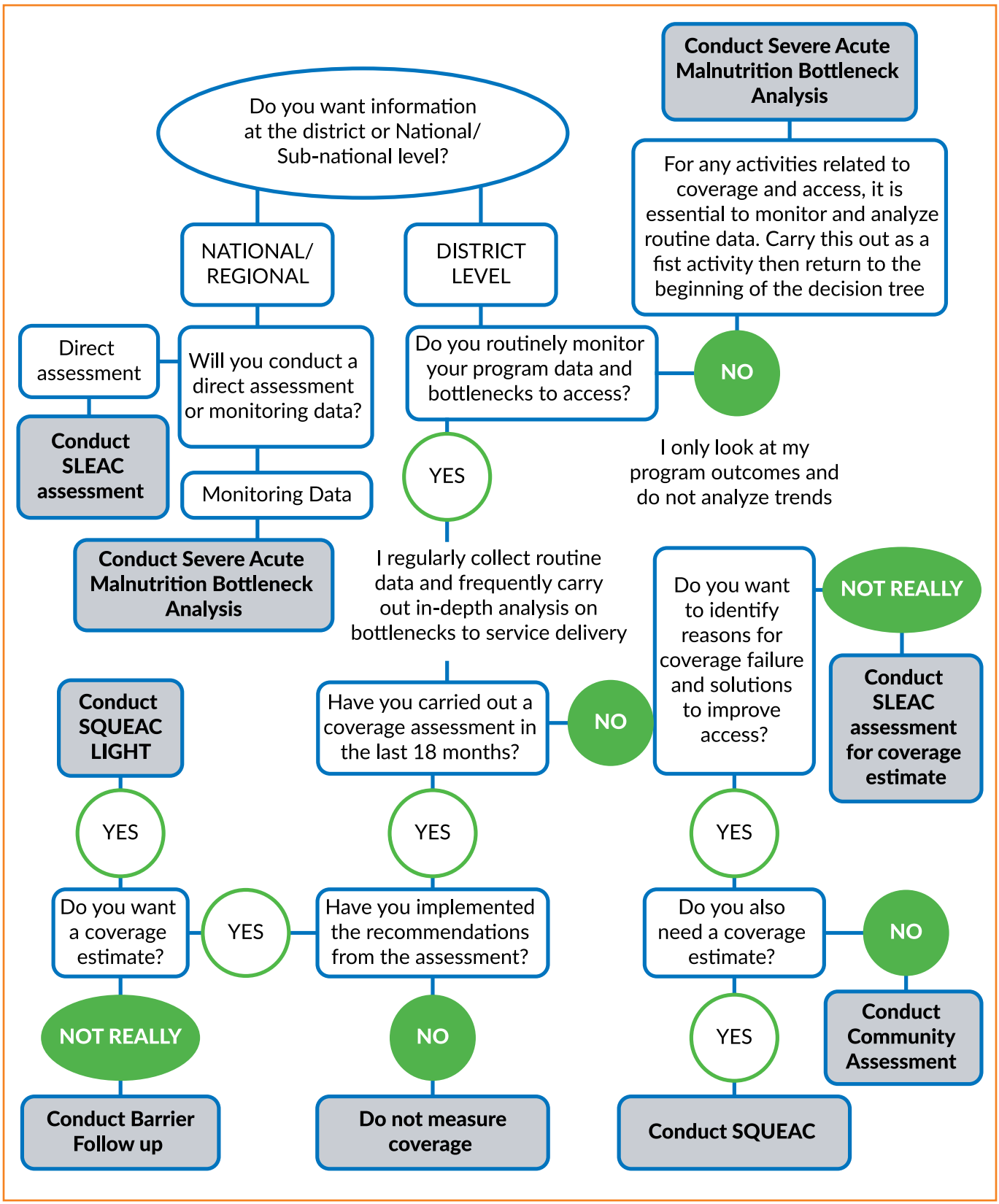
Coverage in context of IMAM program is proportion of acutely malnourished individuals undergoing treatment in the program with respect to total number of acutely malnourished individuals in a particular geographically defined area.

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

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



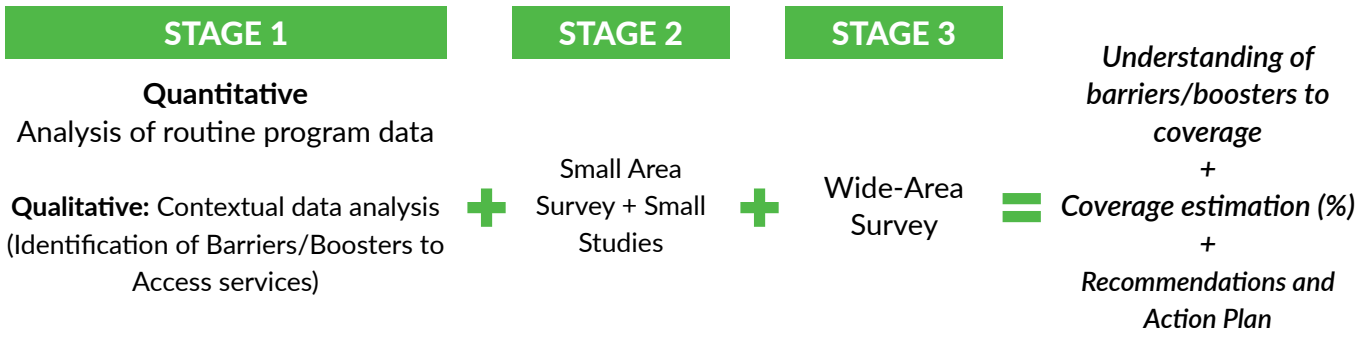
1.1 Rationale for SQUEAC based on coverage decision tree developed by Coverage Monitoring Network



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

1.2 SQUEAC methodology

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 program, **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 program coverage using Bayesian techniques. This stage is undertaken only if it is appropriate and required.



An experienced SQUEAC manager supervised the assessment in Makawanpur district based on the guidelines of the SQUEAC/SLEAC technical reference developed by United States Agency for International Development (USAID) supported Food and Nutrition technical assistance (FANTA) project. The assessment team briefed and consultant the government health staffs at the beginning and end of every stage. Nine enumerators accompanied nine other members of the core team. The core team consisted of people involved in IMAM program. Five teams were formed for field movement.

1.3 Rationale of SQUEAC

Sustainable Action for resilience and Food Security (Sabal) project has been continuously assisting the government's IMAM program in Makawanpur district since December 2015. A year into the program has allowed the program team to come across barriers and boosters. Using SQUEAC method at this point in time will allow the program to build on the positives, take corrective actions, make valid and logical recommendations and chart out a concrete action plan to ensure effective and efficient IMAM program.

1.4 Objectives of SQUEAC

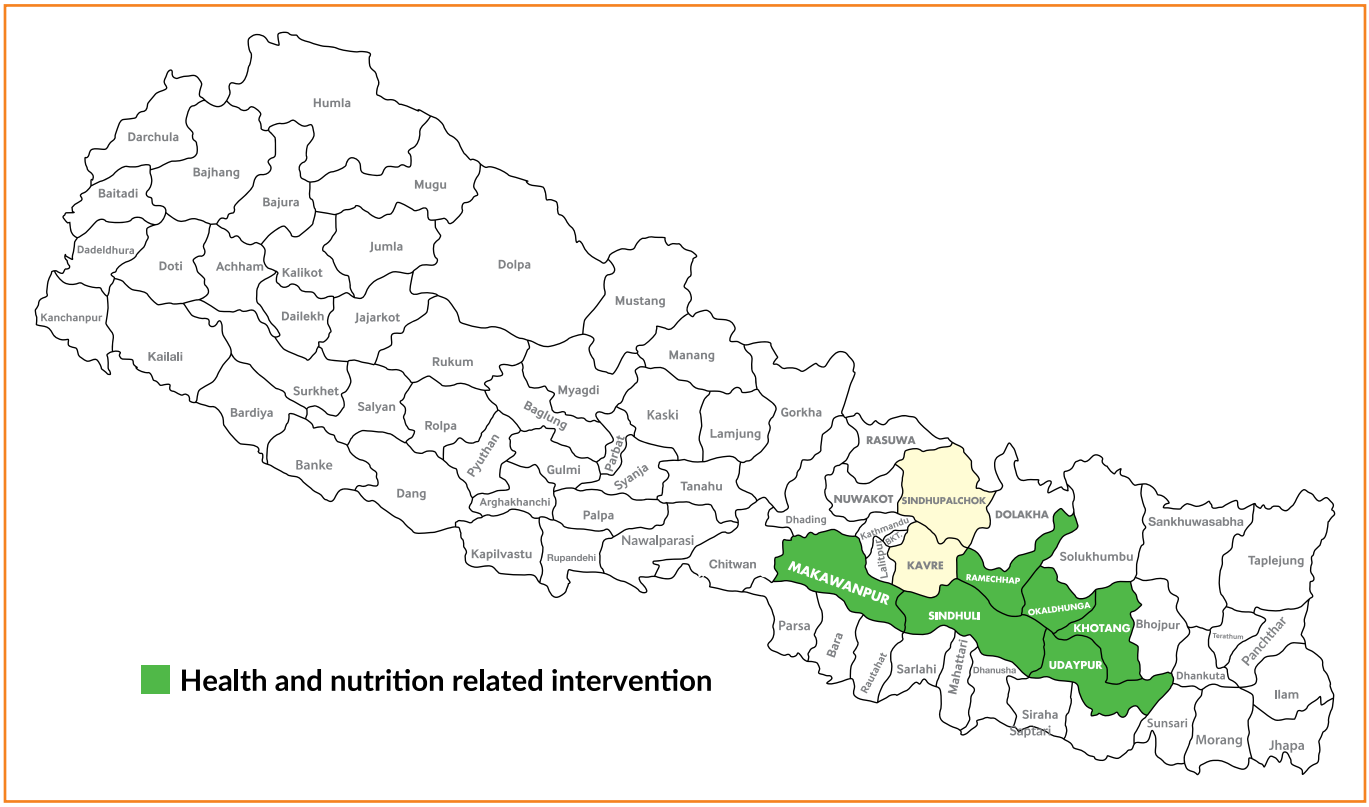
The overall objective of the survey was to evaluate the coverage of IMAM program on management of SAM cases in Makawanpur district of Nepal under the Sabal project. The specific objectives of the survey were:

- To assess the coverage of the IMAM program in Makawanpur district
- Identify boosters and barriers affecting the program
- To develop recommendations/action plan for improvement of IMAM program

2 SUSTAINABLE ACTION FOR RESILIENCE AND FOOD SECURITY (SABAL) PROJECT: AN INTRODUCTION

Sabal is a five-year project that works in 8 districts of Nepal to improve food security and nutrition outcomes at the individual, household, and community levels. A multi-sectoral consortium project includes activities relating to agriculture, livelihood diversification, nutrition and health and disaster risk reduction. The project districts include: **Makawanpur, Sindhuli, Udayapur, Khotang, Okhaldhunga, Ramechhap**, Sindhupalchowk and Kavrepalanchowk[1]. But health and nutrition interventions are present in 6 among of 8 districts (*highlighted in bold letters and by green color in the map below*).

Sabal project's working districts

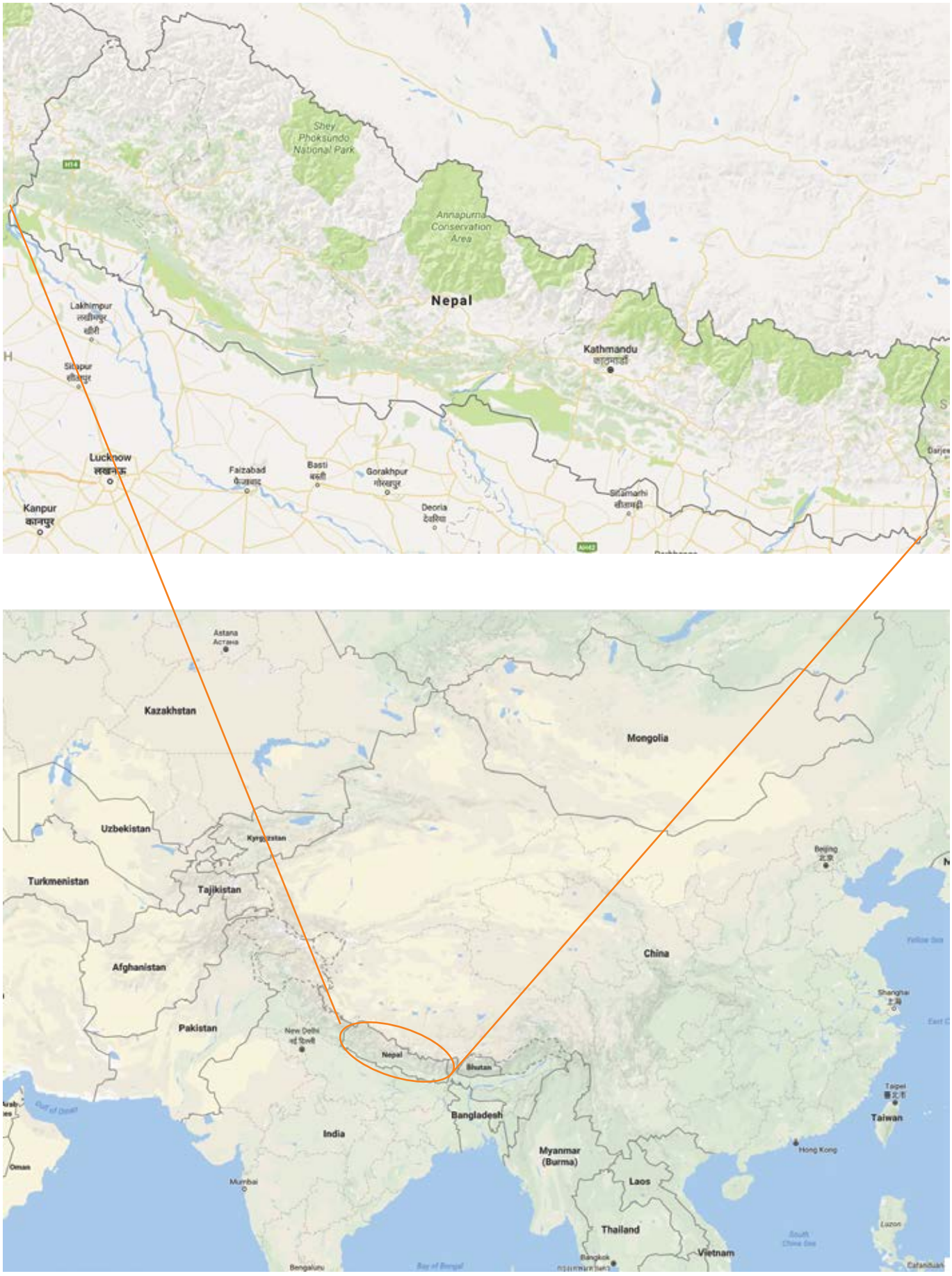


Project Objectives

- Strengthen and diversify livelihoods
- Improve health and nutritional status
- Strengthen the ability of households and communities to mitigate, adapt to, and recover from shocks and stresses

[1] https://www.usaid.gov/nepal/fact-sheets/sustainable-action-resilience-and-food-security-Sabal

Geographical location of Nepal



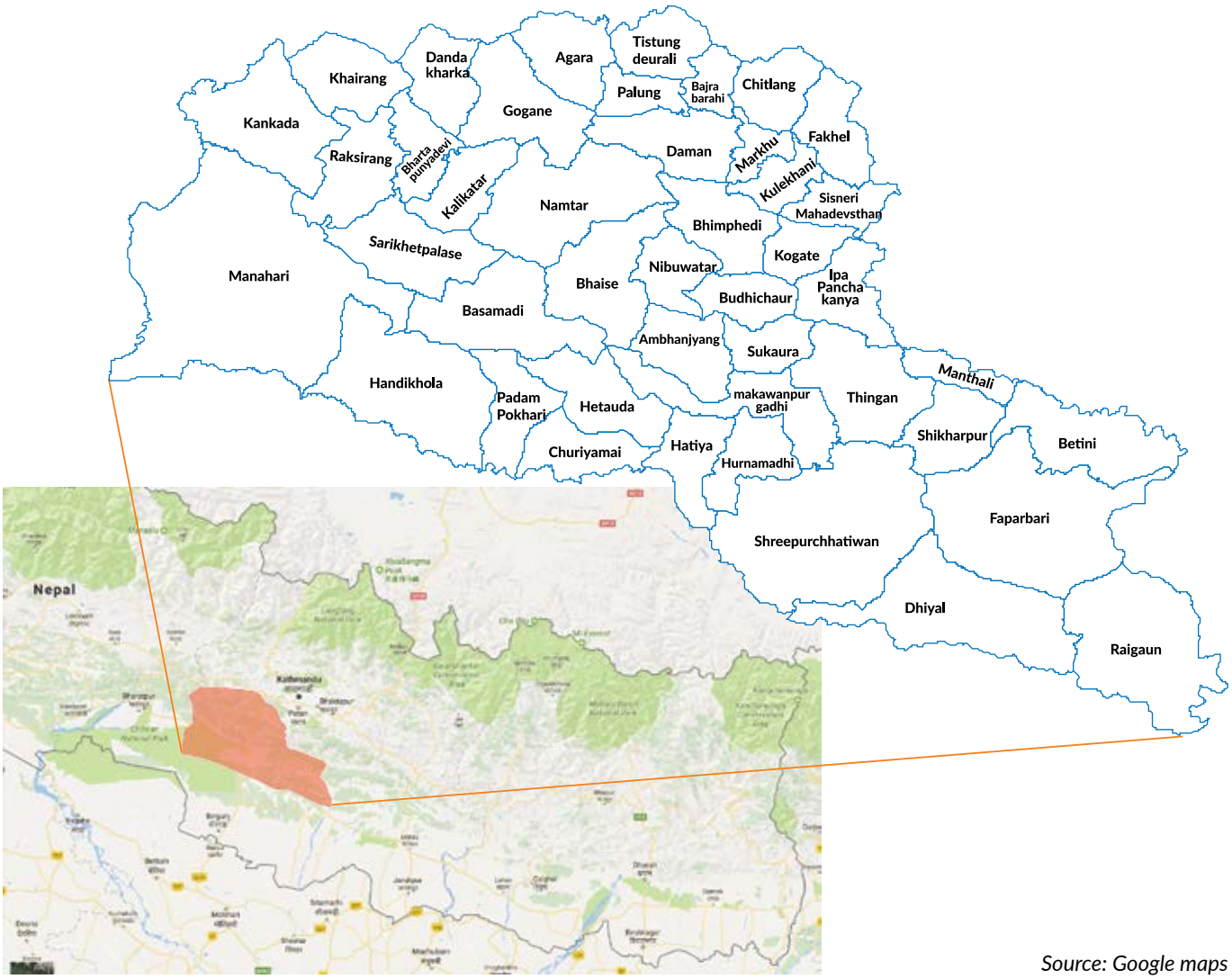
Source: Google maps

3 BACKGROUND

3.1 Makawanpur district: brief introduction

Makawanpur district is located in Narayani zone of Central Development Region. As per the federal structure, it comes under province number 3. Makawanpur district is surrounded by Bara, Parsa and Rautahat districts to the South, Lalitpur, Kavre and Sindhuli to the East, Chitwan district to the West and Kathmandu and Dhading districts to the north (*District Development Committee,2016 available at http://ddcMakawanpur.gov.np/en/*). Currently, the district is divided into 4 electoral constituencies. It has one sub-metropolitan city, one municipality and eight-village council.

Geographical location of Makawanpur District



Source: Google maps

Makawanpur encompasses diverse topography with altitude from 166m above sea level to 2584m above sea level and has an area of 2,426 sq. km. (*District Climate and energy plan, District Development Committee, 2011*). About 75% of the area is hilly and 25% flat land (*Annual health report, Makawanpur, 2015/16*). It has 5 Rivers and 41 Streams. Some major rivers are; Rapti Khola, Bagmati River, Manahari river, Lothar river and Bakaiya river (*Oneclicknepal, 2016 available at http://oneclicknepal.com/Makawanpur/*).

The climate in the Makawanpur district varies according to altitude and aspect from tropical to temperate. The lowest recorded monthly average minimum temperature (data from 1975 to 2005) is –2.7°C in Daman (at 2,300 meters above sea level) and the maximum 37°C in Hetauda (500 meters above sea level) (*Wild Vegetable Species in Makawanpur District, Central Nepal: Developing a Priority Setting Approach for Domestication to Improve Food Security,2015*). The rainfall is mainly due to the southern-eastern monsoon. The monsoon, generally starts from the mid of June and ends by the mid of October. More than 80% of the annual rainfall takes place between June and September. The average annual rainfall, generally, varies from 1971 mm to 2331.3 mm (*District Development Committee, 2016 available at http://ddcMakawanpur.gov.np/en/*).

About 52.83% of people are involved in agriculture as subsistence livelihood and 30.66% in service and 16.51% in others. Major agriculture production of this district is cereal crops (paddy, maize and millet). Paddy production, fruit and vegetable are the main agricultural production in this district for the domestic use and exporting to other districts, particularly in Kathmandu.

Table 1: Snapshot of socio-demographics indicators of Makawanpur district

Demographic characteristic		Makawanpur
Total Population		420,477
	Male	206,684
	Female	213,793
Sex ratio		96.67
Annual population growth rate (2001-2011)		0.69
Total number of households		86127
Average household size		4.88
Life expectancy at birth		68
	Male	67.3
	Female	68.7
Adult Literacy rate		67.85
	Male	75.4
	Female	60.59
***Note:** Makawanpur was ranked 34th among the 75 districts based on literacy status of population 6 years and above in 2011*		
Population density		173
% of urban residents		20.1
% of rural residents		79.9
Caste/Ethnicity (top four)		
	1	Tamang (47.8%)
	2	Brahmin-hill(14.1)
	3	Chhetri (10.7%)
	4	Newar (6.2%)
Mother tongue		
	1	Tamang (45.30%)
	2	Nepali (41.87%)
	3	Newari (4.01%)
	4	Chepang (3.81%)

Demographic characteristic		Makawanpur
Religion		
	1	Hinduism (48.26%)
	2	Buddhism (45.57%)
	3	Christianity (4.8%)
	4	Prakriti(0.6%)
Crude Death Rate		7.93
Infant Mortality Rate		32.38
	Male	32.06
	Female	34.79

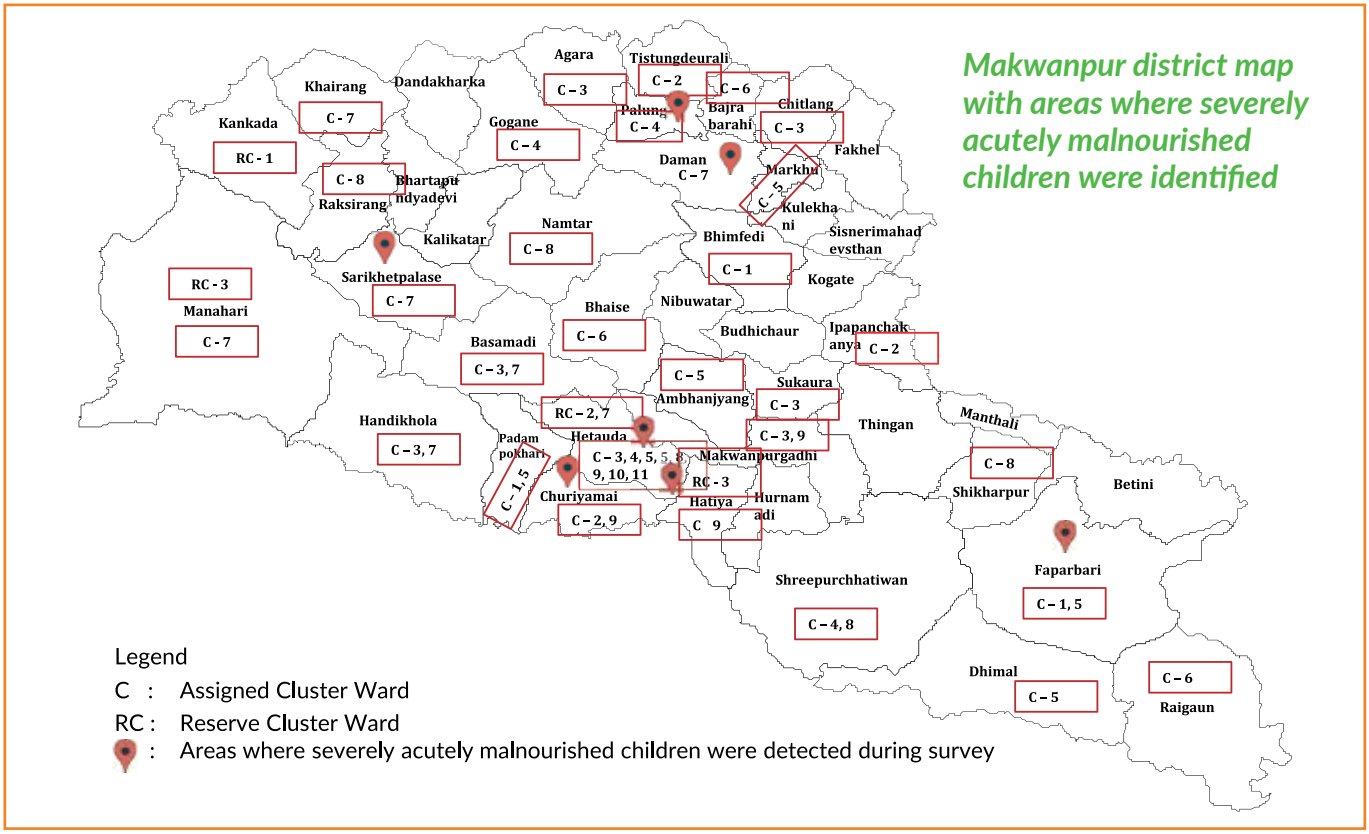
Source: *Population Monograph of Nepal,2014; National Population and Housing Census 2011 (National Report); National Population and Housing Census 2011(Village Development Committee/Municipality)MAKAWANPUR*

3.2 Nutritional status of Makawanpur district

A nutrition survey held in Makawanpur district in April 2016 based on Standard Monitoring and Assessment of Relief and Transitions (SMART) methodology produced the following findings:

- Combined global acute malnutrition rate was 7.7 % (5.2-10.4 95% C.I.).
- Prevalence of stunting was 27.3 % (21.4 - 34.1 95% C.I.).
- Prevalence of underweight was 19.0 % (14.9 - 24.0 95% C.I.).
- Among the wasted children, 32% children were stunted and 74% underweight on top of wasting.

Below is a map showing the VDCs/ Municipality where SAM children were detected during SMART survey.



Wasting indicators	Prevalence	
	Weight for Height Z score (%)	Mid Upper Arm Circumference (%)
Global Acute Malnutrition	6.8 (4.8-9.6 95% C.I.)	2.3 (1.2-4.1 95% C.I.)
Moderate Acute Malnutrition	5.2 (3.3-8.2 95% C.I.)	2.0 (1.0-3.9 95% C.I.)
Severe Acute Malnutrition	1.6 (0.8-3.2 95% C.I.)	0.2 (0.0-1.7 95% C.I.)

3.3 Impacts of April, 2015 earthquake

On Saturday, 25 April 2015 at 11:56 Nepalese Standard Time (NST), Nepal's National Seismological Centre (NSC) recorded a powerful earthquake measuring 7.6 on the Richter scale. Nepal, 11th in the list of most earthquake prone country in the world had not experienced such a powerful tectonic activity in last 80 years. More than 400 aftershocks have been registered so far with four of those measuring six and above on the Richter scale. Official government records states that the earthquake claimed 8,790 lives leaving 22,300 injured and affecting eight million lives. Thirty-one of the seventy-five districts were affected. However, to prioritize rescue and relief operations 14 of them were declared as 'crisis-hit'. (*National Planning Commission: Post disaster needs assessment, 2015*)

3.3.1 Makawanpur: A crisis hit district

Makawanpur is one of the crisis-hit district. Government of Nepal implemented and prioritized Integrated Management of Acute Malnutrition (IMAM) program in the crisis-hit districts as an emergency measure. Hence, IMAM program started in Makawanpur district. In the district, three primary health care centres and twenty-seven health post were damaged including three private sector health facilities. There was a total of 33 deaths and 771 injury cases. (*A report on post disaster needs assessment and recovery plan of health and population sector, 2015*)

Location of Outpatient Therapeutic Care Center (OTCC) along with their catchment areas. *(details of OTCC in next page)*

4 INTEGRATED MANAGEMENT OF ACUTE MALNUTRITION (IMAM)

4.1 Objective of IMAM program in Nepal

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 6-59 months and infants below 6 months. The principles guiding the IMAM includes maximum coverage and access, timeliness of care, appropriate care and care as long as needed.

4.2 Outpatient Therapeutic Care Center (OTCC)

Outpatient Therapeutic Care Center is the point of service for the IMAM program. It is present within a government health facility as a separate room or a desk in conjunction with other child health and nutrition program. The services provided by the center includes nutritional assessment through anthropometric measurements and/or Mid-Upper Arm Circumference (MUAC), counseling 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 center. However, all the public health personnel in the district are trained in IMAM, so that even in the absence of IMAM focal person, service is not interrupted. Sabal project supports the establishment of OTC centers in Makawanpur district logistically and technically. Logistically, the project provides ready-to-use therapeutic food (RUTF), storage box for RUTF, MUAC Tape, height board, salter scale, tripod & bucket for taking weight measurements. Technically, the project 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. As of March 2017, there are 16 OTCC in operation.

4.3 Recording and Reporting system of IMAM program

IMAM is a government run program. The recording and reporting is done as per the existing system of government health system. Screening data comes from Female community Health volunteers (FCHVs)*. These FCHVs report to their respective health facilities every month. OTCC registers is

** The Female Community Health Volunteer (FCHV) Program in Nepal was started in 1988 by the Ministry of Health and Population to improve community participation and enhance the outreach of health services through local women working voluntarily. Initially the strategy was to place one FCHV per ward in rural areas. In the mid-1990s, a strategy was adopted in 28 districts to allocate FCHVs by population, leading to recruitment of additional FCHVs. Currently, nearly 50,000 FCHVs are working in Nepal; 97% are in the rural areas.*

maintained at OTCC. These OTCC registers are owned by OTCC only. OTCC cards given to each enrolled case in the program. In every follow-up visit of each case, both the OTCC cards and OTCC registers are updated.

4.4 Protocols for the management of SAM children

All the children age 6-59 months in the community are screened every month by a FCHV. The identified cases are then referred to OTCCs if the child's MUAC <115mm. At the OTCCs, these cases are re-assessed through the 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
- MUAC <115mm or W/H Z-score <-3SD or presence of bilateral pitting edema +/++
- Appetite test pass
- 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 program with minimum of 42 days stay and maximum of 90 days once enrolled. The cases are discharged from the program as follows:

A. Cured

- MUAC >115 mm and should have been enrolled in the program at least for 42 days
- Weight gain in two consecutive visits
- No signs of bilateral pitting edema 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 different 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 center/in-patient therapeutic care center.

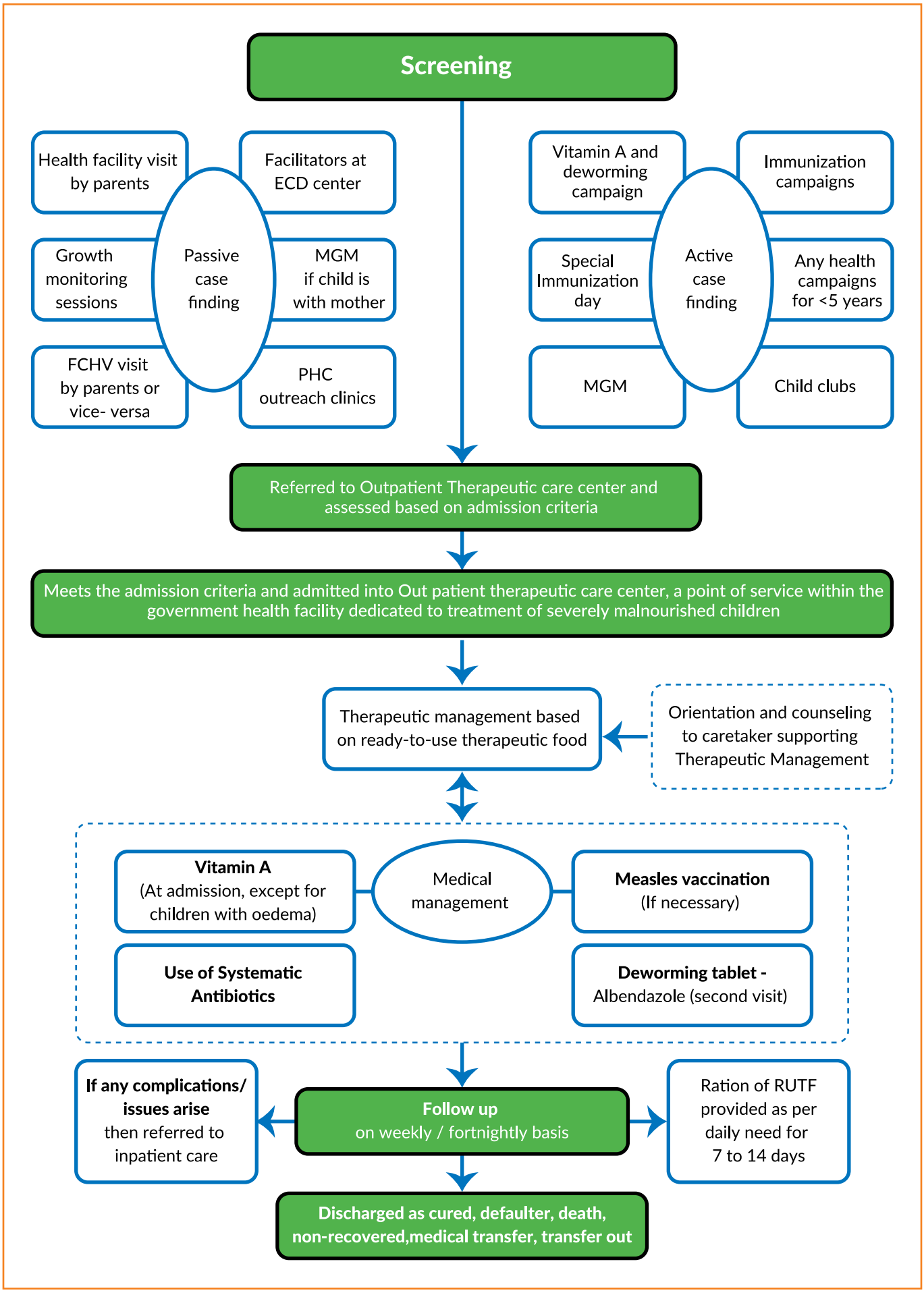
F. Medical Transfer

- The child is referred for medical treatment.

4.5 Program data generation process

In Makawanpur, Sabal collects information from the government registers. IMAM technical officers collect and compile the information monthly during a monthly program team meeting. The register offer detail information on admission criteria, date of admission and follow-ups, presence or absence of complications, the number of RUTFs provided and anthropometric measurements in each visit, the date of exit and type of discharge and discharge criteria.

Framework of treatment in IMAM program



5 DISTRICT HEALTH SYSTEM

At the district level, the District Public Health Office (DPHO) implements essential health care services (EHCS) and monitor activities and outputs of Primary Health Care Centers (PHCCs), Health Posts (HPs). The public service delivery outlets in the district include 40 HPs, 4 PHCC, 1 government hospital, 3 urban health clinics, and 163 Outreach clinics (ORCs) and 251 Expanded Program on Immunization (EPI) clinics in the district. The district has 16 Outpatient Therapeutic Care Centers (OTCCs) for provision of treatment to SAM children.

6 MAPPING CATCHMENT AREA OF OTCC TO FACILITATE DATA COLLECTION

To facilitate data collection the entire district was divided into fifteen catchment areas. *Catchment area* means the areas/VDCs from which severely malnourished children commonly come for treatment to an OTCC. This information was obtained from field staffs and IMAM register used for recording the details of malnourished children. The figure map in page no. 8 shows the location of OTCC along with their catchment areas.

7 ENUMERATOR TRAINING

The enumerators were trained at the beginning of each stage under the supervision of the SQUEAC manager. Training focused on taking MUAC measurement, active-adaptive case finding, and door-to-door sampling, administering the interview guides and conducting group discussions.

STAGE I

Interview with local community leader

Group discussion with FCHVs

Interview with IMAM focal person

Interview with a mother

Group discussion with community members

Interview with facilitators of Early Childhood Development (ECD) Center

8 FINDINGS

8.1 STAGE I: QUANTITATIVE DATA ANALYSIS

The quantitative information of the program was collected from IMAM register-HMIS 2.6*, and OTCC beneficiary database maintained by the program for last twelve months i.e. January-2016 to December-2016. All sixteen OTCCs are functional. However, the HMIS registers for two OTCCs -Gogane health post and Kankada Health post could not obtained during the time of data validation due to remoteness of their location and inaccessibility to collect the registers on time. The assessment team validated, the existing database maintained by the program with the government official register.

8.1.1 Admissions over time

The figure below shows that the admissions peaked in between August and September, 2016. Two months preceding, August i.e. June and July is a rainy season as well as peak season for farming activities. The farming season keeps the entire family engaged in farming activity. The engagement can sometimes be

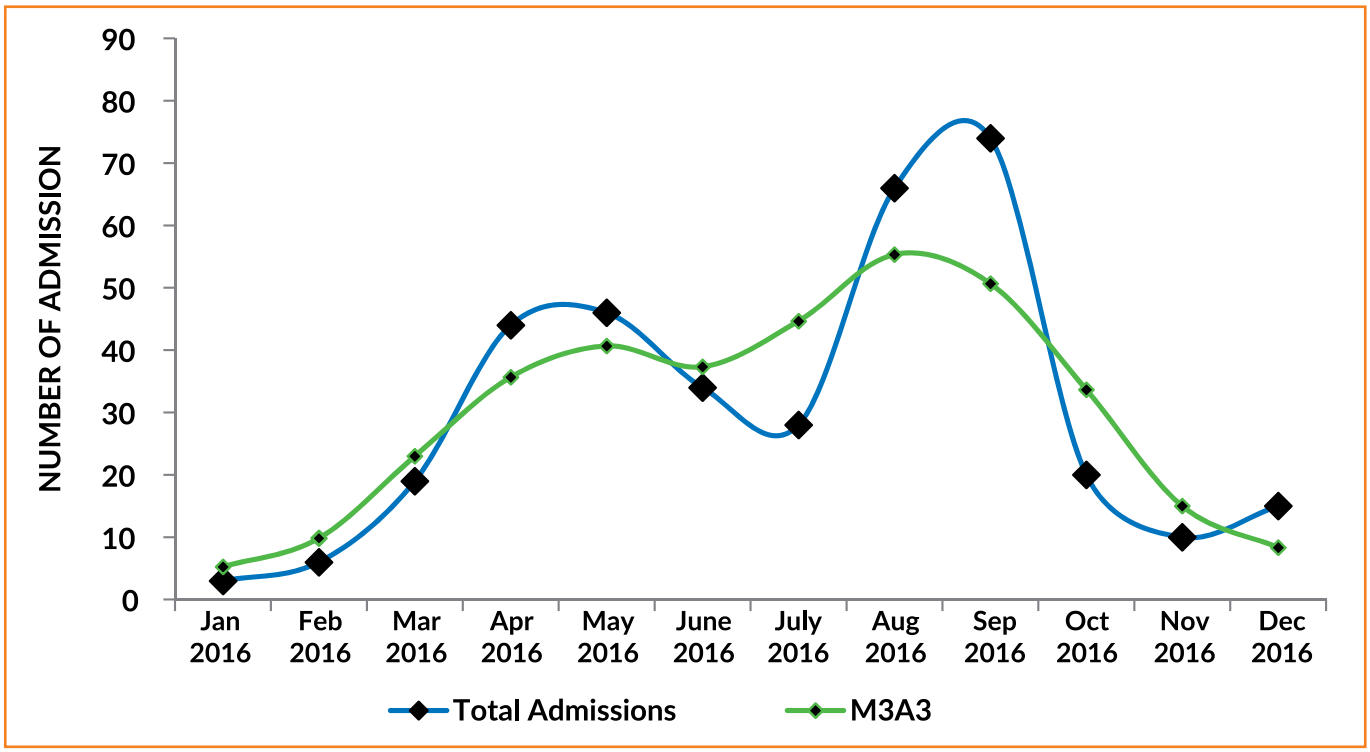


Figure 1: Admissions over time for OTCC in Makawanpur district

** Health Management Information System (HMIS) was established in 1993 it is an organised system of collecting, storing, processing, recording, reporting and feedback of information. It monitors the performance of the health programs, health facilities and health workforce and generates reports.HMIS 2.6 is one of the recording registers.*

detrimental to child's health because there is a probability that children fall prey to acute malnutrition due to lack of proper care. Meanwhile, rainy season also results in higher incidence of water borne diseases, which is an immediate cause of acute malnutrition. Rainy season also results in flooded rivers, damaged or blocked roadways and foot trails because of frequent landslides. Despite the fact that the conditions can make it challenging to travel to health facilities, there is a spike in admissions of SAM children.

Table 2: List of various factors influencing the pattern of admission in between January-December, 2016

2016	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
NGO Support			SABAL Technical support									
RUTF Supply	Adequate Stock											
ARI	Medium				Medium		High			Medium		
Diarrhea			High		Medium	High					Medium	
Farming Activities			Planting			Planting				Harvesting		
Rainfall						Raining						
Temperature	Cold		Warm		Hot						Cold	
Food availability	High		Less							High		
Campaign												
FCHV training												
Cookery Kit distribution												

The community level training for IMAM fell in between August-September, 2016. It was a two-day event with MUAC screening on the second day. This screening activity covered the entire district, which contributed to the peak in admission. Further, the high caseload also coincided with a cookery kit distribution program, supported by UNICEF and Action Against Hunger | Action Contre La Faim (ACF). The distribution program covered entire district. Although it was a distribution event, screening was part of it. Hence, this activity was due in part responsible for the unusual rise in cases.

8.1.2 Admissions per health facilities

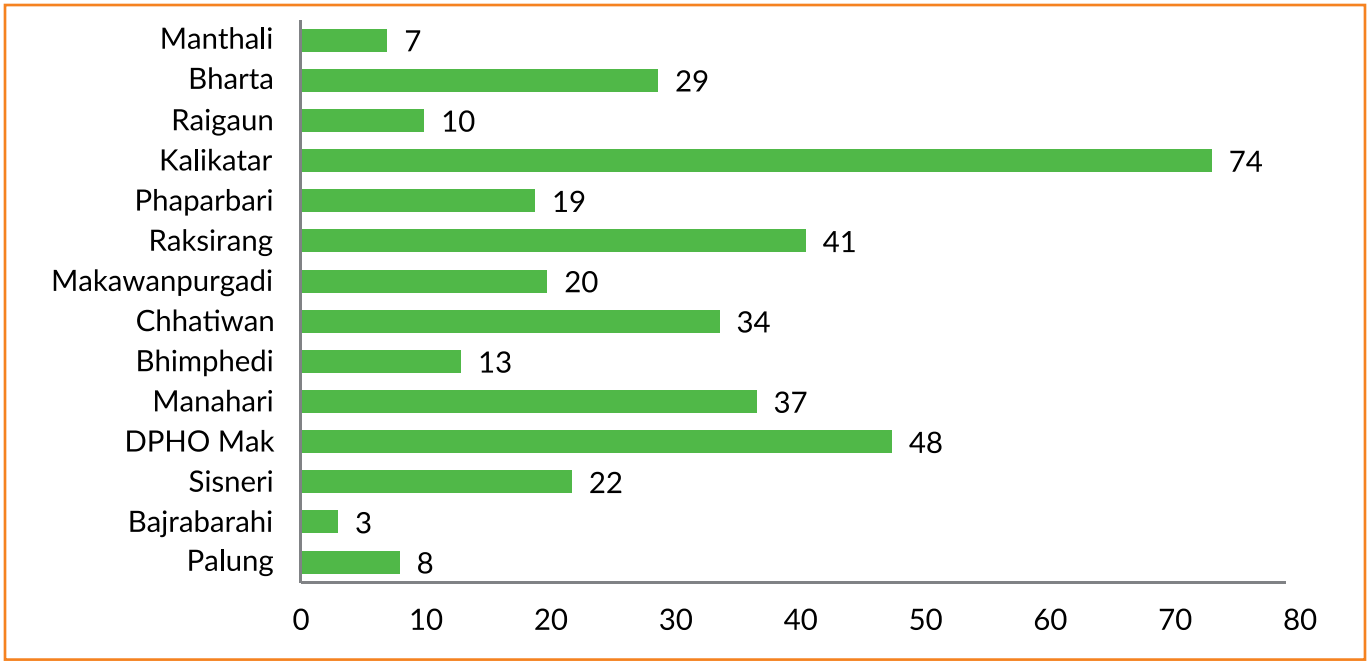


Figure 2: Admissions per OTCC, January - December 2016

8.1.3 MUAC on admission

The analysis of the registers also revealed a clear preference to MUAC criterion than WHZ criterion for admissions. MUAC measurement was used to admit 87.7% and there was no any case admitted by edema. The graph below shows that the median MUAC on admission was 107 mm. There is no any cut-off, which allows for interpretation of "*early case finding*". Hence, in relative terms while many children were admitted at an early stage, there were number of cases admitted below the median MUAC. Therefore, from the program perspective while there is a need to push the median MUAC as close as possible towards the 115 mm mark, there is also need to create more opportunities for case identification at an early stage. Further, MUAC measurements peak at 105 mm and 110 mm, which hint towards the likelihood of a digit preference at 110 mm and 105 mm.

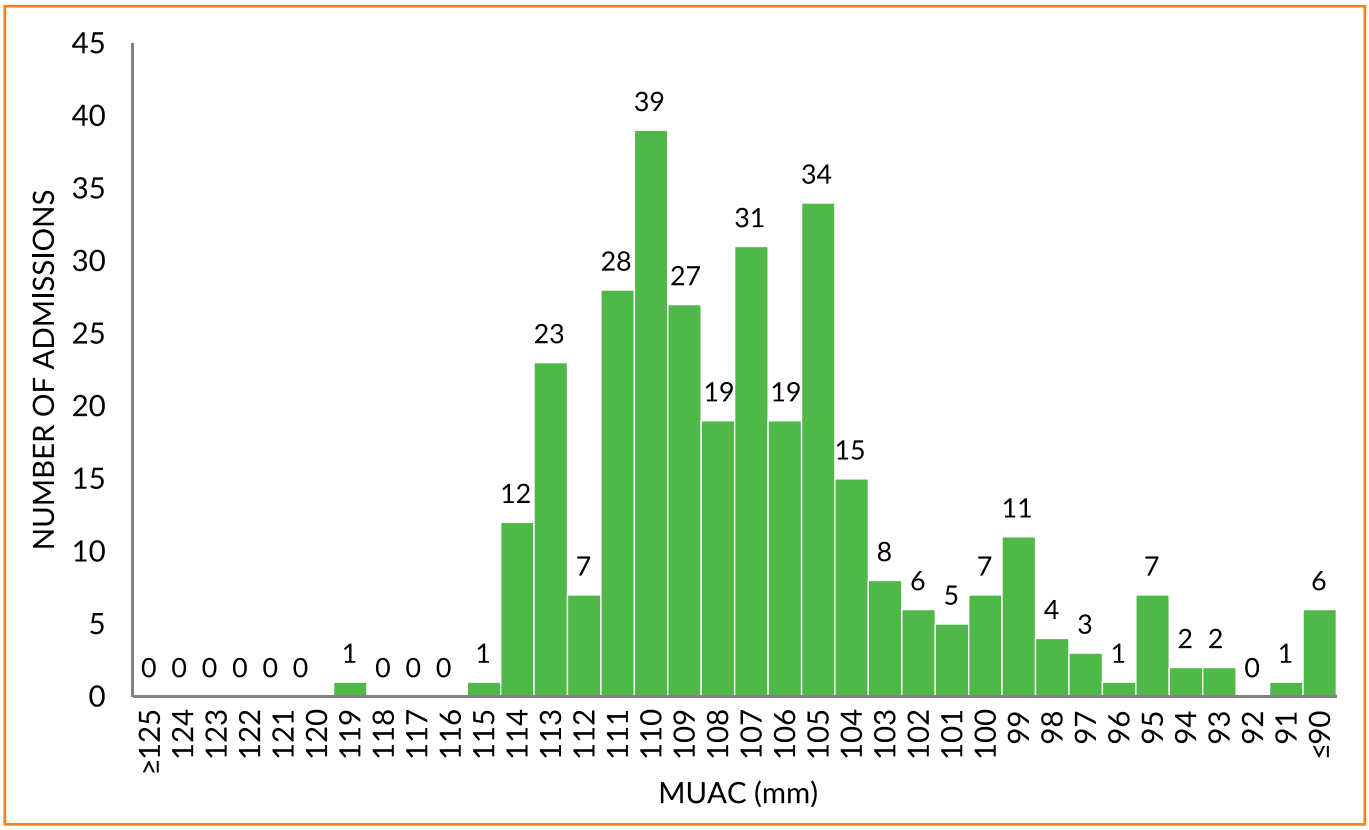


Figure 3: MUAC measurement on admission, January - December 2016

8.1.4 Type of discharge over time

Discharge outcomes include children discharged as cured, default, death and non-recover. A well performing program should have the cure rate of >75%, death rate <10% and default rate <15% (*Minimum standards in food security and nutrition, Sphere Project*[2]). One of the notable issues was detection of hidden defaulter during data validation. The time between the follow-ups exceed 4 weeks, meaning they missed two consecutive follow-up visits resulting in hidden defaulter. In some instance, the official register had no record of type of discharge and criteria used to discharge. Figure 8 shows that there is extremely high rate of defaulting in the program.

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

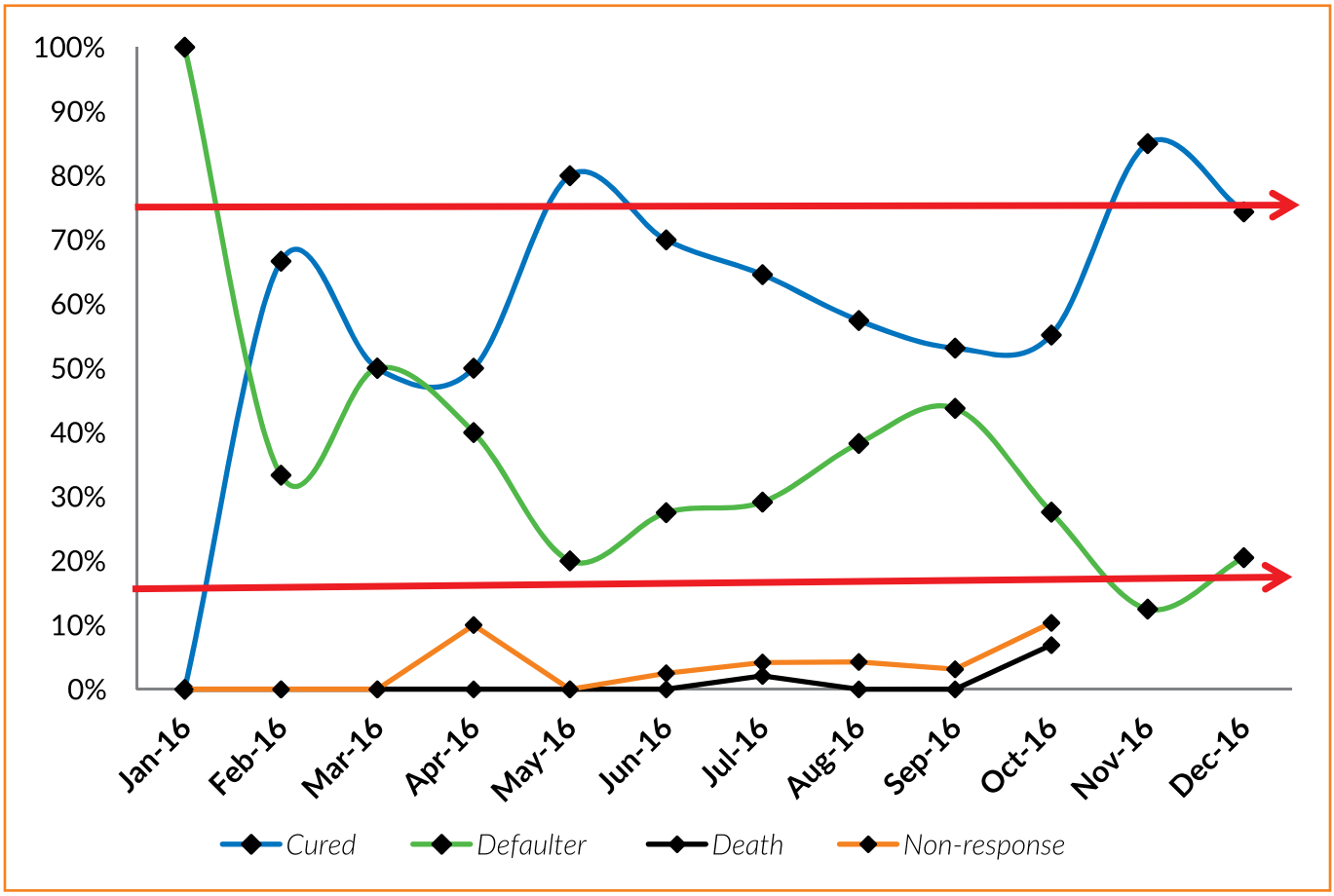


Figure 4: Discharge outcomes based on beneficiary register, January - December 2016

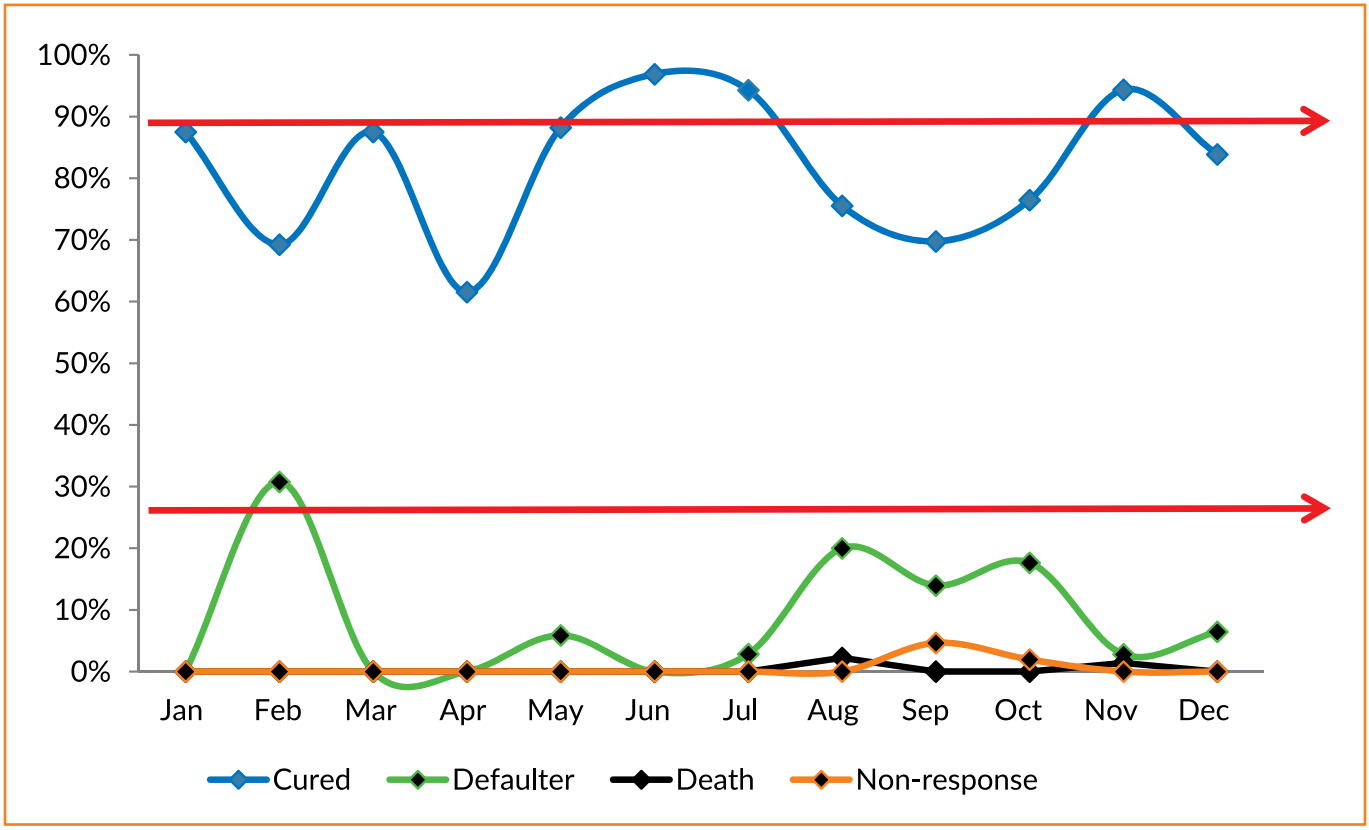


Figure 5: Discharge outcomes based on beneficiary database

8.1.5 Discharge outcomes per health center

The standard treatment protocol on IMAM states that routine follow-up visits in OTCC should be weekly or fortnightly. However, from the beneficiary register it was difficult to identify whether the beneficiary had signed up for a weekly or fortnightly visit to the health facilities. Some beneficiary had follow-up of less than a week, while others showed monthly visits. The date of admission and the date of first follow-up visit were the same in many of the cases. In some cases, the date of follow-up was completely absent. Absence of date of follow-up made it challenging to validate the compliance to treatment protocol. The graph below shows that health facilities in Kalikatar, Raksirang, Makawanpurgadi and Chattiwan had relatively higher percentage of defaulters. The catchment areas of health facilities in Kalikatar, Raksirang and Chattiwan have a very challenging terrain, which makes it difficult for service providers to follow-up cases, and for the beneficiaries to make regularly visits. The location of the health facility in Makawanpurgadi is a bit of a challenge. Accessibility to the health facility from its catchment areas is difficult making it challenging to go for regular follow-up.

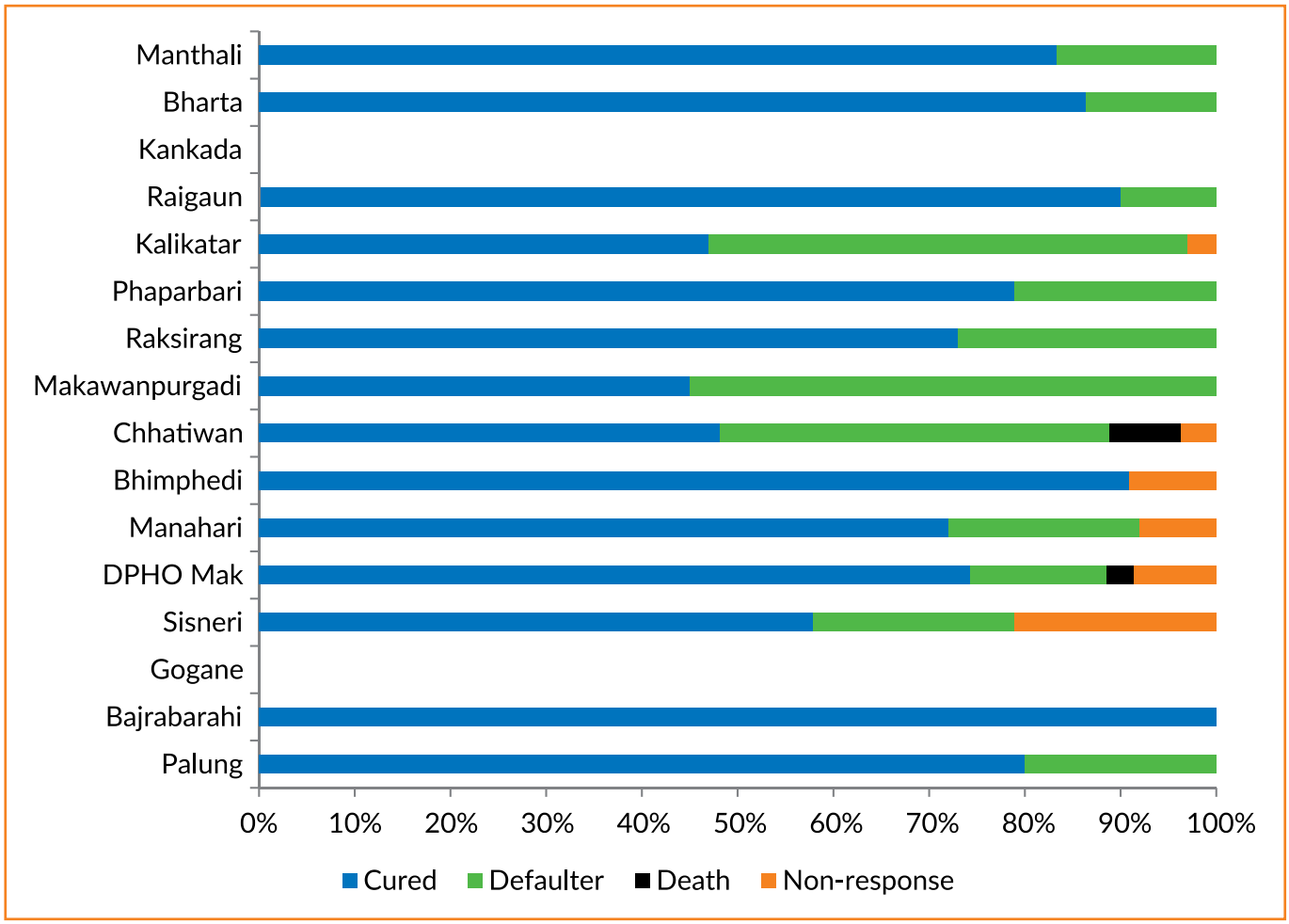


Figure 6: Discharge outcomes per OTCC, January - December 2016

8.1.6 Defaulting over time

The graph below shows that there is a peak in number of defaulters in the months of July-September, 2016. Defaulting is a major issue in the program. Inability to retain the beneficiaries in the program will have a negative effect, as there is a possibility that their condition worsens.

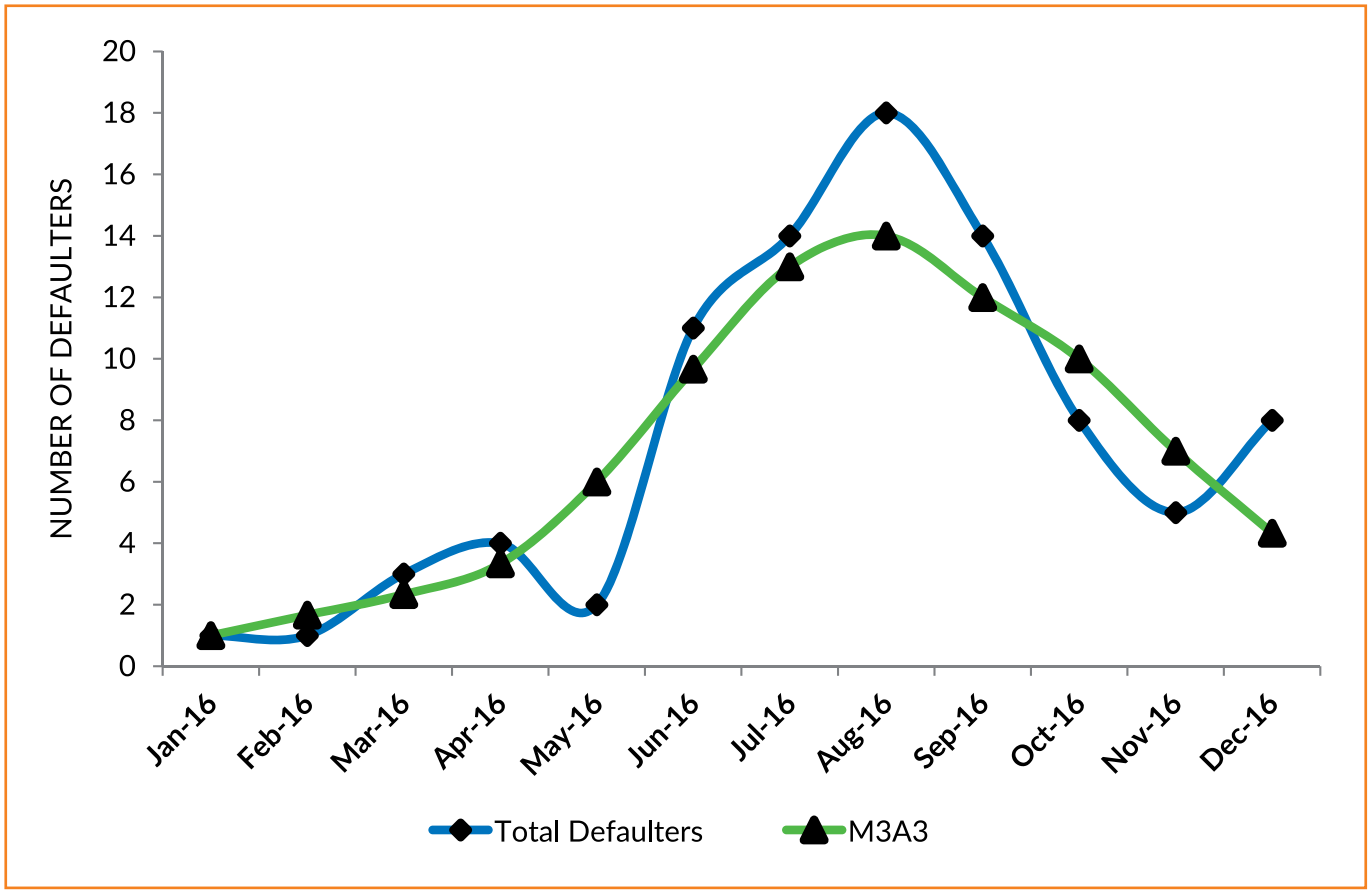


Figure 7: Trends in defaulting, January - December 2016

8.1.7 Time of default

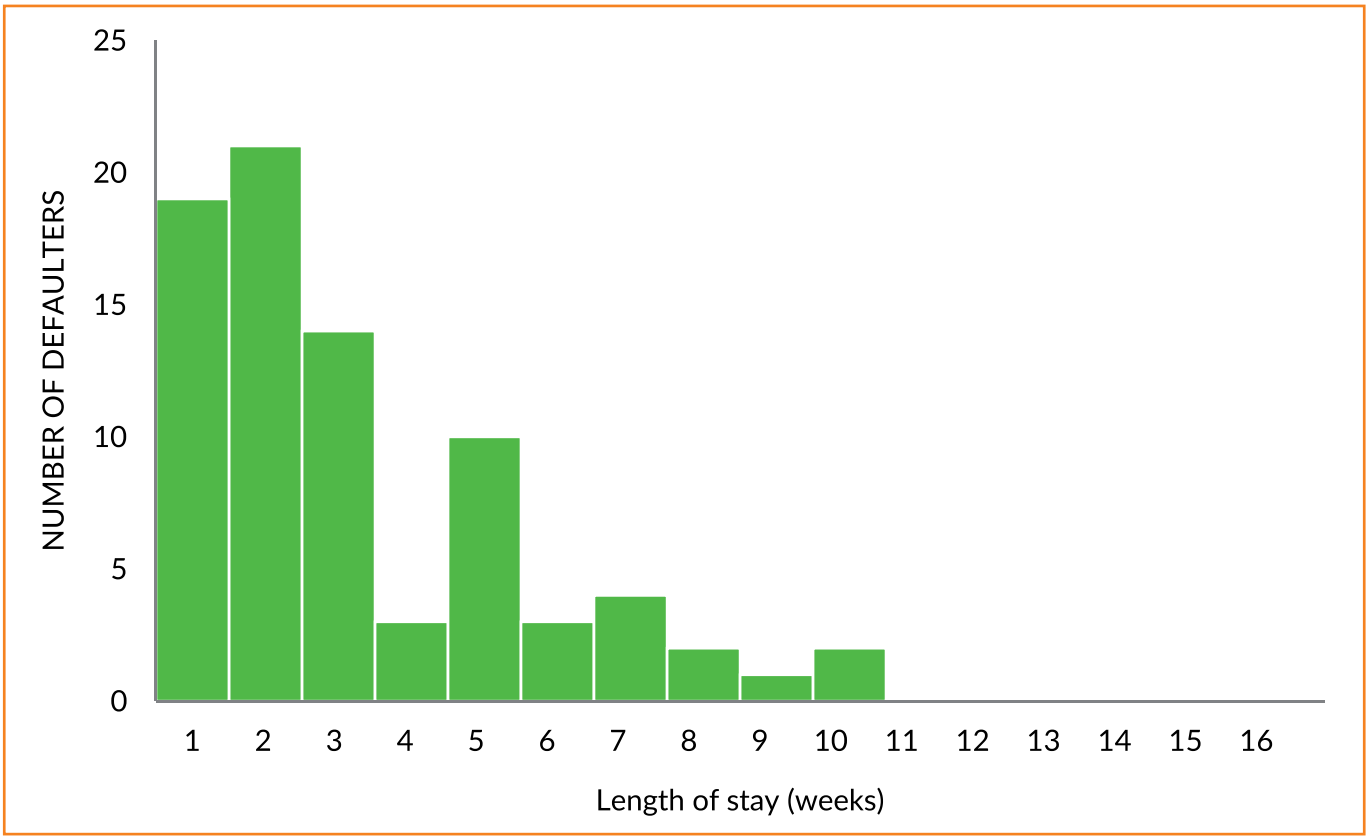


Figure 8: Time to default, January - December 2016

The figure shows that majority of the defaulters defaulted in the first three weeks of enrolment. The defaulters were still malnourished at the time of defaulting, with the median MUAC at default being 112 mm. There conditions are likely to worsen in lack of appropriate treatment. The impact of defaulting on the child depends largely on the stage of defaulting. If a child defaults from the program after having received a minimum of 42 days of treatment equivalent to six weeks of treatment (42 days is the minimum period that the child should receive treatment in the program prior to discharge), recovery from the program is likely despite defaulting. However, if a child defaults early from the program i.e. <6 weeks such children continue to be at risk of continued and worsening acute malnutrition.

8.1.8 Length of stay of cured cases

The median length of stay in the program was 9 weeks. In the meantime, several cases have stayed in the program as long as 13 weeks or more, which is mathematically more than 90 days. The standard treatment protocol of IMAM allows for a maximum of 90 days of treatment from the date of admission, which is equivalent to 12 weeks. Non-compliance is also equally relevant in those children whose length of stay was less than 42 days i.e. 6 weeks.

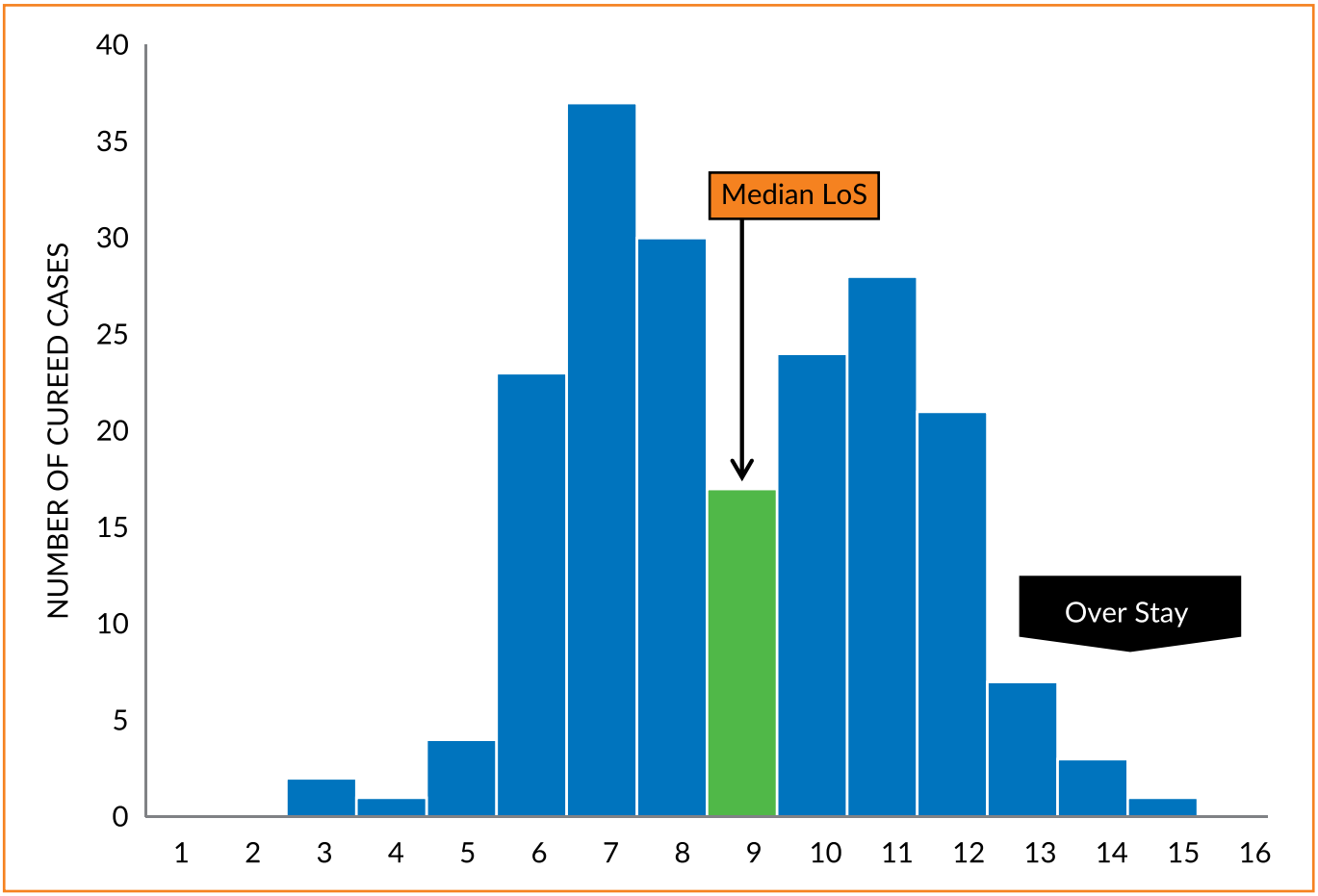


Figure 9: Length of stay (cured cases), January - December 2016

8.1.9 Admission and default by distance

The graph and the table below suggest that distance is one of the prime factors influencing the tendency to default. The proportion of defaulters is at its peak for areas that are 6-10 kilometers from the health facility. Distance is a relative term and how far is too far is sometimes difficult to determine because the context of every beneficiary varies. The numbers of admissions are lower for wards that are more than 10 kilometers. This provides us with some basis to have a reference point for distance from the health facility that we can call far.

Table 3: Admission data by distance from OTCC

Distance	No. of ward	% of ward	No. of Admissions	% of Admissions
<10km	111	66.9%	260	67.5%
>10km	55	33.1%	125	32.5%

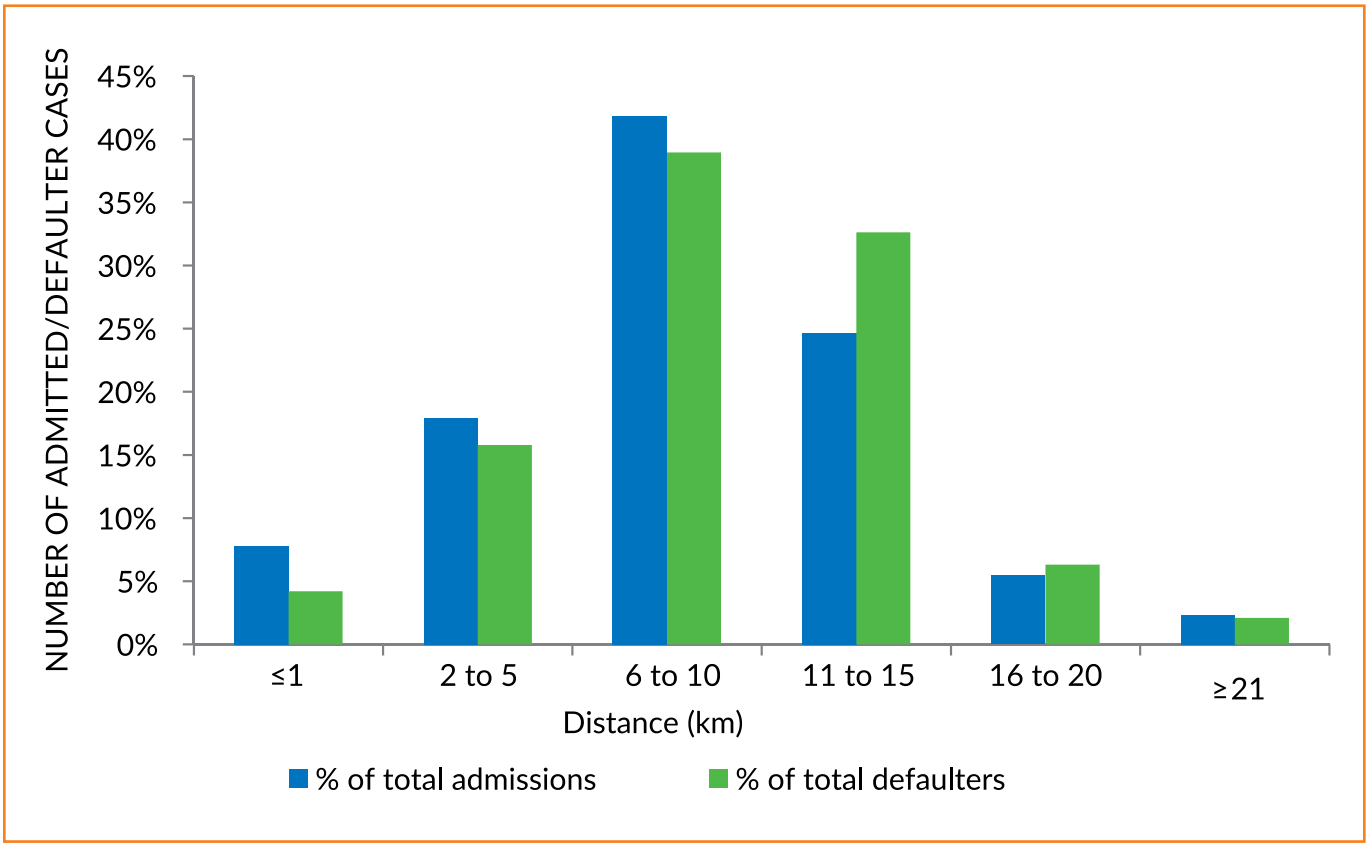


Figure 10: Admissions and defaulters by distance to OTCC, January - December 2016 (Note: The distance from the OTCC to all the wards is rough estimation of distance generated from the field knowledge of the staffs.)

8.1.10 MUAC on discharge

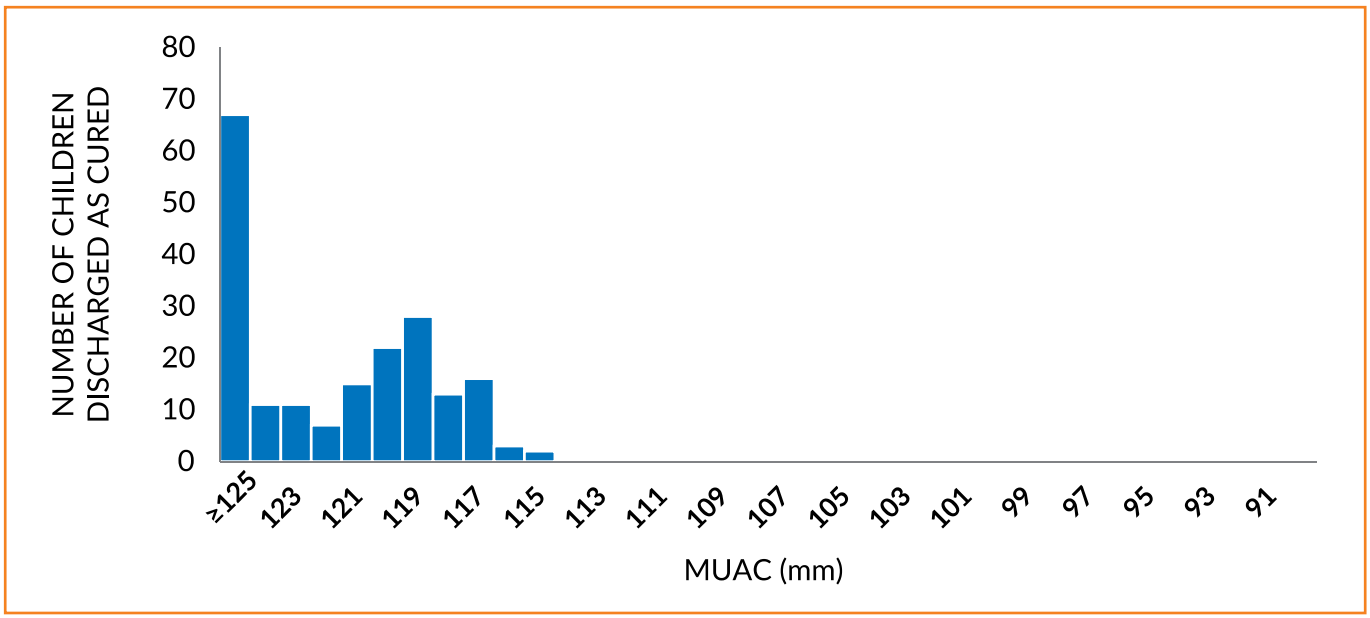


Figure 11: MUAC Measurement at discharge (Cured), January - December 2016

MUAC >115 mm is one of the criteria for discharge. However, there are a number of cases were found discharged at 115 mm and the upper limit goes up to 125 mm. This clearly suggests that health care workers at the OTCC have not clearly understood the criteria for discharge. Further, it also suggests that supportive supervision and monitoring by the program team has not been effective. **Figure 14:** MUAC Measurement at discharge (Cured), January - December 2016 for 14 OTCC

8.2 Qualitative data collection

The interview guides for collecting qualitative information was adapted from the interview guides of the coverage monitoring network posted in their training website. Range of individuals including mothers of under-five children, traditional faith leaders, community leaders, FCHVs, IMAM focal person, teachers and facilitators of Early Childhood Development(ECD)providedqualitativeinformation. The qualitative information was collected using group discussion, in-depth interviews, focus group discussion, semi structured interview as well as observations. The qualitative information helped in getting to know the perception of the community and their sensitiveness on the issue of malnutrition and health seeking behavior. Such information is particularly helpful in analyzing the barriers and boosters of coverage of IMAM program.

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 8 wards, 8 HPs and 2 PHCCs. The assessment team considered two principles of SQUEAC, triangulation and sampling to redundancy. At the end of each day of data collection, there was a discussion on the information generated from the interviews, group discussion and observations in context of them acting as barriers and boosters.

The data collection sites were:

Raksirang-08, Padampokhari-11, Chhatiwan-04, Faparbari-03, Ambhanjyang -07, Manahari-02, Makawanpurgadhi Health Facility, Kalikatar Health Facility, DPHO-Maternal and Child Health clinic, Sisneri Health Facility, Hatiya-22, Handikhola-07, Bhimfedi Health Facility, Hetauda-14.

Figure 12: Spatial distribution of data collection sites in stage -I

BARRIER

People going for treatment to the church or a traditional healer

Mother is not allowed to visit the HF without permission of her husband

Less supportive supervision from health facility

Challenging terrain and long distance to travel to OTCC

Poor families cannot afford to pay for travel to health facility for follow up visit

Storage problems (not enough space in metal trunk to store RUTF safely

Poor follow up system of defaulter cases

Gender bias towards male child to seek appropriate and timely treatment

Language barrier

Parents cannot afford enough time to take care of their child due to high workload

Less belief in nutrition program /HF/FCHV and free service

Children dislike the taste of RUTF

FCHVs are not found using referral slip following screening

Visiting a local medical shop for treatment

Poor screening at community level

Low awareness on IMAM program

Limited or no service to beneficiaries when IMAM focal person is absent

Catchment area of the OTCC and FCHV is big and not able to cover the area

Difficulties in accessing hard to reach areas during the rainy season

Poor counselling from health workers at the OTCC

Wrong admission and discharge criteria

Out of 44 HFs, 28 HFs do not have treatment facility for SAM cases

BOOSTER

Health Education at community and HF level

Trained health workers / FCHVs in IMAM program

HW/FCHV/SM/CNW doing home visit in case follow-up and community mobilization activities

Screening of <5year children in the community during the Immunization days, Vitamin A campaign and PHC/ORC

Necessary IMAM tools and nutrition supplies for the management of SAM

Community awareness about malnutrition

Good referral mechanism between OTC-ITC

Good coordination and communication between FCHV and OTC

Active involvement of FCHVs in nutrition related activities

Appointment of IMAM focal person at all HFs which have nutrition program

Decision making capacity/ Supportive family to seek service at HFs

Timely reporting of HMIS 9.1 by FCHVs to HF

Coordination with other stakeholder working in the district

Establishment of TSFP sites in all OTCCs and additional 7 TSFP sites in other HFs

Table 4: Barriers and boosters identified in stage I and their description

S.N.	Barriers	Explanation	Locations	Sources	Methods
1	People going for treatment to the church and a traditional healer	Pastor of a church or traditional faith healers were the first point of contact when a child falls sick. Belief in traditional faith healers digs deep into the mind-set of the people and is generational. Hence, the children are devoid of clinical treatment or appropriate treatment at the health facility. This is a potential barrier to accessing conventional health services including that of the OTCC. The interviews done with various sources from different location showed that there is a practice of taking the children to traditional healers for the treatment. Whenever mothers find their children sick, the priority for seeking health services is Pasteur of the church or the traditional healers. People believe in bad spirits and ghosts. Therefore, if the child falls sick they think that some bad spirits or ghosts have touched their children.	Rk8/DP14/C4/ A7/Ph3/KF/ M2/MgF/SisF	©℗ʘΦΘ$T	SSI/II/ FGD/GD
2	Mother is not allowed to visit the HF without permission of her husband	Decision making power of the household mostly lies with the husband. Hence, the mother cannot take her children to health facility without the permission of her husband. He may not have knowledge about the program and implications of treatment and hence may not recommend treatment, which can then act as a barrier.	Rk8/DP14/M2	©ʘΦ$	SSI/II
3	Less supportive supervision from health facility	Supportive supervision at community level from health facility has not been sufficient. The advocacy from FCHV alone has proven to be less effective. Therefore, there is less confidence among the community members about the effectiveness of the treatment. .	Rk8/A7/Ph3	©ʘ, Quantitative data, reports	SSI/II/Obs
4	Challenging terrain and long distance from wards to OTCC	The distance between the OTCC and the service seekers is too far. They must walk for longer hours through very challenging terrain; including rivers and rivulets to reach to the health facilities. The opportunity cost of going to the health facility is too high in the context of rural areas. Hence, they choose not to travel long distance to visit the health facility.	Rk8/DP14/ Ph3/C4/M2/ MgF/KF/SisF/ HK2/BhmF	℗ʘΦ©Θ$	SSI/II/GD/ FGD
5	Poor families cannot afford to pay for travel to health facility for follow-up visit	The economic condition of the family is not good enough to afford transportation cost to visit OTCC. The transportation cost is too expensive as they work on daily wage basis, which is enough only to meet their hand to mouth. Apart from this, they cannot afford to feed nutritious food to their children, even though they are aware that their children require nutritious food for the overall growth and development.	Rk8/DP14/A7/ M2/MgF	℗ʘΦ©	SSI/II/FGD
6	Storage problems (not enough space in metal trunk to store RUTF safely	Sometimes there is a high supply of RUTF especially right before the start of monsoon season as part of prepositioning of therapeutic supplies. During the monsoon, some of the health facilities are inaccessible from the district headquarters, due to road blockage with the increased water level in rivers. Under those circumstances, the metal trunk provided to the health facility cannot accommodate all the excess RUTF safely.	Rk8	℗	SSI
7	Poor follow-up system of defaulter cases	As per standard practice, the defaulter cases needs follow-up by the FCHVs. However, in practice this is not the case. In absence of an effective follow-up system, the defaulter is not motivated to visit the health facility.	Rk8/Ph3	ʘ℗/program staff	SSI/GD

S.N.	Barriers	Explanation	Locations	Sources	Methods
8	Gender bias towards male child to seek appropriate and timely treatment	Gender bias still exists in the community. Male child more priority and preference in treatment.	Rk8	ʘ	SSI
9	Language Barrier	In some of the communities of Tamangs, the most predominant ethnic group, people are not fluent in Nepali language. This can act as a barrier as people from such communities are reluctant to come to the health facility for treatment because of the language barrier.	Rk8/Ph3/SisF	ʘ©℗	SSI
10	Parents cannot afford enough time to take care of their child due to high workload	Both parents go to work early in the morning and come in the evening. Hence, they do not have time for their children.	DP14/c4/a7/ M2/Kf/Ph3/ SisF	©℗ʘΦT	SSI/FGD
11	Less belief in nutrition program / HF/FCHV and free service	There are people who do not believe in FCHVs, HFs and the free health services. They have the misconception that the free medicines do not work.	DP14/C4/M2/ SisF	ʘΦ℗Θ	SSI
12	Children dislike the taste of RUTF	Some mother/caretakers of malnourished children stated that the children dislike the taste of RUTF. Therefore, they refuse to take the child for follow-up visits to the OTCC for treatment.	DP14/Ph3/ MgF/KF/SisF	ʘ$©	SSI/GD
13	FCHVs are not found using referral slip following screening	Using the referral slip is one of the best way to send the case to the OTCC and subsequently follow-up that case. However, there was no practice of using referral slip.	DP14/Rk8/ MgF/SisF	ʘ℗@	SSI/GD
14	Visiting a local medical shop for treatment	Community people prefer to seek treatment from local medical stores/pharmacy. This may have curtailed the visit to the health facility.	DP14/Ph3/ MgF/Ht22	Φ©ʘ	SSI/Obs/ Gd
15	Poor screening at community level	Some people do not like to take their children for nutritional assessment, as they do not believe in it. Even though FCHVs counsel them on the importance of screening, they do not bring their children for screening.	DP14/Ph3/M2/ MgF	Φ℗Θʘ	SSI/FGD/ GD/Obs
16	Low awareness on IMAM program	There are still people who do not know about the program. They have heard about the program but unaware about the things it supports. They had also never seen MUAC tapes before.	DP14/c4/a7/ M2/Kf/Ph3/ SisF/HK7	ΦΘ℗ʘ	SSI/GD

S.N.	Barriers	Explanation	Locations	Sources	Methods
17	Limited or no service to beneficiaries when IMAM focal person is absent	In all the health facility, there is an IMAM focal person. However, the designated person is also engaged in other activities of the HF. It was reported that regular IMAM services tends to get affected in his/her absence including recording in IMAM register, using Z-score tables as well as attending and counselling parents of children during follow-ups.	DP14/	Ⓟ/ Φ$©	SSI/GD
18	Catchment area of the OTCC and FCHV is big and not able to cover the area	The catchment area of the OTCC is very large. Larger catchment meaning a large population to cover. HF staff cannot trace all the identified cases and bring them into the program. Further FCHVs were also of a view that they have very large areas of cover and it is always not feasible to track every child or screen.	C4/DPHO	Ⓟʘ	SSI
19	Difficulties in accessing hard to reach areas during the rainy season	The rainy season obstructs the mobility of the people from one place to the other especially at long distance. During rainy season, the public vehicles also fails to operate as water level in the rivers are high, they are unable to cross it, and the roadways are not in good condition for safe travel.	C4	Ⓟ$/program staff	SSI/GD
20	Poor counselling from health workers at the OTCC	When children visit a health facility, the health facility staffs do not respond them in the best way. Hence, the caretakers of children are hesitant to visit the health facility for follow-up visits.	C4/M2	$ʘ	SSI
21	Wrong admission and discharge criteria	The children were admitted when they even did not meet the admission criteria and they were	14 OTC site	Ⓟ@	SSI/Obs/ GD
22	Out of 44 HFs, 28 HFs do not have treatment facility for SAM cases	Not having OTCC in each health facility means, the beneficiaries have to travel beyond their health facility for the treatment. Looking at the geographic terrain of Nepal it is not always feasible to travel 5-6 hours just to get to the OTCC.	Kf/SisF Ⓟ@© SSi, GD		

S.N.	Booster	Explanation	Locations	Sources	Methods
1	Health Education at community and HF level	FCHVs have been delivering the key messages of IMAM to the caretakers of children at ward level through mothers group meeting (MGM) on malnutrition and use of RUTF and Infant and Young Child Feeding (IYCF) practices.	Rk8/DP14/C4/ M2/MgF/Ph3/ SisF/Ht22	Ⓟ⊙Θ	SSI
2	Trained health workers / FCHVs in IMAM program	IMAM program trained health workers with support of the Sabal project. This has helped them in the management of IMAM program.	Rk8/DP14/Ph/ M2/Mg4/BhmF	Ⓟ⊙$	SSI/II/GD
3	HW/FCHV/SM/ CNW doing home visit in case follow-up and community mobilization activities	FCHVs, social mobilizers and community nutrition workers perform home visits.	Rk8/DP14/C4/ M2/MgF	Ⓟ⊙$	SSI
4	Screening of <5year children in the community during the Immunization days, Vitamin A campaign and PHC/ ORC	Health workers screen the children during various events attended by under- five children.	Rk8/DP14/C4/ Ph3	ⓅΘ⊙	SSI
5	Necessary IMAM tools and nutrition supplies for the management of SAM	Adequate supplies of all the tools, i.e., nutrition registers, registration cards, IMAM flex, MUAC tapes, RUTF is available at the health facility	DP14/BhmF	⊙Ⓟ	SSI
6	Community awareness about malnutrition	Community people are aware of malnutrition and on the adverse effects of the malnutrition.	DP14/KF/BhmF	ΦΘ	SSI
7	Good referral mechanism between OTC-ITC	Coordination between OTCC and ITCC is good. Cases with medical complications are referred to ITCC and the cases stabilized in ITCC have been referred back to OTCC	DPHO	Ⓟ	SSI
8	Good coordination and communication between FCHV and OTC	FCHVs have been referring the identified cases to OTCC. OTCCs have also been continually encouraging them for regular screening and refer the identified cases to OTCCs	Ph3/A7/MgF	Θ⊙	SSI/FGD
9	Active involvement of FCHVs in nutrition related activities	In some of the places, FCHVs are active. They have been doing home visits for follow-up of the identified cases to see if they have visited the HFs and to trace the defaulter cases.	C4/A7/M2/ BhmF	Ⓟ$Θ⊙	SSI/FGD

S.N.	Booster	Explanation	Locations	Sources	Methods
10	Appointment of IMAM focal person at all HFs which have nutrition program	Designating IMAM focal person has been a great support in the proper management of the program, which has allowed him/her to focus on the program.	Ph3	Ⓟ	SSI
11	Decision making capacity/ Supportive family to seek service at HFs	Mother could take her child to the health facility because the familywas supportive and helped her in household work. Hence, she had enough time to spend with her child.	C4	$	SSI
12	Timely reporting of HMIS 9.1 by FCHVs to HF	FCHVs have been reporting through the existing government health system as per the protocol	A7/M2/BhmF	ʘ	FGD/SSI
13	Coordination with other stakeholder working in the district	Good coordination with other stakeholders, i.e. coordination of the health facility with local stakeholders, local non-government organization and local bodies. Have contributed in increasing awareness of the program in the community.	MgF/SisF	ʘⓅϴ	SSI/GD
14	Establishment of TSFP sites in all OTCCs and additional 7 TSFP sites in other HFs		MgF, BhmF ,KF	Ⓟ@©	SSI/GD

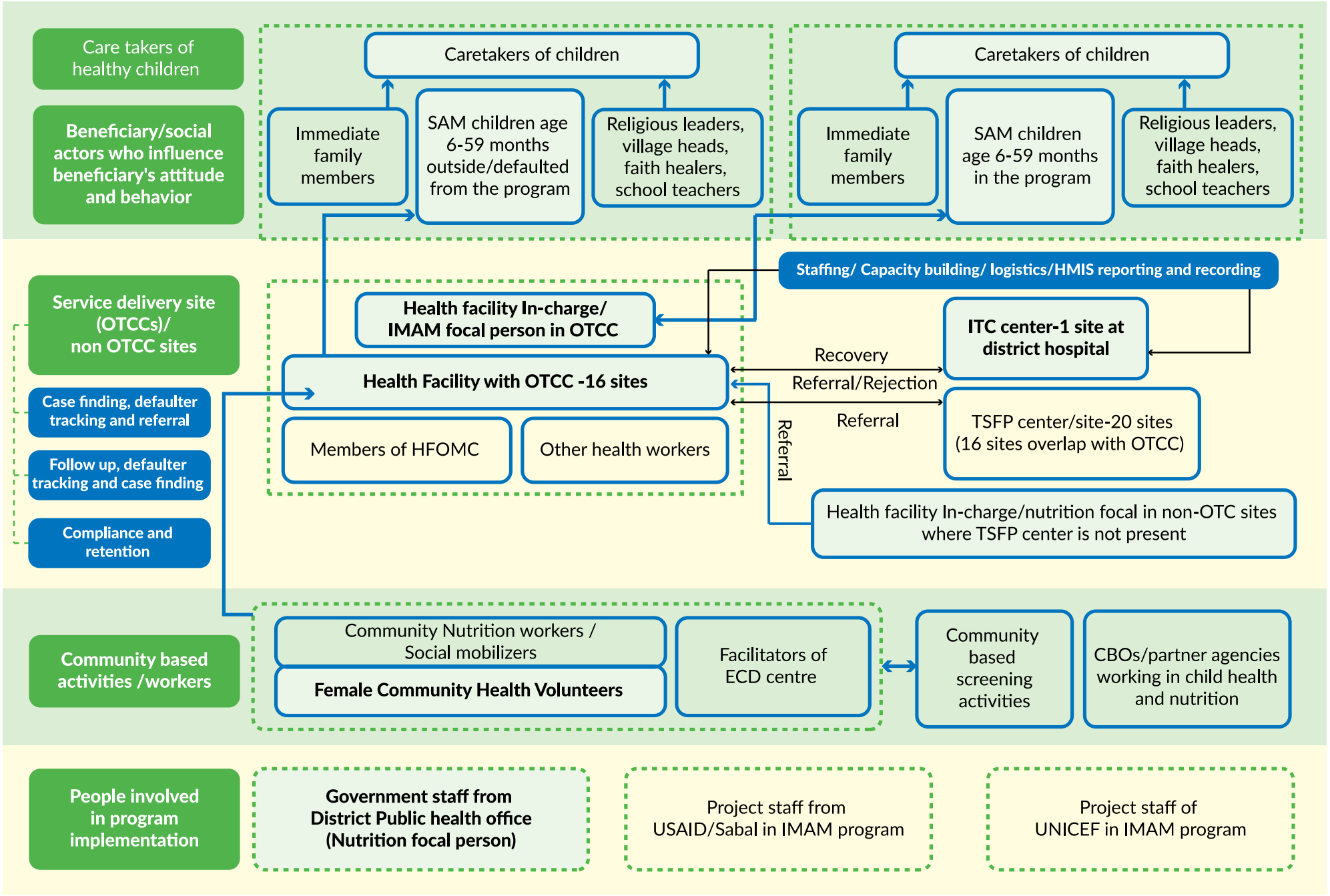


Figure 13: Dynamics of IMAM program in Makawanpur district

Table 5: Quantitative data source with symbol

S.N.	Source	Symbol
1	Mother or Caretaker of Malnourished children who are enrolled in the program	Ώ
2	Mother or Caretaker of Malnourished children not covered in IMAM program	Φ
3	Mother or Caretaker of Malnourished children who defaulted from IMAM program	$
4	IMAM focal person in health facility in Makawanpur 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

Table 6: 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)	FGD
4	In depth Interview	IDI
5	Case study	CS
6	Informal Interviews	IF
7	Observation	Obs
8	Ranking	R
9	Mapping	M

STAGE II

Screening at households

Screening in ECD center

Screening in schools

8.3 STAGE II

8.3.1 Hypothesis formulation and testing

To validate the findings from both quantitative and qualitative data and how they influence program coverage the assessment team developed a hypothesis. The hypothesis stated "*coverage of the program is high in villages near (≤10kms) the OTCC and low in villages far (>10kms) from the OTCC and in the catchment area of those health facilities which does not have SAM treatment program*".

Five villages near to the OTCC (≤10 km), five villages far from the OTCC (> 10km) and other five villages that were in the catchment area of health facilities, which do not have a SAM treatment program was sampled to test the hypothesis. The assessment team used active adaptive and door-to-door case finding (*where applicable*) to look for cases. The survey targeted three categories of children which includes SAM children in the program (covered), SAM children not in the program (un-covered) and SAM children recovering in the program i.e. who are not SAM on the day of measurement but under treatment. In total, the survey team screened 446 children aged 6-59 months in the 15 villages using Mid-Upper Arm Circumference (MUAC) tape as well as oedema checks. The survey found two covered SAM cases. Table 9 provides information on the number of children screened in stage 2.

The findings revealed that villages far (>10km) from the OTCC and in the area catchment area of health facility without OTCC had low coverage while villages near (<10km) from the OTCC had higher coverage confirming the hypothesis. Table 10 provides details on the hypothesis testing.

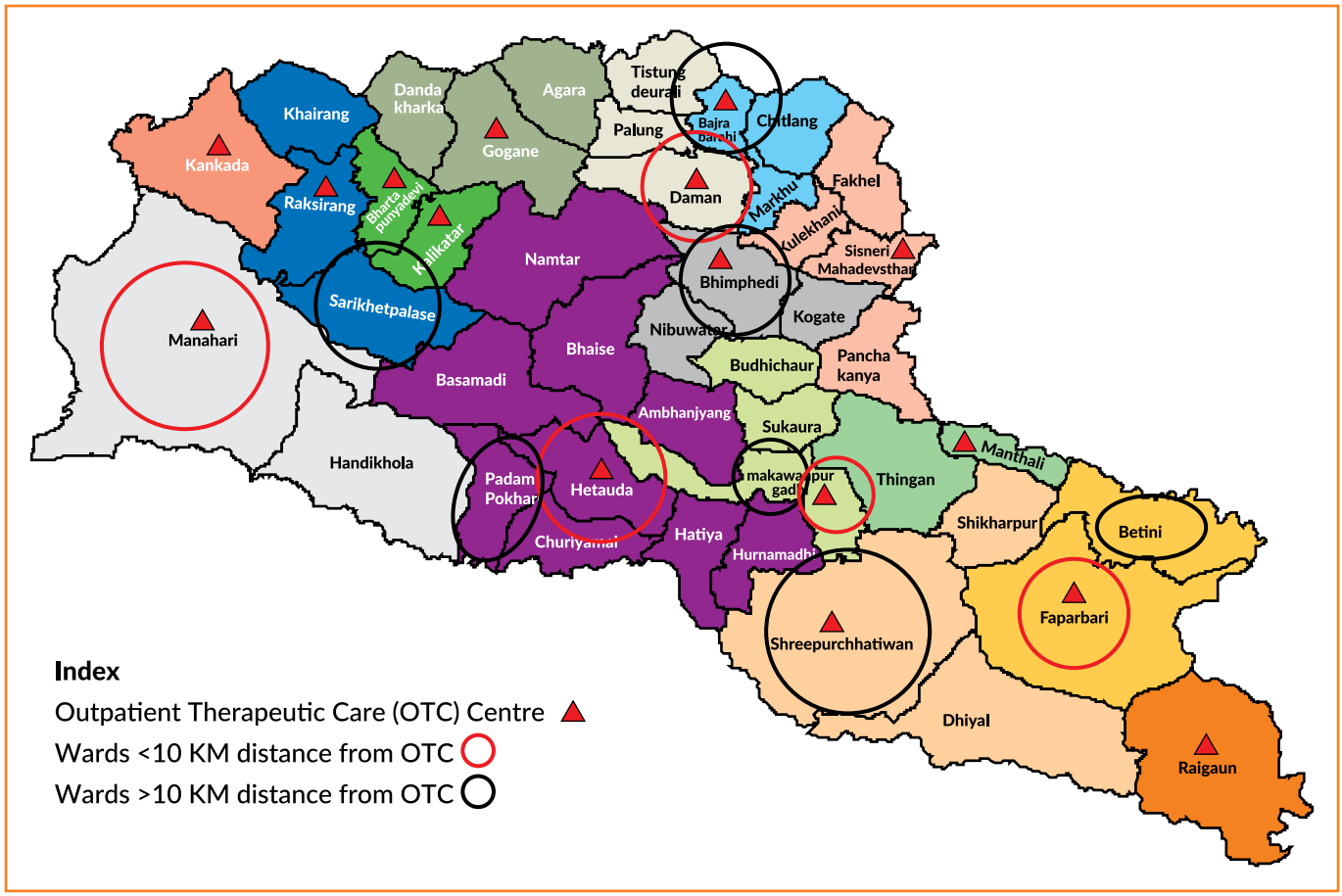


Figure 14: Spatial distribution of data collection sites in stage II

Table 7: Purposively selected villages and findings of the small area studies in stage II

Team	Ward<10Km	Distance	Population	Link facility	U5 Screened	SAM found	SAM covered	Rec. covered	Uncovered
1	1 Sarikhet Palase	8	212	Sarikhet plase HP	38	0	0	0	0
2	2 Bajrabarahi	2	1,349	Bajrabarahi HP	28	0	0	0	0
3	5 Shreepur Chhatiwan	8	1,313	Chhatiwan PHCC	45	2	2	0	0
4	2 Bhimfedi	2	448	Bhimfedi PHCC	24	0	0	0	0
5	4 Makawanpurgadhi	5	1,710	Makawanpurgadi HP	21	0	0	0	0
Team	Ward>10	Distance	Population			0	0	0	0
1	1 Manahari	12	935	Manahari PHCC	25	0	0	0	0
2	8 Daman	11	526	Daman PHCC	28	0	0	0	0
3	1 Faparbari	11	852	Faparbari HP	40	0	0	0	0
4	9 Hetauda Municipality	11	9,602	Hetauda MCH	47	0	0	0	0
5	1 Makawanpurgadhi	12	1809	Makawanpurgadi HP	32	0	0	0	0
Team	Ward without OTCC	Distance	Population			0	0	0	0
1	7 Raksirang	22	462	Raksiran HP	7	0	0	0	0
2	5 Chitlang	13	480	Chitlan HP	38	0	0	0	0
3	6 Betini	7	339	Betini HP	20	0	0	0	0
4	1 Bhaise	12	353	Bhaise HP	4	0	0	0	0
5	1 Padam Pokhari	9	4,639	Padam pokhari HP	49	0	0	0	0

Table 8: Hypothesis result of program coverage

Purposively sampled villages	Hypothesis Result			
Villages near(<10km)to OTC sites:	SAM in program= 2	Coverage Standard	50%	The number of SAM cases covered (2) was more than (1) as per the decision rule 1, which confirms the hypothesis.
	SAM not in Program= 0	Decision Rule (d1)	D1= 2*(50/100) D1=1	
Village far(>10km) to OTC sites and Catchment area of HF without OTC site	Decision rule 2: During 3 days, small area survey by using both methods of cases finding (door by door and active adaptive) no SAM case in that area was found because at this point common childhood diseases are not prevalent which includes ARI and diarrhoea. Furthermore, there is no any reported epidemic of any childhood disease in the past two months. Food availability during the past two months and SAM prevalence in the district, according the SMART survey (April-2016) is 0.2 % (0.0-1.7 95% CI) by MUAC. As per stage one data (quantitative & qualitative data), we believe that the coverage is low in the area far from the OTCC because one of the major barrier was long distance. This was also confirmed by quantitative data admission in the villages which are near to the OTCC ≤ 10km were 67.5% and in the villages which are far from the OTCC >10km were 32.5%.			

8.3.2 Developing the prior

Based on the qualitative and quantitative information collected by the assessment team, it comes up with its belief about the program coverage, which is termed as a **prior**. Prior literally means something based on prior information i.e. the analysis of existing data and information in this case. Simple scoring of barriers and boosters, weighting of barriers and boosters and histogram generated the prior. The table below provides a snapshot 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 program coverage.

Weighted scores

The level of impact of the booster or barrier on program 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 + 44) is equal to **44%**. The total sum of the barriers subtracted from the highest possible coverage (100–61) is equal to **39%**. Hence, the prior mode calculated from the weighted boosters and barriers is {(44%+39%) /2} **41.5%.**

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 + 56) is equal to **56%**. The total sum of the simple barriers was subtracted from the highest possible coverage (100 – 92) is equal to **8%**. Hence the prior mode from the simple boosters and barriers is {(56% +8%)/2} 32%.

Histogram belief

The prior mode from the histogram represents the belief of the program team. Based on the assumption that coverage of the SAM cannot be below 20% and cannot be above 70% due to presence of barriers and boosters respectively prior mode is {(20% +70%)/2} = 45%.

Table 9: Simple and weighted scores for boosters and barriers

S.N.	Positive Factors (Boosters)	Weighting		Negative Factors (Barriers)	Weighting	
		Simple	Weighted		Simple	Weighted
1	Health Education at community and HF level	4	3	People going for treatment to the church and traditional healer	4	4
2	Trained health workers / FCHVs in IMAM program	4	4	Mother is not allowed to visit the HF without permission of her husband	4	2
3	HW/FCHV/SM/CNW doing home visit in case follow-up and community mobilization activities	4	3	Less Supportive Supervision from health facility	4	4
4	Screening of <5year children in the community during the Immunization days, Vitamin A campaign and PHC/ORC	4	4	Challenging terrain and long distance from villages to OTCC	4	4
5	Necessary anthropometric tools and supplies for the management of SAM	4	4	Poor families cannot afford to pay for travel to health facility for follow-up visit	4	3
6	Community awareness about malnutrition	4	2.5	Storage problems (no enough space tin trunk to store RUTF safely	4	1
7	Good referral mechanism between OTC-ITC	4	2	Poor follow-up system of the absent and defaulter cases	4	4
8	Good coordination and communication between FCHV and OTC	4	3	Gender bias towards female child to seek appropriate and timely treatment	4	2
9	Active involvement of FCHVs in nutrition related activities	4	2.5	Language Barrier in some Tamang Communities	4	1
10	Appointment of IMAM focal person at all HFs	4	4	Parents can afford very little time to take care of their child due to high workload	4	2
11	Decision capacity/ Supportive family to seek service at HFs	4	2	Less belief on nutrition program /HF/FCHV and free service	4	2
12	Timely reporting of HMIS 9.1 by FCHVs to HF	4	2	Children dislike the taste of RUTF	4	2
13	Coordination with another stakeholder working in the district	4	4	Not using referral slips by the FCHV	4	2
14	Establishment of TSFP sites in all OTCCs and additional 7 TSFP sites in other HFs	4	4	Visiting a medical shop for treatment	4	3
15				Poor screening at community level	4	2.5
16				Low awareness about the program	4	4
17				Workload at HF	4	1
18				Limited or no health service to beneficiaries when IMAM focal person is absent	4	1.5

S.N.	Positive Factors (Boosters)	Weighting		Negative Factors (Barriers)	Weighting	
		Simple	Weighted		Simple	Weighted
19				Catchment area of the OTCC and FCHV is big and not able to cover the area	4	2
20				Difficult in accessing hard to reach areas during rainy season	4	3
21				Poor counseling from health workers at the OTCC	4	4
22				Wrong admission and dis-charge criteria	4	3
23				Out of 44 HFs, 28 HFs does not have treatment facility for SAM cases	4	4
		56	44		92	61
		56	44		(100-92) 8	(100-61) 39

8.3.3 Prior plot

The Bayes SQUEAC estimate calculator version 3.01[3] produced a plot of the prior mode. The plot considered a high uncertainty of ±25 % since this is the first coverage assessment in the district. The prior mode derived from the summation of weighted, simple score and histogram values {(41.5%+32%+45%)/3} is 39.5%.

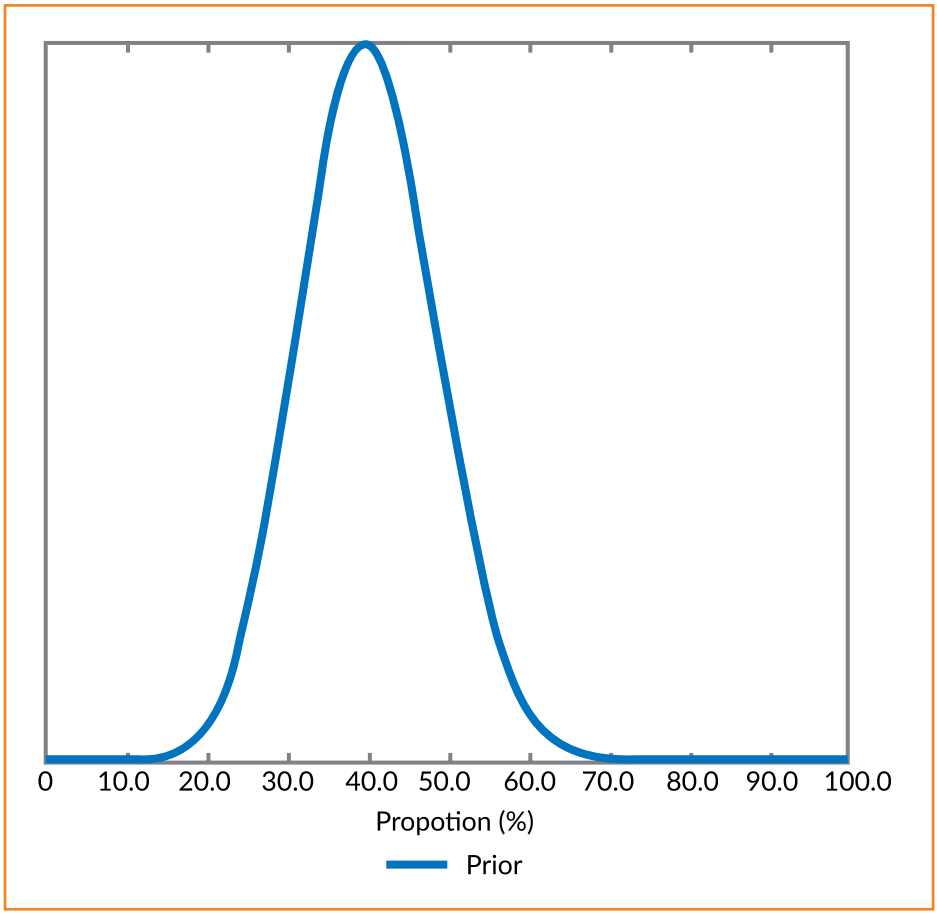


Figure 15: Prior plot

STAGE III

MUAC measurement of a child at a school in Phapharbari

MUAC measurement of a child in Nibuwatar

STAGE III: WIDE AREA SURVEY

Five teams each with a supervisor were involved in the data collection in 21 wards. The survey team did not find minimum number of sample to make a valid estimate of the coverage data. The team carried out exhaustive screening in all the villages using door-to-door sampling in all the households targeting children of 6-59 months. During the screening, only two SAM uncovered cases and one recovering SAM case was found. MUAC screening was used since the sample size for the SAM cases was calculated using the MUAC prevalence.

Table 10: Purposively selected villages and findings of the small area studies in stage II selected villages and findings of the small area studies in stage II

S.N.	Health Facility	Ward-VDC	Distance in KM	Number of Household	Population
1	Sukaura HP	5 Sukaura	7	73	447
2	Makawanpurgadhi HP	7 Makawanpurgadhi	8	168	787
3	Shikahrpur HP	9 Shikharpur	9	77	416
4	Betini HP	2 Faparbari	12	582	3,172
5	Betini HP	4 Betini	10	43	255
6	Raigaun HP	6 Raigaun	4	272	1355
7	Palung HP	6 Palung	3	104	412
8	Bajrabarahi HP	4 Bajrabarahi	2	185	853
9	Chitlang HP	6 Chitlang	16	229	1,083
10	Kulekhani HP	1 Kulekhani	11	69	295
11	Bhimfedi PHCC	5 Bhimfedi	5.5	145	646
12	Nibuwatar HP	9 Nibuwatar	8.5	114	416
13	PadamPokhari HP	8 Padam Pokhari	10	380	2,010
14	Nawalpur UHC	10 Hetauda Municipality	1	1725	7219
15	Hatiya HP	1 Hatiya	11.7	183	863
16	Ambhanjyang HP	3 Ambhanjyang	12	215	1006
17	Basamadi HP	5 Basamadi	7.5	866	3,875
18	Bhaisa HP	7 Bhaise	9	346	1709
19	Bharta HP	1 Bharta Pundyadevi	5	43	235
20	Manahari PHCC	6 Manahari	4	168	814
21	Handikhola HP	8 Handikhola	8	390	1,847

[3] This version of Bayes estimate calculator is available freely at www.brixtonhealth.com

9 DISCUSSION AND CONCLUSION

As per official records, in between January and December 2016, Makwanpur district registered 405 SAM children aged 6 to 59 months. There are an estimated 41,013 children of that particular age group in the district[4]. Given the prevalence estimates of SAM, 1.6 (0.8-3.2 95% C.I.) by WHZ and 0.2 (0.0-1.7 95% C.I.) by MUAC, it is plausible that district registered 405 SAM children during the year. However, the main issue is not about plausibility and not even about the SAM children whom the program is yet to identify and enroll. One of the critical issues with the IMAM program is retention of the children currently enrolled in the program. Majority of the defaulter left the program in first three weeks. There is high probability that the children who exited untimely were still SAM and there condition is likely to worsen in absence of further treatment.

Investigation into the reasons for defaulting showed that long distance and travel time to the service delivery points and financial backing to support regular visits to the health facility were major ones. Further, social factors such as deep-rooted belief of the community in traditional faith healers can influence the choice to visit the health facility. On the other hand, large proportion of the children admitted into the program from Raksirang, Bharta, Kalikatar and Chhattiwan which have high to very high concentration of disadvantaged groups (DAGs) residing in the area. In context of Nepal, concentration of DAG in an area is determined based on households with food sufficiency for less than 3 months, concentration of marginalized households, condition of primary schools, condition of health posts, participation of women, dalit & indigenous groups in planning, execution & decision-making, prevalence of gender discrimination and vulnerable household. These areas are remote hilly areas with seasonal roads where uninterrupted service throughout the year is questionable supporting the above reasons for defaulting.

Meanwhile, the assessment team made some interesting observations that is contrary to the reasons outlined. They found that people do not hesitate to spend money in treatments offered by the traditional faith healers no matter how poor they are. Community's belief in traditional faith healers is deep-rooted and generational and they are easily accessible in the community. Further, community does not believe that malnutrition is a health problem that has therapeutic solutions. The urgency to go to the traditional healer in context of any illness is more than to go to the health facility. Thus, the reasons provided for defaulting from the program could be misleading. However, it is hard to refute both the versions.

While the above reason are subject to context and hence refutable. However, the assessment did report some irrefutable issues. In some of the children discharged as cured, the gap between the consecutive follow-up visits were longer than standard. As a result, the children had already defaulted from the program as per standard protocol while they were still in the program. Hence, having these hidden defaulters is manifestation of the fact that service providers have a knowledge deficit on this regard.

Getting people to come to the health facility for SAM treatment leaving aside their deep-rooted socio-cultural practices of treatment is a challenging issue. It will take valiant and comprehensive effort on the part of conventional health services to attract them and keep them interested. Such issues are some prominent externalities, but what the program must take control of is cutting down on

[4] Department of health services: Annual health report,2015/16

Inquiring a mother about the reasons for defaulting from IMAM program.

the hidden defaulters and improving the recording system at the OTCC. The supportive supervision and monitoring on the part of the project needs improvement.

Meanwhile, the case admission as well as number of defaulters peaked in between July-September, 2016. While intensive screening activities resulted in high case admissions, it goes to show that it failed to translate into fully compliant SAM cases. This a classic backlash of a campaign based screening activity. Thus, in coming days it is important to intensify follow-up efforts in months following the campaign.

One of the important objectives of the assessment was to obtain coverage of SAM program. Despite the fact that the prevalence of SAM in the district is quite low, the assessment team did decide to go ahead with estimating coverage because it was being done for the first time in the district. However, the team could not find enough sample required to make an estimate of coverage with any precision. The assessment team did make an effort to obtain required sample by randomly selecting more villages. Nevertheless, given the low prevalence of SAM the number of villages/ wards that the team would have to reach was way beyond the financial and logistical capacity to support it. While we do not have the number to talk about how many children are still outside the program, it is critical from program perspective to be able to retain the children enrolled in the program.

A single defaulter often sets a bad precedent and wrong impression for immediate neighbors and family members especially if it is due to service side barriers. Therefore, there is need to minimize the effect of factors that causes a child to default.

10 ACTION PLAN

A half day workshop was organized on 23 March, 2017 including the representatives of the district public health office, IMAM focal person of selected OTCC, and the local-non-government organizations. The workshop was focused on sharing the findings of SQUEAC and to discuss on actions or activities to mitigate the challenges.

On the occasion, the Chief of district public health office Mr. Ram Chandra Pathak highlighted the need to uphold the recommendations of SQUEAC assessment and improve IMAM program. He also talked about the need to retain the SAM children in the program and reduce the number of defaulters. Similarly, Nutrition focal person Mr. Bhimsagar Guragain reinforced the need to reduce defaulters and increase program coverage. Some of the recommendations that came up during the discussion are as follows:

- Need refresher training on Z-score calculation.
- Need to intensify efforts to increase awareness on malnutrition and its impacts in short term and long term.
- Need to extend screening services in PHC/ORC.
- Need to look for an alternative to RUSF with locally made super porridge "*Sarbottam pitho*".
- Remove the concept of making only IMAM focal person answerable for the program.
- Awareness building efforts should also be conducted targeting schools
- Extension of IMAM program through outreach clinics in pocket areas.
- Orientation to traditional faith healers on malnutrition and IMAM program
- Involvement of local leaders to advocate to the community
- Communication efforts should be focused on interpersonal communication rather than making brochures and posters

Mr. Ramchandra Pathak Chief, District Public Health Office talking about importance of SQUEAC assesment in Makawanpur district.

Table 11: Actions required to improve IMAM program

	Recommendation	Evidence	Action	Means of Verification	Responsibility	Deadline	Priority	Challenges /remarks
Recording	Improve standard of recording in IMAM register in OTCC (HMIS 2.6)	Date of admission and date of first follow-up were the same Information on number of RUTF provided on the date of admission was absent Date of follow-up was missing The date of follow-ups was mentioned in a mixture of Gregorian and Nepalese Calendar	Develop a mobility map of field staffs and ensure that each of them visited all health facility in their area at least once in three months, considering the hard to reach areas; A scanned copy of the registers will be sent to the center office once every three months; The technical officers should mention their date of supportive supervision in the IMAM register including the recommendation	IMAM observation Checklist; Scanned copy of the registers, Date of supportive supervision by the technical officers mentioned in the IMAM registers along with their signatures and recommendation	IMAM Program Manager and Technical officer; Senior monitoring and evaluation officer	July,2017	High	
Reporting	Improve standard of reporting	During data validation, it was known that technically several cases had defaulted but they continued to enroll in the program as fully compliant cases	Inclusion of date of follow-up and date of admission in beneficiary database maintained by the program, Random verification of database record against the scanned copies of the IMAM register	Scanned copy of the registers, Date of supportive supervision by the technical officers mentioned in the IMAM registers along with their signatures and recommendation	IMAM Program Manager and Technical officer; Senior monitoring and evaluation officer	October,2017	High	

	Recommendation	Evidence	Action	Means of Verification	Responsibility	Deadline	Priority	Challenges /remarks
Capacity building	Increasing the number of admissions based on WHZ	A total of 87.7% children were admitted to the program by MUAC while only 12.2% children were admitted to the program by WHZ	Conduct a session on z score in a gathering of IMAM focal person organized by the DPHO	Quarterly report	IMAM program manager and nutrition focal person	July,2017	Medium	
			Provide on the job coaching to the health personnel during supportive supervision and monitoring visit;	IMAM observation checklist	IMAM technical officers	October,2018	Medium	The approval process of the mobile application can be time consuming
			Develop a mobile application in Nepali for Z score calculation	Approval for design of mobile application	Senior capacity building officer	August,2018		
Defaulter tracking	Follow-up the defaulter cases specially in health facilities such as Bharta, Raksirang, Chattiwan and Kalikatar	The health facilities have relatively higher number of defaulter	Prepare a list of children who defaulted during the supportive supervision and monitoring visit along with contact numbers and provide it to the health workers for follow-up and attach it in the register; Contact the FCHV of that ward for follow-up	IMAM observation checklist and quarterly reports	IMAM technical officers	July,2017	High	
Outreach	Extension of screening services in PHC/ORC in Bharta and Kalikatar linking up with PHC/ORC strengthening activities of Sabal project in the district	These health facilities have relatively higher number of caseload and defaulters at the same time; The catchment area of this health facility has very high concentration of DAG	Request the 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	Request letter from DPHO, quarterly reports	IMAM program manager	June,2017	High	PHC/ORC primarily covers family planning, essential health care services and maternal health issues. Hence Screening would be cited as additional task requiring additional human resource

	Recommendation	Evidence	Action	Means of Verification	Responsibility	Deadline	Priority	Challenges /remarks
Integration	Orient health workers and female community health volunteer on enhanced homestead food production	Communities does not perceive balanced diet as an important issue and tend to consume one sort vegetable for a three to four month straight despite being involved in farming activities	Coordinate with nutrition focal person to conduct such orientation of health workers; coordinate with EHFP officer to provide composite seed package to SAM households and health workers of targeted health post.	Letter of request from DPHO to Sabal to conduct such orientation	IMAM program manager	November, 2017	Medium	This was one of the activities proposed by the nutrition focal person of the district public health office
	Share beneficiary database with enhanced homestead food production (EHFP) officer to include SAM households in EHFP beneficiary list and groups			Quarterly report	IMAM program manager	July,2017	Medium	
	Share beneficiary database with the livelihood component of Sabal in the district to provide opportunity to SAM household in vocational training program	Economic unaffordability was reported to be one of the barriers to seek services under IMAM program specially to do with travel to health facility	Request the senior district coordinator of Sabal in Mawakpur district to include member of SAM households in vocational trainings	Quarterly report	IMAM program manager	April,2017	High	This activity will help boost income generation of very poor households
Communication	Design a brochure and hoarding boards for strategic locations	Lack of awareness about the program is mentioned as one of the barriers	Prepare a draft of brochure and hoarding board and have a discussion in DPHO for approval	Final design and draft design	Senior capacity building officer	July,2017	Medium	

11

ANNEXES

Annex 1: General demographic information of Makawanpur district segregated by VDC/ Municipality

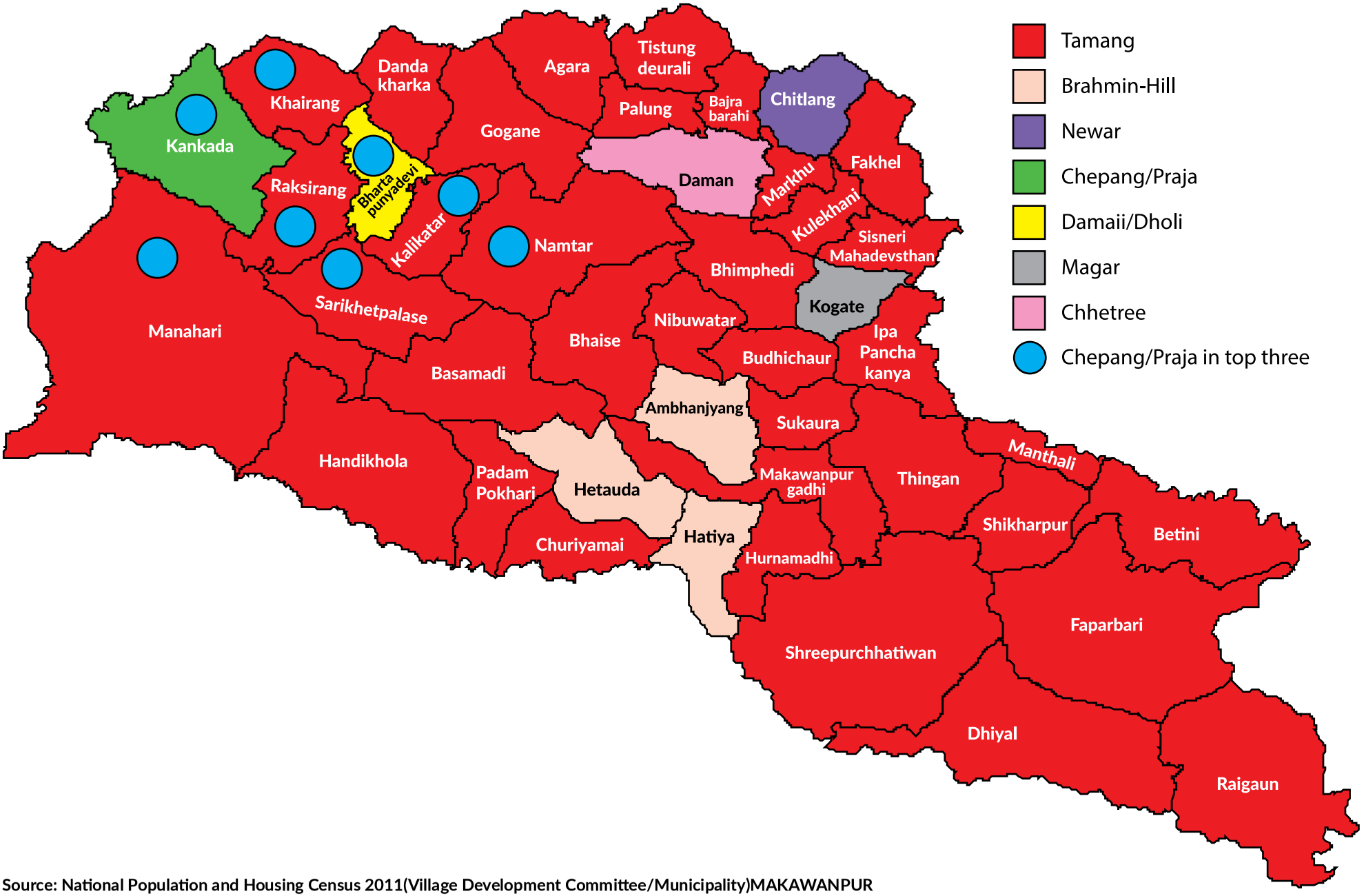
V.D.C. / Municipality	Household	Total population	Population as % of total population	Population		Average HH size	Sex Ratio
				Male	Female		
Hetauda Municipality	19,851	84,671	20.14	42,194	42,477	4.27	99.33
Agara	1,572	7,836	1.86	3,850	3,986	4.98	96.59
Ambhanjyang	1,403	6,906	1.64	3,330	3,576	4.92	93.12
Bajrabarahi	1,630	7,675	1.83	3,622	4,053	4.71	89.37
Basamadi	3,557	17,130	4.07	8,358	8,772	4.82	95.28
Betini	617	3,351	0.80	1,667	1,684	5.43	98.99
Bhaise	1,388	6,717	1.60	3,228	3,489	4.84	92.52
Bharta Pundyadevi	693	4,169	0.99	2,143	2,026	6.02	105.77
Bhimfedi	1,161	5,440	1.29	2,503	2,937	4.69	85.22
Budhichaur	370	2,085	0.50	1,041	1,044	5.64	99.71
Chitlang	1,172	5,029	1.20	2,237	2,792	4.29	80.12
Churiyamai	2,980	14,274	3.39	6,846	7,428	4.79	92.16
Daman	1,913	8,439	2.01	4,074	4,365	4.41	93.33
Dandakharka	720	4,021	0.96	2,020	2,001	5.58	100.95
Dhiyal	1,090	5,945	1.41	2,937	3,008	5.45	97.64
Fakhel	1,011	4,524	1.08	2,102	2,422	4.47	86.79
Faparbari	3,221	16,776	3.99	7,991	8,785	5.21	90.96
Gogane	983	5,345	1.27	2,598	2,747	5.44	94.58
Handikhola	3,676	18,415	4.38	8,890	9,525	5.01	93.33
Hatiya	2,751	13,099	3.12	6,379	6,720	4.76	94.93
Hurnamadi	1,524	6,615	1.57	3,204	3,411	4.34	93.93
Ipa Panchakanya	459	2,497	0.59	1,256	1,241	5.44	101.21
Kalikatar	796	4,723	1.12	2,384	2,339	5.93	101.92
Kankada	1,304	7,840	1.86	3,959	3,881	6.01	102.01
Khairang	583	3,389	0.81	1,744	1,645	5.81	106.02
Kogate	280	1,279	0.30	593	686	4.57	86.44
Kulekhani	670	2,969	0.71	1,401	1,568	4.43	89.35
Makawanpurgadhi	2,576	12,806	3.05	6,187	6,619	4.97	93.47
Manahari	4,215	19,984	4.75	9,630	10,354	4.74	93.01
Manthali	509	2,762	0.66	1,352	1,410	5.43	95.89
Markhu	634	3,071	0.73	1,452	1,619	4.84	89.68
Namtar	1,709	8,816	2.10	4,395	4,421	5.16	99.41
Nibuwatar	884	4,259	1.01	2,006	2,253	4.82	89.04
Padam Pokhari	3,607	17,086	4.06	7,983	9,103	4.74	87.7
Palung	1,236	5,603	1.33	2,619	2,984	4.53	87.77
Raigaun	1,893	10,368	2.47	4,977	5,391	5.48	92.32
Raksirang	1,152	6,572	1.56	3,247	3,325	5.70	97.65
Sarikhet Palase	1,518	8,391	2.00	4,160	4,231	5.53	98.32
Shikharpur	1,054	5,896	1.40	2,851	3,045	5.59	93.63
Shreepur Chhatiwan	4,172	20,747	4.93	9,952	10,795	4.97	92.19
Sisneri Mahadevsthan	739	3,245	0.77	1,554	1,691	4.39	91.9
Sukaura	654	3,525	0.84	1,721	1,804	5.39	95.4
Thingan	713	4,270	1.02	2,037	2,233	5.99	91.22
Tistung Deurali	1,405	7,041	1.67	3,409	3,632	5.01	93.86

Source: National Population and Housing Census 2011(Village Development Committee/Municipality)MAKAWANPUR

Annex 2: Map showing percentage of children age 0-4 years in each VDC/Municipality with respect to total population of VDC/Municipality

Source: *National Population and Housing Census 2011(Village Development Committee/Municipality)MAKAWANPUR*

Annex 3: Map showing predominant ethnicity in each VDC along with VDCs where Chepang population is among top three populations



Source: National Population and Housing Census 2011(Village Development Committee/Municipality)MAKAWANPUR

Annex 4: Schedule of SQUEAC assessment

			Stage 1					Stage 2					Prior	Stage 3				Recommendation	Presentation
Date	8-Feb	9-Feb	10-Feb	11-Feb	12-Feb	13-Feb	14-Feb	15-Feb	16-Feb	17-Feb	18-Feb	19-Feb	20-Feb	21-Feb	22-Feb	23-Feb	24-Feb	27-Feb	28-Feb
Days	WED	THUR	FRI	SAT	SUN	MON	TUE	WED	THUR	FRI	SAT	SUN	MON	TUE	WED	THUR	FRI	SAT	MON
Activity			**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**18**	**20**
Travel to Makawanpur district and introduction of the SQUEAC Manager with district team																			
Discussion with program team on upcoming field activities, discuss on interview and FGD guide ; briefing session on SQUEAC to DPHO and relevant staffs																			
Qualitative Research Training/Preparation for Qualitative Data Collection- Role playing(Supervisors and Enumerators)																			
Qualitative Data Collection and Analysis & BBQ																			
BBQ+ Formulation of Hypothesis + planning for Stage 2 + training of (Supervisors and Enumerators																			
Stage 2: small area survey																			
Hypothesis analysis and Formulation of Prior																			
Preparation for Wide Area Survey (Sample, Log etc.) + training enumerators and Supervisors																			
Stage 3: Wide area survey																			
Analysis of results and posterior calculations																			
Formulation of recommendations and action plan																			
Preparing Presentation of Survey Finding																			
Sharing of preliminary finding with district public health office and discuss on recommendation and action plan																			
Return to Kathmandu from Makawanpur																			

Annex 5: Questionnaire used during stage I of SQUEAC assessment

Interview Guide: Care taker of malnourished children who are enrolled in the program 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 program					
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	
उपचार सम्बन्धी जानकारी					
Treatment related Information					
तपाइँको बच्चा पहिलो पटक आइमाम कार्यक्रममा भर्ना भएको हो ? Is this the first time that your child has been enrolled in IMAM programme?	हो Yes		होइन No		
आइमाम कार्यक्रम अन्तर्गत उपचार सुरू गरेको कति समय भयो ? Since when have you been in the program?					
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 CMAM 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 program more than once)Why has your child returned to the programme?					
तपाइँका अरू कुनै बच्चा आइमाम कार्यक्रममा भर्ना भएका छन् ? Do you have other children enrolled in CMAM programme?	छ Yes		छैन 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 program?	
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 neighbor?	
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 neighbors 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) तपाईंले RUTF तपाईंका 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 program					
आइमाम कार्यक्रमको बारे तपाईंको के धारणा छ ? र किन ? What do you think about IMAM program and why?					
यस कार्यक्रममा कुनै परिवर्तन गर्ने अधिकार तपाईंलाई दिईयो भने के परिवर्तन गर्न चाहनुहुन्छ ? If you were given the right to make changes in the program what changes would you make?					
के तपाईं 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 program

कोड
Code

अन्तर्वार्ता निर्देशिका: आइमाम कार्यक्रम अन्तर्गत उपचार नलिएका बालबालिकाको हेरचाह गर्ने व्यक्ति						
Interview Guide: Care taker of Malnourished children not covered in IMAM program						
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						
तपाईंको बच्चाको स्वास्थ्य कस्तो छ ? के तपाईंलाई लाग्छ तपाईंको बच्चा बिरामी छ ? How is your child's health? Do you think that you child is ill?	लाग्छ Yes		लाग्दैन No			

तपाइँले तपाइँको 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					
तपाइँलाई तपाइँको 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

तपाइँले 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)					
तपाइँलाई 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 ? तपाइँको 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 ?					
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?	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 program dedicated to the treatment of severely malnourished children (IMAM program)? Have you any of your family members, relatives or friends and neighbors 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 program					
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 program

						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 program							
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 पूर्ण रूपमा स्वस्थ भइसक्यो ? How is your child's health? Do you think that your child is completely healthy now?	लाग्छ Yes		लाग्दैन 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 बच्चाबच्चाहरुको 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 program				
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 program what changes would you make?				

Interview Guide: IMAM focal person in health facility in Makawanpur district

				कोड Code
अन्तर्वार्ता निर्देशिका आइमाम कार्येक्रम हेर्ने स्वास्थ्यकर्मी				
Interview Guide: IMAM focal person in health facility in Makawanpur 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 program better?	
आइमाम कार्यक्रमको गुणस्तर	
Quality of IMAM program	
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 ? अर्कै 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 program? 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 program? 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 program? 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 program 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 program 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 program	
IMAM कर्यक्रमका सबल र दुर्बल पक्षहरु के के हुन् ? What do you think are the strengths and weakness of the IMAM program?	
कार्यक्रममा अझै सुधार ल्याउन के कुरा परिवर्तन वा बदल्न चाहनुहुन्छ ? What would you like to change or add in the program 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 program?	

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 तपाईंले IMAM को तालिम प्राप्त गर्नु भएको छ ? यदि छ भने के यो तालिमले तपाईंलाई 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 program	
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 program? 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 program 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 program? 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 program 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 program	
IMAM कार्यक्रमका सबल र दुर्बल पक्षहरु के के हुन् ? What do you think are the strengths and weakness of the IMAM program?	
कार्यक्रममा अझै सुधार ल्याउन के कुरा परिवर्तन वा बदल्न चाहनुहुन्छ ? What would you like to change or add in the program 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 program?	

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 Name of Interviewee		मिति (ग/म/सा) Date (dd/mm/yy)	
संस्थाको नाम Institution		अन्तर्वार्ता लिने व्यक्तिको नाम 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 गरे को 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 program					
तपाईलाई IMAM कार्यक्रमबारे थाहा छ? Do you know about IMAM program?	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 program?					
कार्यक्रममा अझै सुधार ल्याउन के कुरा परिवर्तन वा बदल्न चाहनुहुन्छ? What would you like to change or add in the program to improve further?					
समुदायले IMAM कार्यक्रमलाई कसरी लिइरहेको छ? How does the community perceive IMAM program?					

Interview Guide: Community member or leader

			कोड Code
अन्तर्वार्ता निर्देशिका: समुदयका सदस्य वा नेतृत्वदायी भूमिकामा रहेका व्यक्ति			
Interview Guide: Community member or leader			
अन्तर्वार्ता दिने व्यक्तिको नाम Name of Interviewee		मिति (ग/म/सा) Date (dd/mm/yy)	
संस्थाको नाम Institution		अन्तर्वार्ता लिने व्यक्तिको नाम 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 program 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 program 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 कार्येक्रमलाई पृष्ठपोषण
Feedback to IMAM program
कार्यक्रममा अझै सुधार ल्याउन के कुरा परिवर्तन वा बदल्न चाहनुहुन्छ ? What would you like to change or add in the program to improve further?

Annex 6: Questionnaire used during stage II and III of SQUEAC assessment

Questionnaire for Covered SAM cases

Date: _____ Name of Child: _____

District : _____ MUAC: _____

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

Name of Carer : _____ Sex: _____

Enumerator/Supervisor name : _____ Age: _____

Proof that child is in the programme (e.g. packet of RUTF/OTCC 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/OTCC?

□ Yes ; How? _____
And why did you then go to the health facility? _____

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

_____

Questionnaire for Uncovered SAM cases

Date: _____ Name of Child: _____

District : _____ MUAC: _____

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

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 OTP or SFP or TFU? (circle appropriate)	
□ Yes ; why are they no longer in the programme ?	□ No → STOP
□ 1. Defaulter; when ?	why ? _____
□ 2. Discharged cured ; when ? _____	□ 3. Discharged non-cured ; when ? _____
□ 4. Other reasons : _____	

Thank the carer and provide with a referral slip

Any additional comments/observations :

Overall Wide Area Survey Data

Annex 7: Daily data collection form in stage II and Stage III

Date:	
Enumerator team:	
Village:	
Distance from nearest OTC site:	
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 8: Makawanpur district Health Facilities list

S.N.	Name of health facility	Type	OTCC/TSFP	Supporting agencies for nutrition program
1	Maternal and child health clinic, district public health office	MCH CLINIC	OTCC and TSFP	USAID/SABAL project and UNICEF/ACF project
2	Manthali health post	HP	OTCC and TSFP	USAID/SABAL project and UNICEF/ACF project
3	Daman primary health care center	PHCC	OTCC and TSFP	USAID/SABAL project and UNICEF/ACF project
4	Sisneri health post	HP	OTCC and TSFP	USAID/SABAL project and UNICEF/ACF project
5	Budhichaur health post	HP		
6	Sukaura health post	HP		
7	Manahari primary health care center	PHCC	OTCC and TSFP	USAID/SABAL project and UNICEF/ACF project
8	Faparbari health post	HP	OTCC and TSFP	USAID/SABAL project and UNICEF/ACF project
9	Bhaise health post	HP	TSFP	UNICEF/ACF project
10	Dandakharka health post	HP		
11	Chhatiwan primary health care center	PHCC	OTCC and TSFP	USAID/SABAL project and UNICEF/ACF project
12	Sarikhet health post	HP	TSFP	UNICEF/ACF project
13	Khairang health post	HP	OTCC and TSFP	USAID/SABAL project and UNICEF/ACF project
14	Dhimal health post	HP		
15	Kulekhani health post	HP		
16	Bhimfedi primary health care center	PHCC	OTCC and TSFP	USAID/SABAL project and UNICEF/ACF project
17	Kogate health post	HP		
18	Agara health post	HP	TSFP	UNICEF/ACF project
19	Handikhola health post	HP	TSFP	UNICEF/ACF project
20	Churiyamai health post	HP		
21	Hurnamadi health post	HP		
22	Ambhanjyang health post	HP		
23	Shikharpur health post	HP		
24	Raigaun health post	HP	OTCC and TSFP	USAID/SABAL project and UNICEF/ACF project
25	Kalikatar health post	HP	OTCC and TSFP	USAID/SABAL project and UNICEF/ACF project

S.N.	Name of health facility	Type	OTCC/TSFP	Supporting agencies for nutrition program
26	Kankada health post	HP	OTCC and TSFP	USAID/SABAL project and UNICEF/ACF project
27	Namtar health post	HP	TSFP	UNICEF/ACF project
28	Makawanpur gadhi health post	HP	OTCC and TSFP	USAID/SABAL project and UNICEF/ACF project
29	Tistung health post	HP	TSFP	UNICEF/ACF project
30	Padam pokhari health post	HP		
31	Markhu health post	HP		
32	Basamadi health post	HP		
33	Bajrabarahi health post	HP		
34	Nibuwatar health post	HP		
35	Thingan health post	HP	TSFP	UNICEF/ACF project
36	Palung health post	HP		
37	Hatiya health post	HP		
38	Chitlang health post	HP		
39	Betini health post	HP		
40	Bharta health post	HP	OTCC and TSFP	USAID/SABAL project and UNICEF/ACF project
41	Gogane health post	HP	OTCC and TSFP	USAID/SABAL project and UNICEF/ACF project
42	Fakhel health post	HP		
43	Ipapanchakanya health post	HP		
44	Raksirang health post	HP	OTCC and TSFP	USAID/SABAL project and UNICEF/ACF project

Annex 9: Map showing concentration of disadvantaged community in various VDCs/ Municipality.

Annex 10: SQUEAC assessment Participants list

SQUEAC TEAM

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15	Hom Nath Sapkota	Aambhangyang-9, Makawanpur	9745056875	Enumerator	
16	Shwornima Waiba	Phaparbari-8, Makawanpur	9845907499	Enumerator	
17	Supriya Gautam	Hetauda-2, Makawanpur	9807170915	Enumerator	
18	Shankar Bista	Bajura, Nepal	9848442065	Enumerator	
19	Debaki Dahal	Thingan-4, Makawanpur	9865011353	Enumerator	
20	Chandra Dip Bhujel	Thaha-6, Makawanpur	9849391231	Enumerator	
21	Sanjay Kumar Chaudhary	Rajbiraj-2 Saptari	9842535099	Enumerator	

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