

District Dadu
Sindh Province, Pakistan
March 2015
ACF-International Pakistan



ACKNOWLEDGEMENTS

The Nutrition Survey Team would like to thank the ACF team of district Dadu for supporting the SQUEAC assessment. Special thanks for the technical support from Shahid Fazal Head of Department (HoD) Nutrition Pakistan. Thanks to Dr. Ghulam Ali, Nutrition PM, as well as Haq Nawaz, Nutrition DPM, for the daily arrangements and facilitation. Most of the credit goes to Mr Trenton Chawly Daily, Regional coverage advisor CMN who took lead on this survey and made it possible in a timely and professional manner.

The SQUEAC assessment would not have been successful without the support of the Field Coordinator and other support departments for their operational support at every stage of assessment, and showed keen interest in the assessment.

Last but not least, the hard work of the whole SQUEAC team, Enumerators, Team Leaders, Data encoders is acknowledged who participated in this exercise.

Gratitude is also extended to the community leaders and community based volunteers as they were the major respondents of the SQUEAC study.

ACRONYMS

ACF	Action Contre la Faim
BBQ	Barriers, boosters and questions
BCC	Behaviour change communication
CBV	Community Based Volunteers
CI	Confidence Interval
CMAM	Community Management of Acute Malnutrition
CM	Community Mobilizer
CMN	Coverage Monitoring Network
DNA	Did Not Attend
DPM	Deputy Program Manager
ECHO	European Community Humanitarian Office
FBF	Fortified Blended Food
HEB	High Energy Biscuits
LHWs	Lady Health Workers
MAM	Moderate Acute Malnutrition
MUAC	Mid Upper Arm Circumference
OTP	Outpatient Therapeutic Programme
PM	Program Manager
PPHI	Pakistan Primary Health care initiative
SAM	Severe Acute Malnutrition
SC	Stabilization Centre
SQUEAC	Semi Quantitative Evaluation of Access and Coverage
TBA	Traditional Birth Attendants
UC	Union Council
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WSB	Wheat Soya Blend

EXECUTIVE SUMMARY

Action Contre la Faim (ACF) is funded by the European Union (EU) to implement a program in Dadu District, Sindh, Pakistan entitled Women infants/children Improved Nutrition in Sindh (WINS). The EU-WINS program focuses on strengthening the government's capacity at the provincial and district levels to address high rates of acute and chronic malnutrition.⁽¹⁾

The EU funds support an integrated program with Nutrition (CMAM and IYCF), food security and livelihoods (FSL) and water sanitation and hygiene (WASH). The nutrition component has infant and young child feeding (IYCF) and nutritional education is integrated into CMAM programming.

The CMAM program has Outpatient Therapeutic Program (OTP) sites in each of 30UCs, supplementary feeding programs (SFP) that ran in tandem with them (SFP till Dec 2013). Severely acutely malnourished (SAM) children without medical complications are treated in OTP. SAM cases with medical complications are referred to the SC for stabilization and nutritional therapy and are then transferred to the OTP site nearest their community. Prior to December 2013 when the SFP programme was operational, children discharged as cured from OTP were enrolled in the SFP programme for the treatment of moderate acute malnutrition (MAM) to prevent SAM relapse. Since then the children cured at OTP are retained within the OTP and shifted to one Sachet of RUTF per day as a replacement of SFP protocol and to prevent SAM relapse.

It is notable that recent humanitarian crises have also been increasingly protracted and evaluations show that it can be difficult to sustain the quality of SAM treatment programs once the NGO's resources available during the acute crisis phase are reduced.

Evidence from research in Pakistan indicates that linking the Lady Health Workers (community-level health agents) with wider community leaders and committees for the delivery of essential maternal and newborn care promotion, in conjunction with key services delivered by the LHW, improves neonatal mortality rates and home practices⁴. There is therefore reason to believe that taking treatment of SAM to the level of the LHW with similar links to the wider community will have positive impacts. Recent evidence from integration of household new-born health care interventions through the LHWs in rural Pakistan (Bhutta et al, Lancet 2011)⁵ and community delivery of diarrhea treatment strategies indicates that LHWs can undertake a complex series of tasks and could be instrumental in reducing the burden of malnutrition.

In protracted crises, such as those seen in Pakistan, the traditional model of delivering CMAM services through parallel systems set up and supported by NGOs does not support linkages and integration with on-going child health services nor sustained early identification and treatment of acute malnutrition. This means that programs tend to focus on treating large numbers of cases of SAM each year rather than trying to prevent it through providing an integrated package of interventions. This increases risks of relapse for children and is resource intensive. In addition current CMAM models focus on facility level delivery of treatment whereas, as identified in the R2HC evidence review, health systems and infrastructure in particular are often disrupted during humanitarian crisis⁶. The evidence for effective alternatives that can be implemented achieving high coverage in both acute and protracted crises is limited. Evidence for effective community models of delivery of nutrition education (IYCF) alongside SAM treatment at community/household level is also lacking.

This study will examine the impact of integrating early identification and treatment of severe acute malnutrition with RUTF (defined as < 115 mm MUAC) and IYCF counseling delivered by Lady Health Workers at household level in Dadu district of Pakistan. This study will also examine the impact on cost effectiveness and coverage of enabling LHWs, the community-outreach infrastructure in Pakistan, to deliver an integrated package including treatment of severe acute malnutrition and IYCF. This will fill an evidence gap on successful delivery of platforms for child health and nutrition actions in crisis affected areas.

The Semi-quantitative Evaluation of Access and Coverage (SQUEAC) was undertaken in the UCs in which CMAM programming is provided in Dadu District. To evaluate the effectiveness (rate of recovery, relapse & coverage), of SAM treatment of children under-five years delivered at household level by first level health care providers (Lady health workers) compared with the standard CMAM program delivered at health facility by Government and ACF staff. Coverage assessments are of particular interest in order to access the population that is not accessing treatment and understand its barriers to access.

The SQUEAC investigation purposed to establish various barriers and boosters to access and program uptake, measurement of program performance, as a means to improve CMAM programming for the future.

Control: Coverage¹ = 43.9% (95% CI =33.2%-55.2%)

Coverage is below the SPHERE minimum standard for rural areas of 50%.

Control arm where ACF is providing CMAM services through OTP sites in different areas of the particular 03 union councils with the district health authorities.

Intervention: Coverage = 40.6% (95% CI =29.9%-52.2%)

Coverage is below the SPHERE minimum standard for rural areas of 50%.

Intervention arm where ACF is supporting lady health workers to provide SAM treatment at household level in 03 union councils.

¹Based on the Bayesian Squeac calculator

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1. Overview Of The Province:

Sindh province of Pakistan is bordered to the west by Balochistan and the Kirthar Mountain Range, to the north by Punjab, to the east by the Indian states of Gujarat and Rajasthan and the Thar desert and to the south by the Arabian Sea.⁽¹⁾ The capital of Sindh province is Karachi, which is the largest and most populous metropolitan city of Pakistan and its main seaport and financial center.⁽²⁾

Sindh is divided into three climatic regions: (1) *Siro* (the upper region, centered around Jacobabad); (2) *Whicholo* (the middle region, centered around Hyderabad); and (3) *Lar* (the lower region, centered around Karachi).⁽¹⁾

The thermal equator passes through upper Sindh, where the air is generally quite dry. The area is also influenced by regional monsoons, flooding of the Indus and Himalayan snow melting.⁽¹⁾ Sindh region is considered a disaster-prone area including large-scale flooding and earthquakes. Inundations source from riverine flood from Indus River inflow and torrential flood related to heavy rain break in the province.⁽³⁾

Sindh province is composed of the following 23 regions: Qambar-Shahdadkot, Larkana, Shikarpur, Ghotki, Sukkur, Khairpur, Khashmore, NauShahroFeroze, Jacobabad, Badin, Shaheed Benazir Abad (Nawabshah), Thatta, Jamshoro, Sanghar, Matiari, Dadu, Tando Allay Yar, Tando Mohammad Khan, Hyderabad, Mirpurkhas, Umerkot, Tharparkar, Sanghar and Karachi.

2. Overview of The District:

Dadu District derives its name from the chef-lieu of the zone, the city of Dadu. The district begins at Dhamrah Wah embankment, bordering Larkana and Qamber Shahdadkot Districts in the north and ends at Pir Sahkh, bordering Jamshoro District in the south; it begins at the Kirthar mountains, bordering Lasbela and Khuzdar districts in the west and finally ends at the Indus River (Dadu Moro Bridge), bordering NausheroFeroz District in the east.⁽¹⁾

The climate in Dadu is extremely hot in summer and relatively cold in winter. The annual maximum and minimum temperatures remain around 24° C and 5° C in January and above 45° C and 29° C in June.

3. Description of The Population:

Dadu District is comprised of four Talukas (Dadu, Johi, Mehar and Khairpur Nathan Saha) and some 52 Union Councils (UC) spanning 7,866 km with an estimate population of 1.1 million people. Inhabitants are divided into three main ethnic communities: (1) the kach'o inhabit the semi-arid western border zone along the Kohistan mountains; (2) the pakko live in the barrage area, home to the districts cities and towns; and (3) the kacho inhabit the lowlands riverine area.

4. Nutritional Situation

The broad situation of nutritional status in Pakistan indicated that malnutrition rates are unacceptable high, reporting around 57% of the 30,000 households surveyed nationally face food insecurity.⁽⁴⁾

The most recent available data indicate a global acute malnutrition (GAM) rate of 14.3 (10.8 - 18.7) and a severe acute malnutrition rate of 2.6 (1.5 - 4.4) for Dadu District.

In order to evaluate the effectiveness (rate of recovery, relapse & coverage) of SAM treatment of children under-five years delivered at household level by first level health care providers (Lady health workers) compared with the standard CMAM program delivered at health facility by Govt and ACF staff (Control area), a Semi Quantitative Evaluation of Access and Coverage (SQUEAC) was implemented in Control and intervention area. Coverage

assessments are of particular interest in order to access the population that is not accessing treatment and understand its barriers to access.

5. OBJECTIVES

The survey was guided by the following objectives:

2.1. To evaluate the effectiveness of SAM treatment of children under-five years delivered at household level by first level health care providers compared with the standard CMAM program delivered at health facility.

2.1. Establish barriers and boosters to CMAM program coverage and uptake by the community

2.2. Measure CMAM (SAM) coverage for purpose of measuring its performance

2.3. Provide informed recommendations for improvement of CMAM program

6. INVESTIGATION PROCESS

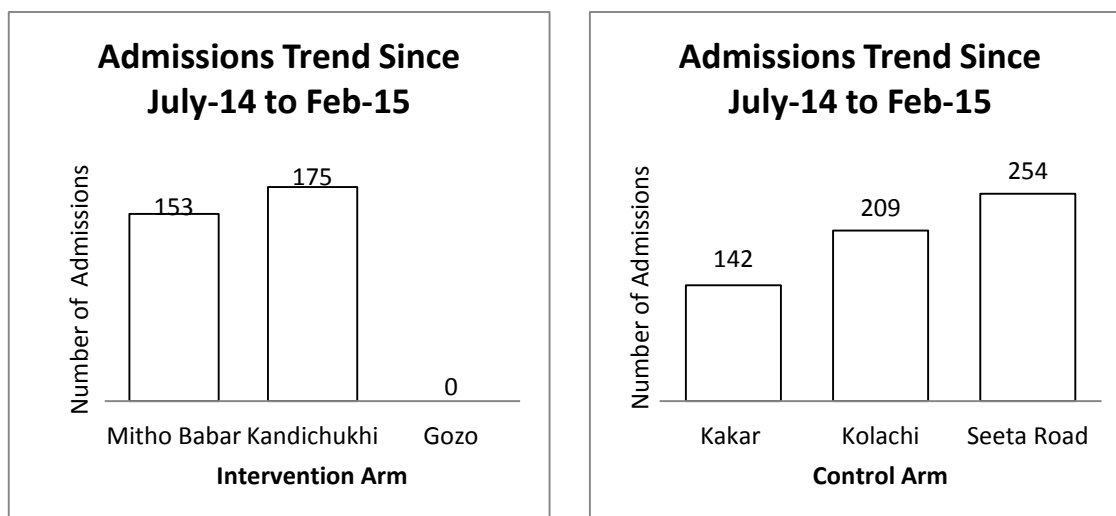
The investigation followed the SQUEAC process. Details of the methodology can be found in annex 1.

QUANITATIVE DATA

GLOBAL ADMISSIONS: TRENDS AND NEED MET

The most important element of routine program data is the number of admissions over time. The capacity of treatment services to respond to SAM needs is dependent on a constant, systematic and significant improvement of coverage.⁽⁶⁾ FIGURE 1: illustrates the evolution of admissions and defaulting in both control and intervention arm over a period of 09 months (July 2014 – Mar 2015). Admissions data is presented as smoothed time-series data. This figure is compared to a seasonal event calendar that was elaborated by the investigation team presented in Table 1. Together these two figures helped determine to what degree the program was able to respond to seasonal need.

FIGURE 1 and 2 separate for control and intervention arm; total admissions data is plotted by union councils supported by program, which shows the number of admission in both arms



SAM admissions are relatively equal across the union councils of control and Intervention arm. No admission in intervention arm union council Gozo as this there is no program activities going on.

TABLE 2. OTP performance indicators (July 2014 – Feb 2015); control arm, district Dadu, Sindh , Pakistan 2015.

Indicators	Rates
Cure rate	94.4 %
Default rate	2.2 %
Death rate	0.2 %
Non-response rate	3.2 %

Based on the available data, these OTP indicators report overall satisfactory values for CMAM program according to SPEHERE references.

Figure 3 reports the evolution of OTP performance indicators (July 2014 – Feb 2015).

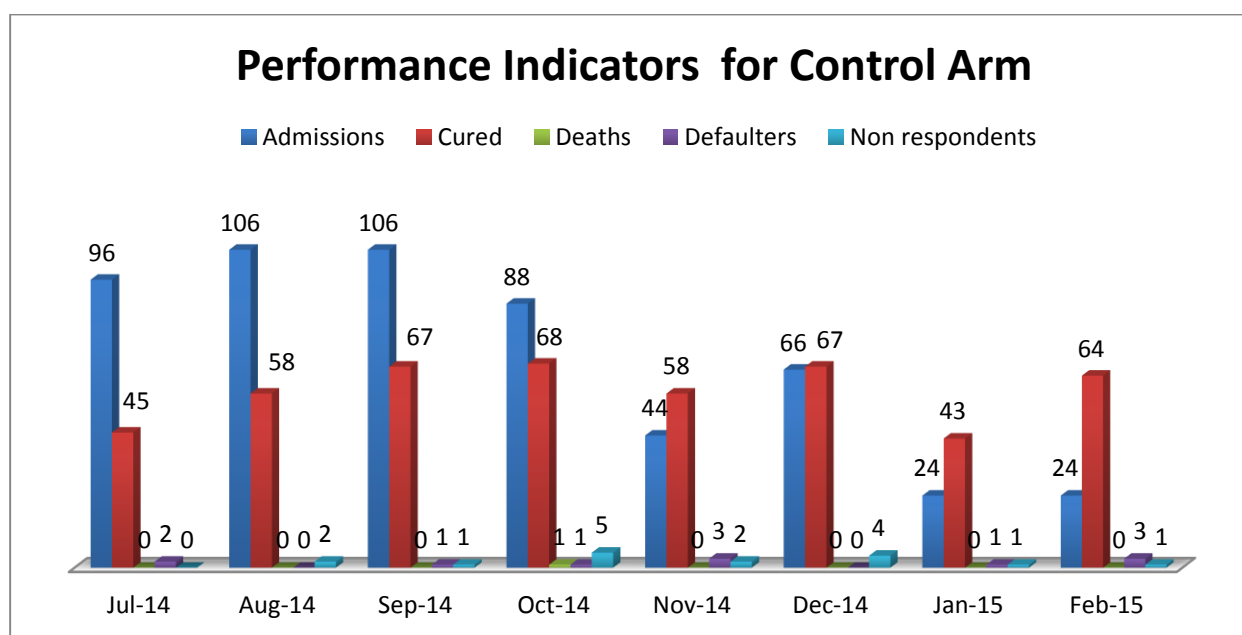


Figure 3 shows an overall constant improvement in cure rate from the beginning of the Program.

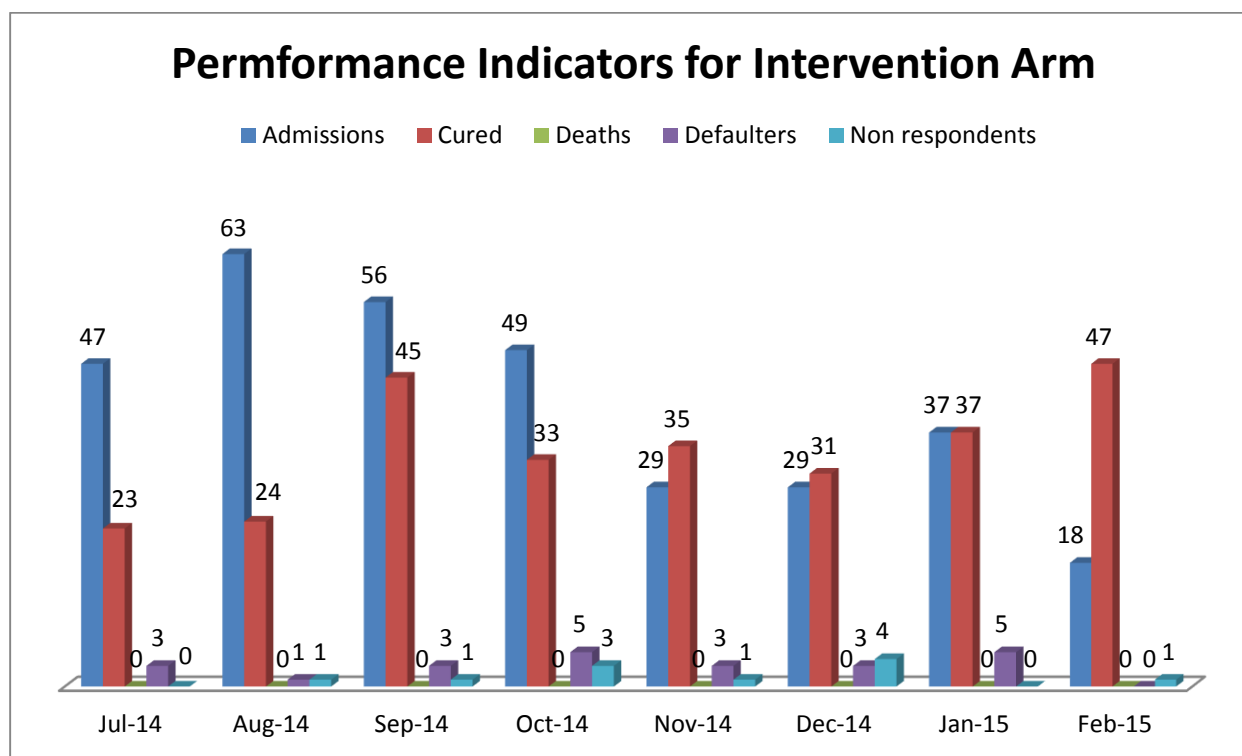
From July 2014 to Feb 2015 a total 554 children were newly admitted in CMAM program control arm union councils with an average of 69 children per month.

TABLE 3. OTP performance indicators (July 2014 – Feb 2015); Intervention arm, district Dadu, Sindh , Pakistan 2015.

Indicators	Rates
Cure rate	88.3 %
Default rate	7.6 %
Death rate	0.0 %
Non-response rate	4.1 %

Based on the available data, these OTP indicators report not better than control arm but overall satisfactory values for CMAM program according to SPHERE references.

Figure 4 reports the evolution of OTP performance indicators (July 2014 – Feb 2015).



From July 2014 to Feb 2015 a total 328 children were newly admitted in CMAM program two union councils of control arm with an average of 41 children per month.

COMPLEMENTARY QUANTITATIVE DATA

ADMISSION MUAC ANALYSIS

Admission MUAC is an indicator that reports on the timeliness of case detection, presentation and admission; a low median admission MUAC can indicate late presentation, an example of direct coverage failure as SAM cases have spent a considerable amount of time non-covered before admission. Late presentation also affects coverage directly because it is often associated with the need for inpatient care, extended lengths of stay in the OTP, defaulting and overall poor treatment outcomes.

MUAC at admission was analyzed from the period of July 2014 to Feb 2015. This timeframe corresponds with the time from which nutritional activity began. Individual beneficiary treatment cards were examined and verified with program registers. All OTP sites supported by ACF were included in the analysis. Most MUAC measurements at admission are close to admission criteria, followed by a steady decrease in lower MUACs and finally few critically low MUACs; together these elements suggest high coverage and strong case-finding and recruitment. The median MUAC at OPT admission was 112 mm for children admitted by MUAC (presented in solid red). Additionally, 64.0% of these children were admitted to the OTP with a MUAC less than or equal to 112 mm, in other words in a state of moderate wasting. Lastly, MUAC data shows a slight over estimation of rounded numbers (i.e. multiples of 5 like 110, 105, 100, 95 and 90) suggesting error in anthropometric measurement. 100% of children discharged from the OTP from September 2013 - June 2014 had a MUAC $\geq$ 115 mm. In other words, no cases were discharged prematurely.

LENGTH OF STAY BEFORE DISCHARGE AS CURED

The length of stay in the OTP before discharge for cured SAM cases is an indicator that reports on the duration of the treatment episode (i.e. the time between admission and discharge). Long treatment episodes are associated with advanced SAM at admission and late presentation, both of which are linked to poor treatment outcomes. Analyses show that 52.3% of SAM cases in Kohat district were cured within the first 8 weeks of treatment, constituting a relatively acceptable performance in the OTP.

DISTANCE-TO-TRAVEL: ADMISSIONS & DEFAULTING

Distance-to-travel is one tool for assessing the impact on coverage distance of distance beneficiaries and program sites. Note that a limitation of distance-to-travel analyses is that it does not consider factors relevant to travelling such as means of transportation, quality of roads, geographical barriers, etc. Analyses show an inverse relationship between admissions and distance; the majority of admitted SAM cases reside nearby OTP sites which promotes accessibility and reduces opportunity cost.

QUALITATIVE DATA

Qualitative data was collected and triangulated by various sources and methods. Qualitative methods used included in-depth group discussions, semi-structured interviews, simple structured interviews, case studies and observations. These various methods helped uncover various boosters and barriers (positive and negative elements) that influence coverage and access. Interviews and discussions took place at various community and OTP sites across the intervention zone that were strategically selected to assure equal representation. Interview guides were adapted and oriented to facilitate the collection of data that was pertinent to program coverage and barriers to access. Finally, the investigation team also elaborated a list of local terminology employed when referring to malnutrition and ready-to-use therapeutic foods (RUTF);

All results were regularly categorized and organized in one of three categories in using the BBQ tool. Table 3 presents a legend of the different sources and methods used during the investigation.

6.1 Stage 1

Visit to the OTP sites

The survey teams were taken to Bahawalpur UC on the 10th of Feb for an orientation visit. Additional site visits were planned on a daily basis. Interviews were conducted at the OTP sites in both Intervention and Control Arms in February 2014. In-depth and semi-structured interviews were held with carers attending the OTP sites and with ACF program staff.

In-depth interviews with carers

Perception of **Nutrition**: Male and female carers interviewed mentioned that prior to the start of the CMAM program they did not perceive malnutrition as a disease and that they did not know it can result in death. The common health problems that children experienced were reported to be malaria, diarrhoea, cholera, vomiting, malnutrition, waterborne diseases, asthma and tuberculosis. The carers stated that the symptoms of malnutrition are weakness, fat belly and no growth of children, they call it *Sokhra* and *kanghi* in the local language. The parents and caregiver's prefer to take sick children to the nearby Government Health Facility due to free treatment.

Perception of CMAM program: Below are some highlights about the perception of CMAM program amongst the carers

- This program is a free of cost treatment program for weak, sick children and mothers.
- Volunteers and program staff visit households with a coloured tape for the identification of diseases in children and mothers. Most of the carers have heard about the program from volunteers, ACF staff and neighbours.
- Many weak children with this program get healthy.
- As the CMAM program for both the mother and the child several community elders suggested is the need for labour room services and one medical doctor at every OTP site.
- The community terms 'CMAM' as 'a site where the treatment of small weak children and mothers is provided'. They give chocolate in a soft sachet & biscuits (RUTF) to the sick and/or weak small children for treatment and give advice on feeding of mother milk to her sick small child.
- A positive perception reported was that the child gets cured by this program. A negative perception carers shared was that some religious leaders were saying that the 'food' (RUTF) could cause future impotency in children.
- The carers also knew that children defaulted due to migration and seasonal labour demand.
- Overall they reported that their experience was good with the service provided.

4.1.1.2. Key informant interview with community elders/leaders:

The community elders and religious leaders interviewed generally were aware about the CMAM program they were playing a positive role in promoting referrals for treatment. They suggest that honest and hardworking volunteers must be selected so that they will meet village leaders regularly. They suggested that the community is very poor and cannot afford transport expenses so the service should be provided in each village. One interviewee also suggested increasing number of centers or number of satellite sites. They also suggested expanding the scope of services to health facilities, including hygiene, livelihood and especially education which they felt a need for.

Please see Annex 2 for full details of qualitative analysis.

6.2 Stage 2:

A hypothesis was formulated on the basis of active CHWs increasing coverage. Unfortunately the hypothesis was not confirmed as the sample size was not reached.

6.3 Stage 3:

TABLE 4. List of barriers and boosters, control group; Dadu District, Sindh, Pakistan, March 2015.

Barriers	Source	Method	Ethnicity	Frequency
General lack of awareness of CMAM services (due to weaknesses in community outreach) (7.5, 4) Untrained and inactive CNVs, no MUAC Infrequent in community sensitization sessions in certain communities Lack of IEC materials for community sensitization No budget for NCMs to carry out CNV meetings	BFM, CNV, IYCF, MG, NCM, ON, RL, T, WG,	IGD, O, SSI	BL, RH, SD, UR	3, 3, 5, 5, 6, 6, 8, 8, 13, 15, 15, 25, 25, 25, 26, 26, 49, 53
RUTF non-medicinalized (5.5, 3) Adult consumption RUTF described as “chocolate” and “ice cream”	BFM, CL, CNV, MG, RL, WG	IGD, OBS, SSI	BL, SD	3, 3, 3, 5, 7, 8, 19, 25, 26, 25, 56
Misperception and confusion regarding malnutrition (3.5, 2) Traditional methods used to treat SAM Causes unknown: hepatitis, breastfeeding during pregnancy Blood-related diseases	BFM, CL, MG, RL, T, TH, WG	IGD, SSI	BL, SD, UR	3, 7, 8, 15, 15A, 16, 25, 25, 25
Stigmatization of malnutrition (3.5, 2) Poverty Shame	BF, ON, TH, WG	OBS, SSI	BL, SD	1, 13, 13, 16, 32, 62
Gender issues (5.5, 3) Women forbidden to leave the house unescorted Poor decisional authority of women Poor implication of men in children’s health issues Women unable to meet with male ACF Community Mobilizer for screening because he was male	CNV, MG, RL, WG	IGD, SSI	SD	5, 8, 25, 25, 26
Mistrust of INGO services in very localized situations (1.5, 1) Foreign aid is considered “haram”	MG, PM	CS, IGD	SD	25, 44A

Boosters	Source	Method	Ethnicity	Frequency
Baseline awareness of CMAM programming and SAM in certain communities (7.5, 4) Community sensitization activities and active screening	BFM, CNV, LHV, LHW, MG, ON, WG	CS, IGD, O, SSI	RH, SD	3, 3, 3, 5, 5, 5, 7A, 8, 8, 10, 10, 10, 10, 13, 16, 17, 19, 19, 25, 25, 26, 26, 38 54
Strong collaboration between government health agents and ACF staff (7.5, 4) Preparing for handover Government HA are trained in CMAM Strong referral mechanism (for vaccination)	CNV, IYCF, ON, SUP,	O, SSI	SD	5, 9, 13, 13, 13, 41, 58
Positive opinion of CMAM program (caregivers & community members) (9.5, 5) Treatment is effective Willingness to follow treatment (motivated in part by FSL vouchers) Cost-free	BF, CNV, LHV, LHW, MG, MO, ON, RL	CS, O, IGD, SSI	BL, RH, SD	1, 1, 1, 5, 5, 5, 8, 10, 10, 13, 13, 25, 25, 36, 36, 57
Positive opinion about, (and recognized efficacy of) RUTF (7.5, 4) Children enjoy RUTF	BF, CNV, LHW, ON, WG	IGD, SSI	BL, RH, SD	1, 5, 10, 13, 26
Strong community outreach and communication (7.5, 4) Monthly meetings with active CNVs in each UC CNV-NCM coordination Active screening activities	NCM, CNV, LHW	SSI, O	SD	5, 5, 6, 6, 13, 50
Robust routine programming data (5.5, 3) Proper registering and quality documentation	ON	O, SSI	SD	13, 13, 58, 58, 58,

Restricted access to family planning options by males (7.5, 4) Oral contraception is thought to be unhealthy for women Oral contraception can 'disturb' ladies' figures	MG, PM, WG	CS, IGD	SD	25, 44A
HR issues (7.5, 4) Phase out Staff shuffling Closing of some OTPs Closing of SC	CNV, NCM, ON, SUP	CS, SSI	BL, RH, SD	6,5,13,13, 13, 32, 41
Therapeutic itinerary (3.5, 2) Traditional methods used in the treatment of SAM (1) Home- based treatment, (2) traditional healer, (3) OTP nurse	BFM, LHW ON, FB, WG	CS, IGD, SSI	BL, SD	1, 3, 3, 6, 10, 13, 26, 26
Geographical barriers, distance and opportunity costs (5.5, 3) OTP Domestic obligations Reference refusal to SC	CNV, NCM, ON, WG	CS, IGD, SSI	BL, SD	5, 6, 6, 13, 13, 26, 32

Good quality of care in the OTP clinics (7.5, 4) Short wait time Polite Warm welcome MMT & folic acid supplements IEC material Good communication in local language Crowd control Referrals for vaccination Strong anthropometry Daily stock registered Default follow up Clean storage	NCM, ON	O, SSI	BL, SD	13, 50, 58, 58, 58
Peer-to-peer referrals and sensitization (7.5, 4) Colostrum	BF, WG	IGD, SSI	BL, SD	1, 1, 26
Bi-weekly RUTF rationing during harvest season or for beneficiaries living far from OTP sites (7.5, 4) Subsequent low default rates	IYCF, ON	CS, SSI	BL, SD	13, 35

TABLE 5. List of barriers and boosters, control group; Dadu District, Sindh, Pakistan, March 2015.

Barriers	Source	Method	Ethnicity	Frequency
No knowledge about CMAM programe	TBA,CBO,IM AM,CL,LHW	SSI,IGD,SSI	SD,SK	16,20,8,7,10
Stigmatization Poverty Shame	TBA,IMAM, MEN,F BEN,WG	SSI,IGD,	SD, SK	16,8,25,1,26
Poor outreach	Men teacher,BFM ,CBO	IGD, SSI,IGD	Sk, SD	25,15,19,20, 56
CFV (favouritism)	OBS	IGD	SK	56

Boosters	Source	Method	Ethnicity	Frequen cy
Some awareness (low level) of programme	WG,IMAM,C NV,TH,CL,TB A	SSI	SD, SK	8, 8,16,19, 7,7,7,25 ,15,5,26
Outreach activities	BFM,WG	IGD,	SK	19,26,
CFV	MEN	IGD	SK	25,25
Cnv,s are active (CNv well trained)	TBA,MEN,M. BNF,BNF,CN V	SSI,IGD	SK,BL	16,25,2, 1,5,5

RUTF recognised as chocolate	MEN,teacher ,BFM,TH	IGD, SSI	SK,SD	25,25,15,	Awareness about programme Modalities (No sharing of RUTF)	CL,TEACHER, BNF,M.BNF, CBO,WG,ME N	SSI,IGD,OBS	SK,SD	7,15,19, 16,2,2,1 ,4,26,46
Lack of transport(Cost of travel)	CI,IMAM,CNV,M.BNF,WG ,M.BNF,	SSI,IGD	SK,SD,BL	7,8,2,5,2,6,9, 2	Positive opinion about programme	CL,BNF,M.B NF,M.O,CNV, WG	SSI,IGD	SD,BL,SK	7,1,2,12 ,5,5,26, 2,
CNVS are not active (MUAC tape taken back)	BFM,CNV,W G	IGD,OBS	SD	19,48,5,26	Strong referral mechanism (peer referral, CNV,MtMSG)	CNV,M.BNF, F.BNF,M.O,IY CF,MBNF		SD,BL,SK	5,2,2,1, 12,9,9,2
Lack of communication between staff and CNv	TBA, TAECHER,W G, IYCF	SSI,IGD	SK	16, 15,26,9	Quality service at OTP site (strong anthropometry measurement,consultation,noting,motivation to follow treatment, despite barriers like distance	M.BNF, IYCF	OBS,SSI	BL	53,2,53
Lack of awareness about programme modalities	IMAM	SSI	SD	8					
Distance	CNV, BNF,IYCF, M.BNF	SSI	SK	5,2,9,2					
Labour Demand	IYCF	SSI	BL,SK	9					

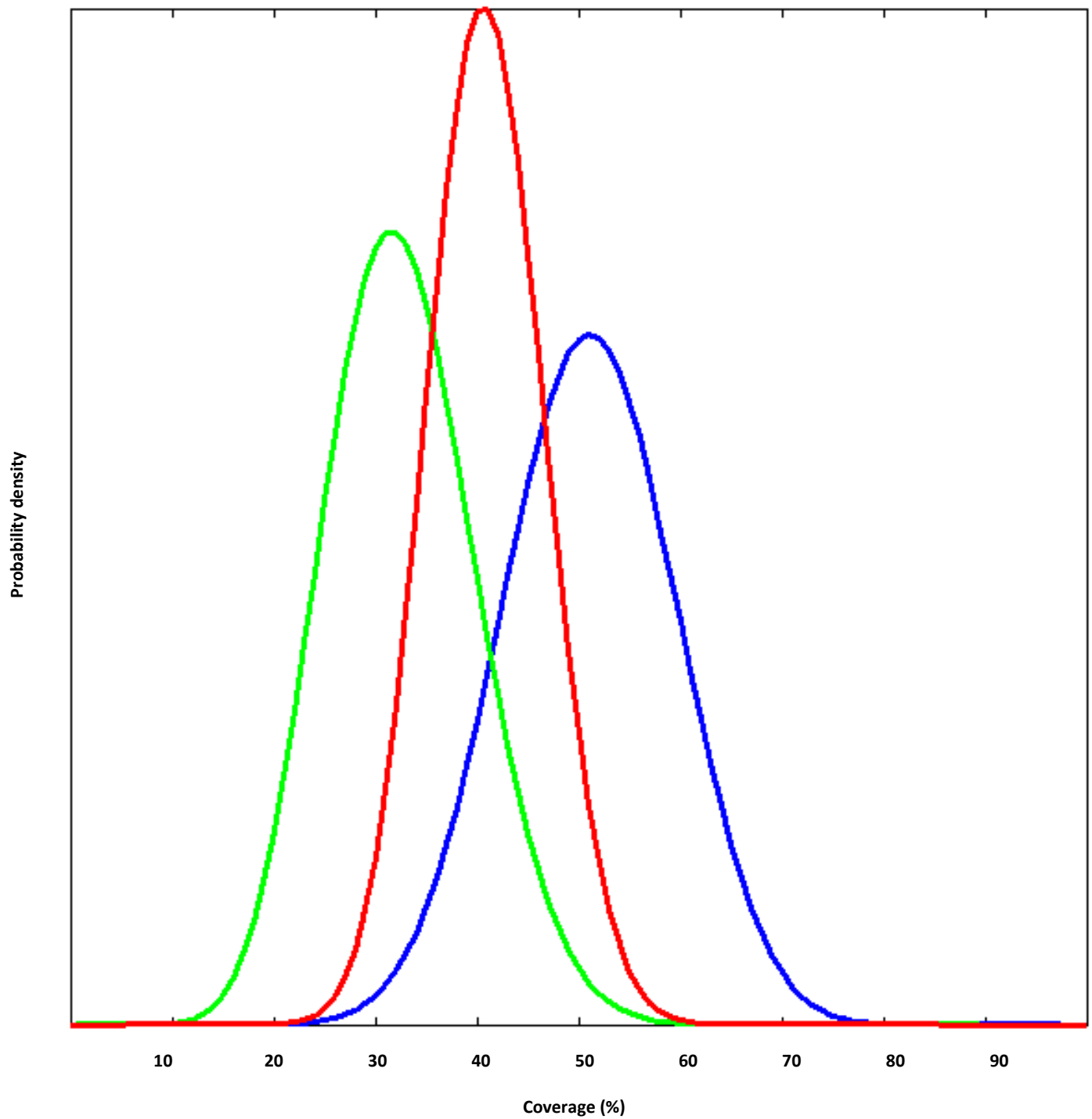
TABLE 6. Prior Formulation; Dadu District, Sindh, Pakistan, March 2015.

Tool	Barrier	Booster	Calculation	Result
Control cluster				
Weighted BBQ	$\sum_{\text{Barriers}} 51\%$	$\sum_{\text{Boosters}} 67.5\%$	$Coverage = \frac{(100\% - 51\%) + (0\% + 67.5\%)}{2}$	58.3%
Simple BBQ	10	9	$Coverage = \frac{[100\% - (10 \times 10\%)] + [0\% + (9 \times 10\%)]}{2}$	45.0%
Concept map	23	19	$Coverage = \frac{[100\% - (23 \times 4\%)] + [0\% + (19 \times 4\%)]}{2}$	42.0%
Histogram prior				56.0%
SQUEAC 2014				53.1%
Prior				50.9%
Intervention cluster				
Weighted BBQ	$\sum_{\text{Barriers}} 42\%$	$\sum_{\text{Boosters}} 51\%$	$Coverage = \frac{(100\% - 42\%) + (0\% + 51\%)}{2}$	54.5%
Simple BBQ	11	8	$Coverage = \frac{[100\% - (11 \times 9\%)] + [0\% + (8 \times 9\%)]}{2}$	36.5%
Concept map	18	23	$Coverage = \frac{[100\% - (18 \times 4\%)] + [0\% + (23 \times 4\%)]}{2}$	60.0%
Histogram prior				50.0%
SQUEAC 2014				53.1%
Prior				50.8%

TABLE 7. Results from active and adaptive case finding

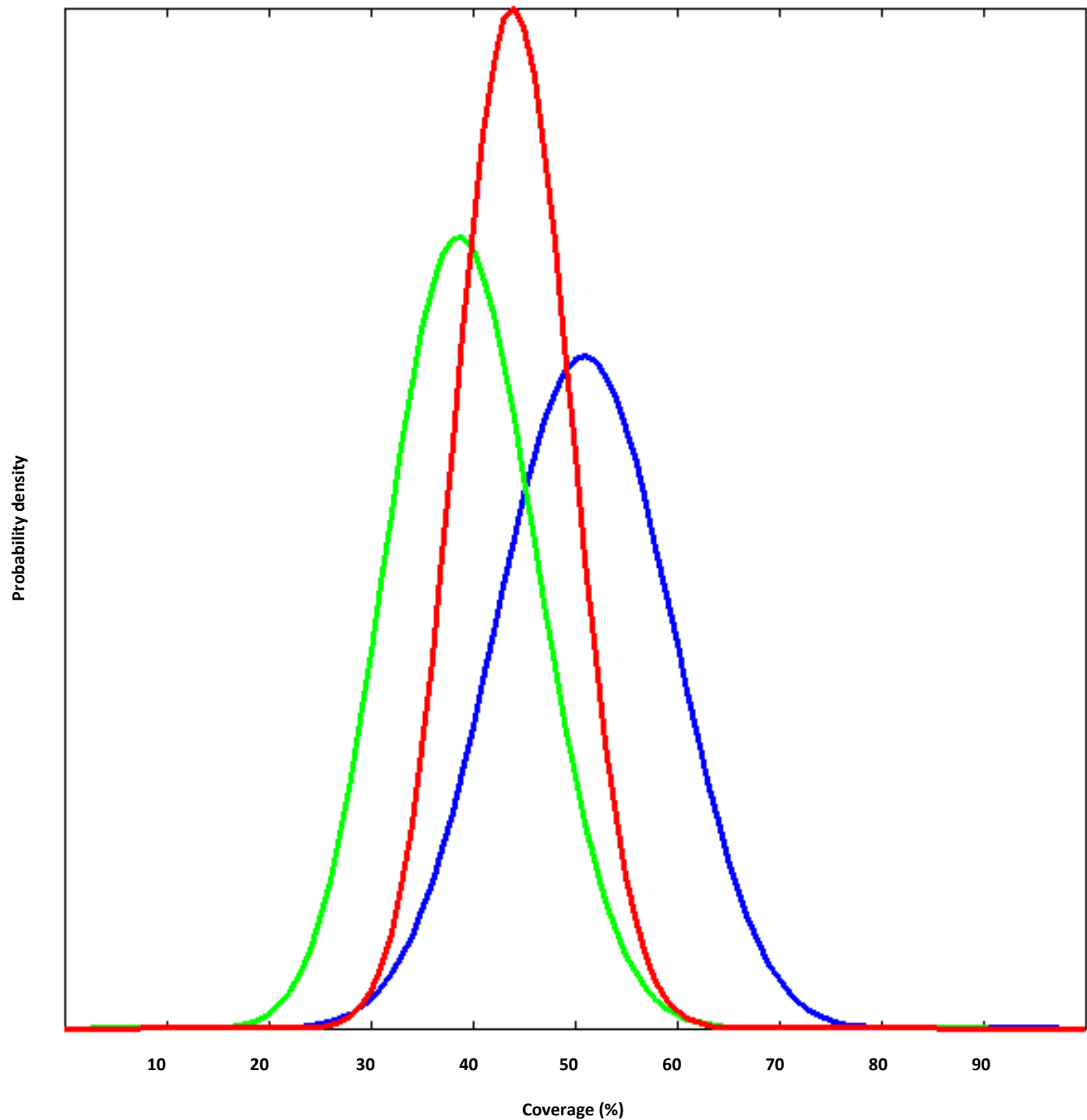
Results	Dadu
Control cluster	
C _{in} : SAM cases in-program	10
C _{out} : SAM cases not in-program	23
R _{in} : recovering cases in-program	7
R _{out} : recovering cases not in-program	4
Intervention cluster	
C _{in} : SAM cases in-program	9
C _{out} : SAM cases not in-program	24
R _{in} : recovering cases in-program	3
R _{out} : recovering cases not in-program	2

TABLE 8. Beta-binomial conjugate analysis, Intervention; Dadu District, Sindh, Pakistan, March 2015.



— Prior probability distribution = Beta (17.81; 17.18), Mode = 50.9%
— Likelihood survey = Binomial (12; 38), Mode = 31,6%
— Posterior probability distribution, mode = 40,6.% (95% CI $\approx$ 29.9%; 52.2%)
Z-test : $z = 1.67$, $p = 0.0958$

TABLE 9. Beta-binomial conjugate analysis, Control; Dadu District, Sindh, Pakistan, March 2015.



— Prior probability distribution = Beta (17.78; 17.22), Mode = 50.8%
— Likelihood survey = Binomial (17; 44), Mode = 38.6%
— Posterior probability distribution, mode = 43.9% (95% CI ≈ 33.2%; 55.2%)
Z-test : z = 1.07, p = 0.2829

FIGURE 5. Distance to Health Centers; Dadu District, Sindh, Pakistan, March 2015.

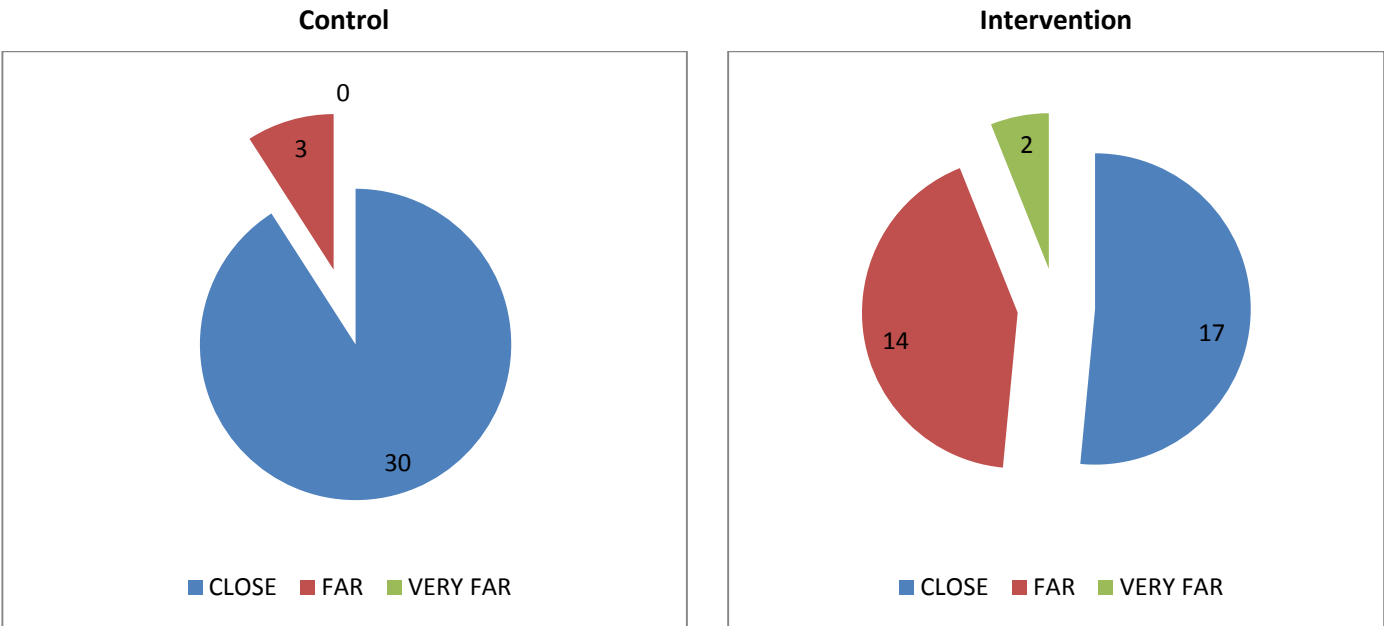


Figure 5 demonstrates that, according to caregivers’ perception of distance from their home village to the health center, more care givers live further from HCs in the intervention arm than in the control arm.

FIGURE 6. Ethnic Group Composition; Dadu District, Sindh, Pakistan, March 2015.

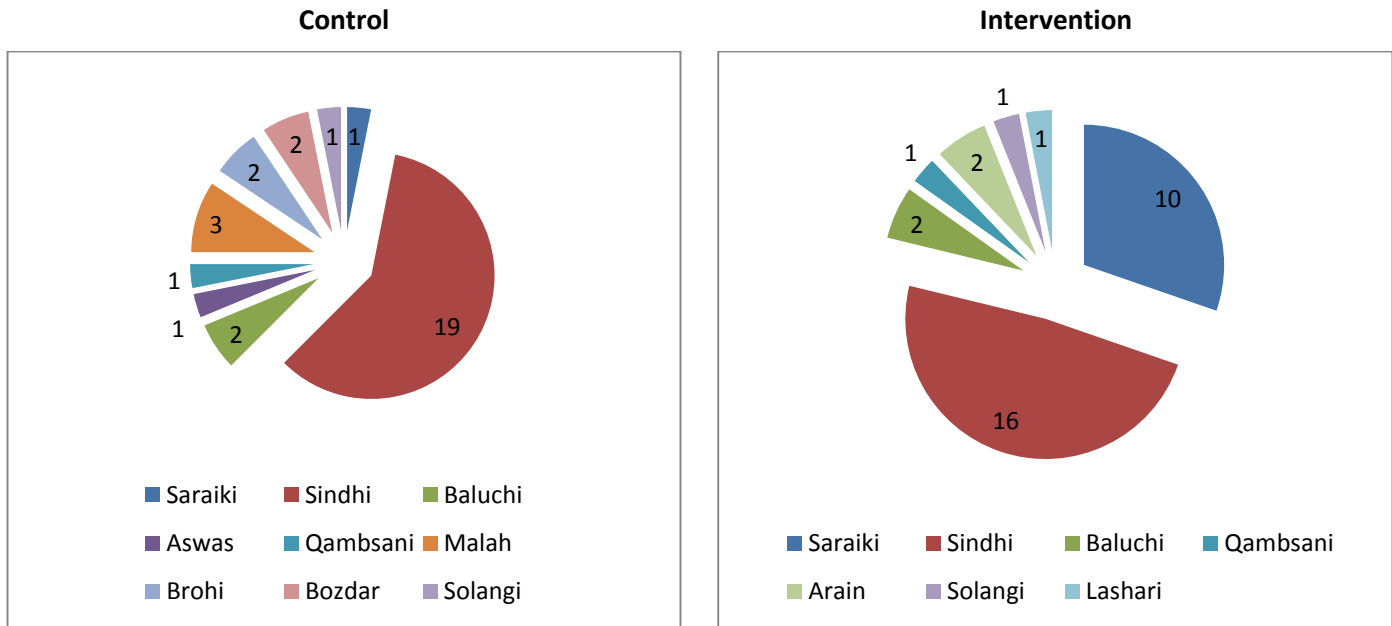


Figure 6 demonstrates that ethnic group composition is relatively homogeneous between the two survey arms.

FIGURE 7. Sam cases not in-program, Control, Sindh, Pakistan, March 2015.

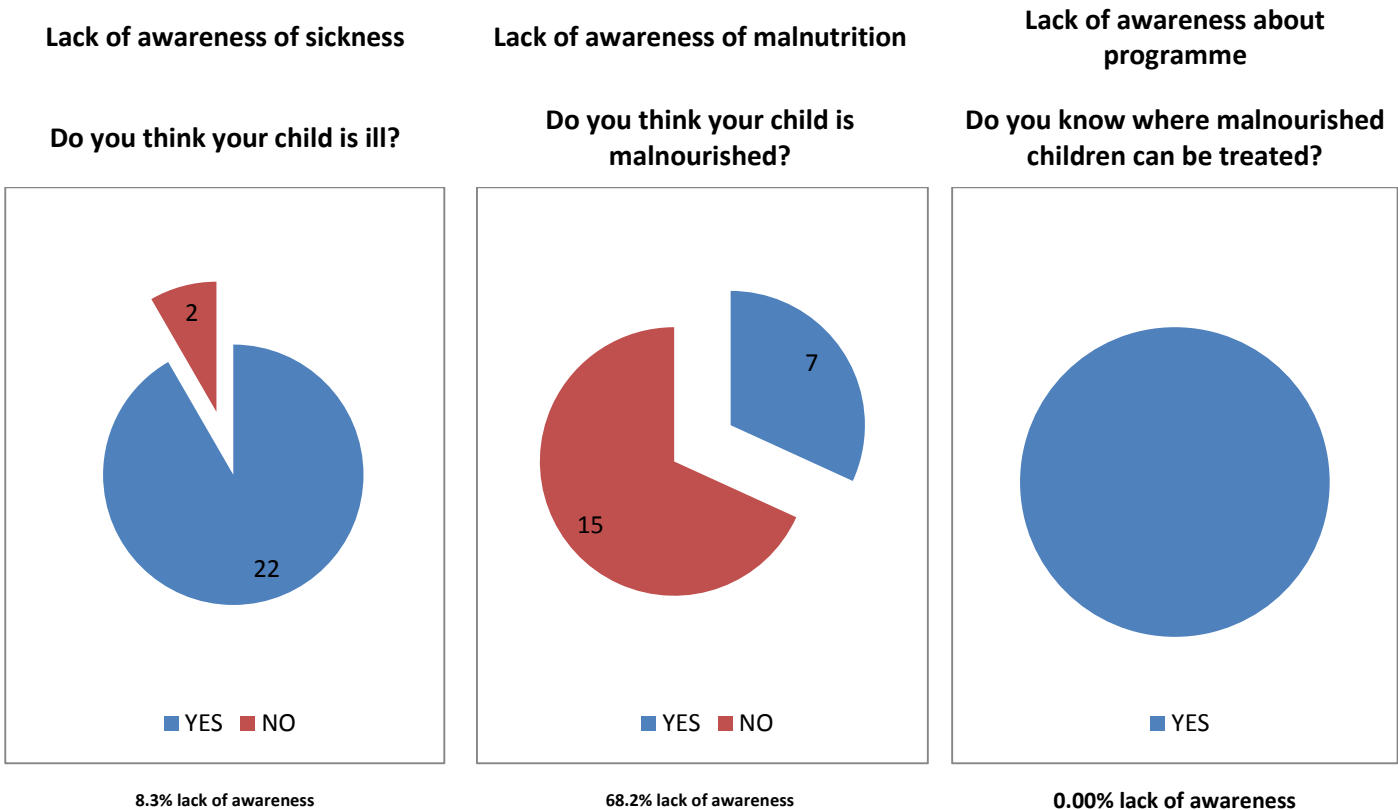
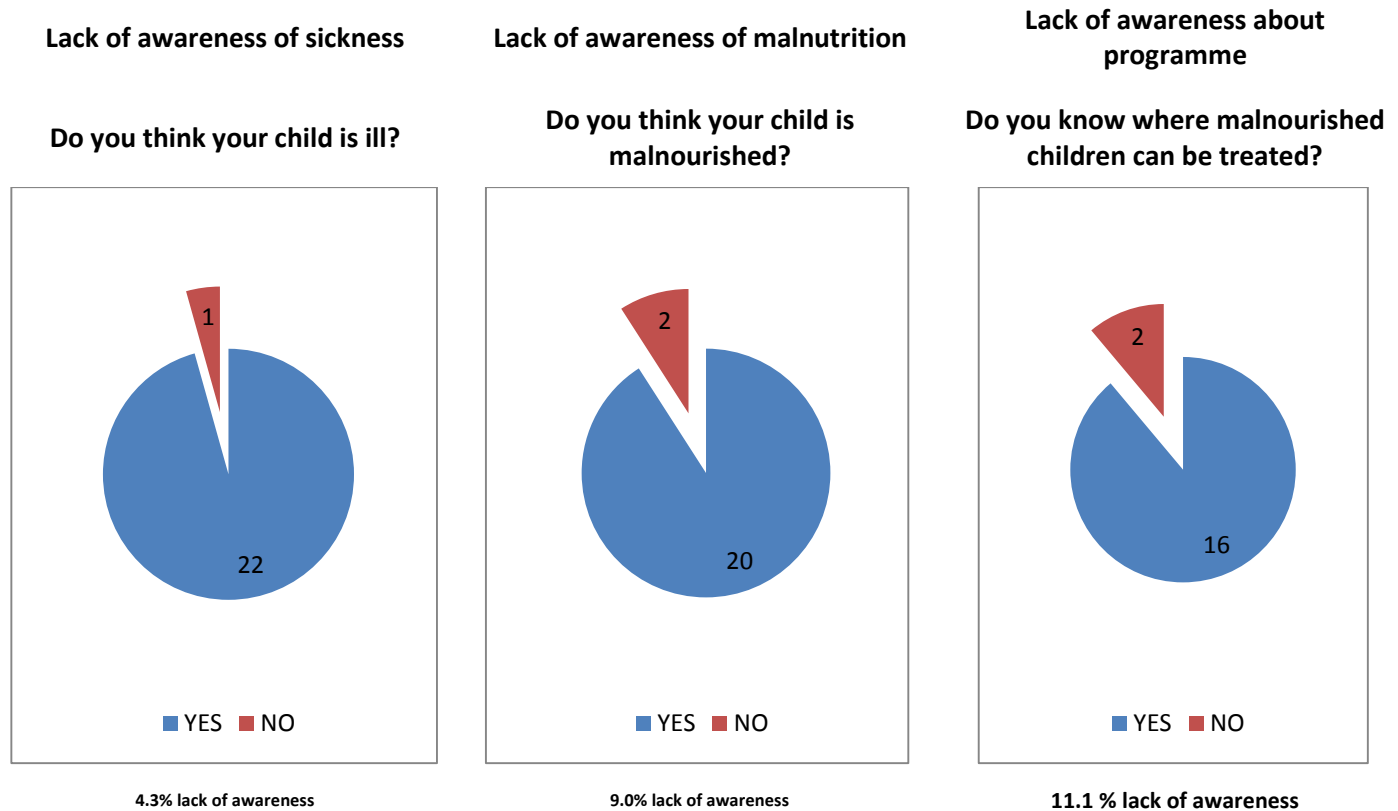


FIGURE 8. Sam cases not in-program, Intervention, Sindh, Pakistan, March 2015.



*Huge difference in awareness about malnutrition in the intervention arm versus control arm, which doesn't really make sense seeing as ACF had been working in the control arm for a while (and these people should have been sensitized); however, the control arm has better awareness about the program.

FIGURE 10. Sam cases not in-program, Intervention, Sindh, Pakistan, March 2015.

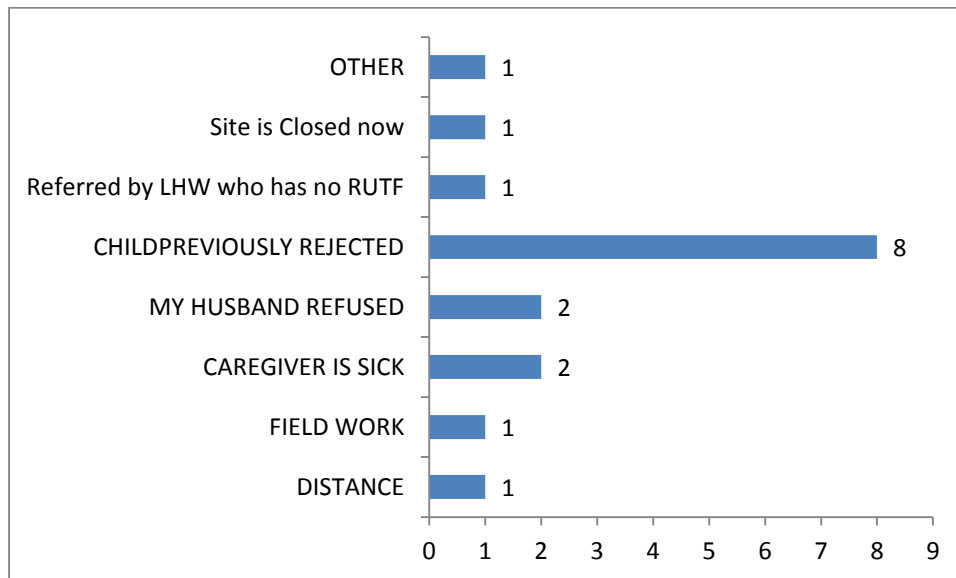
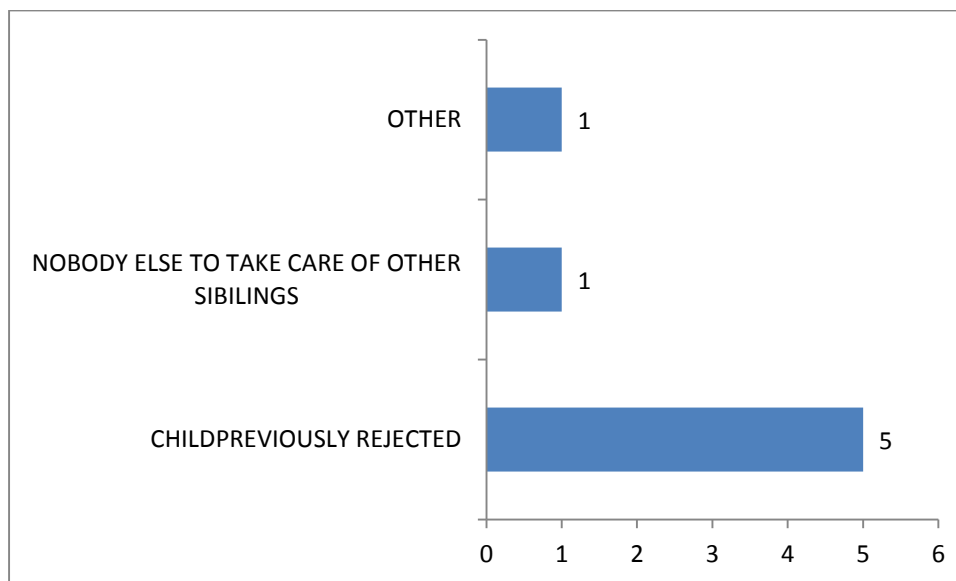


FIGURE 11. Sam cases not in-program, Control, Sindh, Pakistan, March 2015.



7. Annexes

Annex 1: METHODOLOGY

SQUEAC approach is used which consist of a set of tools each of which is designed to identify and investigate coverage and factors influencing coverage. It uses Semi-Quantitative data which is a mixture of quantitative (numerical) and qualitative data as listed below:

Routine monitoring data such as charts of trend of admissions, exits, recovery, as well as in-program data for defaulting are collected. Also, data that are already collected on beneficiary record cards such as admission MUACs and home villages of the program beneficiaries are included.

Use of data from the nutritional anthropometric surveys to estimate SAM in villages.

Use small studies, and small area surveys to confirm or deny hypothesis about program coverage that arise from analysis of program and qualitative data.

Use Bayesian techniques to estimate overall program coverage with a small sample survey.

Use of informal group discussions, case studies, simple structured interviews with carers, qualitative data collected using informal group discussions and interviews with carers, community elders, religious leaders, Traditional Birth Attendants (TBAs), Community Based Volunteers (CBVs), Lady Health Visitors/ Workers (LHV/W) and private medical practioners.

Calendar of events data obtained from the informal group discussions with variety of informants to inform the trends in seasons, labour demands, climate conditions, diseases and hunger gaps are done.

The process of SQUEAC can be described as investigative, iterative, innovative, interactive, intelligent, informal and in the community process¹³. Information collected is done continuously from various sources and methods using technique of triangulation by source and method and sampling to redundancy¹⁴. The SQUEAC method is broken down into a two stage screening test model thus:

Stage 1: Identified areas of low and high coverage as well as reasons for coverage failure using routine program data. Also, qualitative information was collected through informal group discussions and simple structured interviews. This was done mainly through visits to the OTP sites to get information from program staff, carers, CBVs and community members. The information obtained was analyzed into barriers, boosters and questions. The information obtained from the respondents was triangulated by source and method to validate the findings.

Stage 2: Confirmed the location of areas of high and low coverage and the reasons for coverage failure identified in stage 1 through using small studies, small area surveys and case studies. The barriers and boosters as well as reasons for coverage failure were identified. Barriers boosters developed in stage 1 were also weighed to determine their possible impact on program access and uptake. This was developed into belief of what the program coverage would likely be in the light of the available information. Prior probability is determined at this stage.

triangulated by source and method. The barriers and boosters were ranked in a series of analysis to develop a prior for the Stage 3 survey.

3.3 Stage 3: Bayesian techniques were used to estimate overall program coverage with a small sample survey². Statistical analysis was done using the Bayes SQUEAC software.

Annex 2: QUALITATIVE INVESTIGATION

INTERVIEW GUIDE: TRADITIONAL HEALERS, TRADITIONAL BIRTH ATTENDANTS, STREET MEDICINE SELLERS

PERSONAL PROFILE

- What is your role in the community?
- How long have you been practicing this activity?
- How have you learnt it?
- Do you have any apprentices?
- How often are you consulted?
- Do you collaborate with other THs/TBAs? Why? Why not?
- Do you collaborate with health centres? Why? Why not?
- Is there any difference between your treatment and others?

If yes, what difference?

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: Traditional Birth Attendant, Date: 14-03-2015

She conducts deliveries in this community since 20 years. She learnt it by herself. She collaborates with other TBAs as well. She refers her patients to health centres if any of her case gets complicated. She conducts deliveries in an easy way because she gives others medicines as well to her patients.

Date:14-03-2015 UC: Kande chuke Vill: Baid (TH)

Ans: I have diploma in Nursing from Hyderabad & providing treatment of minor diseases from last 5 years, and as community is poor, so I suggest them to go to health centre for free treatment, THs and TBAs are consulted by near hospital staff.

Date:14-03-2015 UC: Kakar Vill: Boriri (TBA)

Maternal help of community from 10-12 years, I just deal with deliveries so it's different from other THs.

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad Arain (TBA)

Maternal help in community from 7 years, No collaboration with other THs TBAs.

COMMUNITY PROFILE

Feeding practices

- What staples are available in your community?
- Is there any food, which community members cannot eat?

If yes, what? Why?

- Is there any food, which women cannot eat when they are pregnant/breastfeeding?

If yes, what? Why?

- Is there any food, which children cannot eat?

If yes, what? Why? At what age?

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: Traditional Birth Attendant, Date: 14-03-2015

Green vegetables are available in this community. They don't eat sheep meat as it is forbidden according to their religious beliefs. Pregnant/breastfeeding women cannot eat vegetables, rice, cold water, berries as it will cause them stomach pain. There is no such food which children cannot eat.

Date:14-03-2015 UC: Kande chuke Vill: Baid

Poor community can't access to meat products, they take vegetables, milk products(home made),Rice & pulses, pregnant women have to take same food not different from family members, they can eat any available food in their income range.

Date:14-03-2015 UC: Kakar Vill: Boriri (TBA)

Vegetables, Everyone can eat everything, only children are not giving EGG because it is not food causing skin problems

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad Arain (TBA)

Pulses, Vegetables Mostly potatoes, pregnant women eat fish sometime or milk, children eat KHEER(mix of rice and milk) after 5-6 months of age, No such food which not giving to children

Breastfeeding / weaning

- Do women breastfeed their children?

If yes, until what age? How often?

- Do they give babies the first milk (« colostrum »)? Why? Why not?
- Do they give babies other types of food/drink?

If yes, what? At what age? Why?

- Do they experience any problems when breastfeeding?

If yes, which? Why?

- Do they come to you to be treated?
- Do they breastfeed children when pregnant? Why? Why not?
- Do you advise women on breastfeeding practices?

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: Traditional Birth Attendant, Date: 14-03-2015

Women breastfeed their children till 2 years of age. But in case if she gets pregnant again then she will stop breast feeding her child. They give colostrum to their baby because it is good for them. They give buffalo milk to child after 21 days of his/her birth. They experience problems while breastfeeding. Such patients come to her but she refers them to the nearest health facility. They don't breastfeed while being pregnant as it will cause the new baby to be low weight.

Date:14-03-2015 UC: Kande chuke Vill: Baid

Aware about colostrum importance and are given to children, Women breast feed their children up to 2 years, but stop at any age when again pregnant, Children below 7-8 months are giving semi solid food 'KHEER' (made by Rice milk) 3 or 5 time a day, After 4 months complementary feeding starting. some lactating women facing difficulties like decrease in milk production and weakness in mothers, but they did not go for this treatment because its normal, can recover again in some time.

Date:14-03-2015 UC: Kakar Vill: Boriri (TBA)

Yes breast feed their children, After 6 months complementary feeding starting with (KHEER and Biscuits), Mothers weak in community that's why in pregnancy anaemia can occur. colostrum is consider powerful milk

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad Arain (TBA)

Yes breast feed their children, complementary food after 6 months, Many women start breast feeding from initial milk colostrums', a little of community don't do this, KHEER are given to child after 6 months.

Pregnancy / Childbirth

- What care do women receive when they are pregnant?
- Who advises them during the pregnancy? Why? How?
- Do they experience any difficulties during the pregnancy?

If yes, which? Why? What do they do to remedy them?

- What role do fathers play during the pregnancy?
- Do you think their role is sufficient? Why? Why not?
- Where do women give birth? Why?
- Who accompanies them? Why?

- Would they like to give birth elsewhere/differently? Where? How?
- Which care do they receive after giving birth? Why?

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: Traditional Birth Attendant, Date: 14-03-2015

Pregnant women don't receive care. TBA advises mother in laws to take care of them. During pregnancy they experience weakness and headache. They don't use any remedies and consider it normal during pregnancy. Fathers take them to doctor if there is any complication. Most women give birth at their home and those who are financially sound they give birth in Hospitals. While giving birth at home, TBA, husband and mother accompany them. They would like to give birth at private hospitals because they are treated well there. After birth the care they receive is getting rest and have good food like chicken and fish.

Date:14-03-2015 UC: Kande chuke Vill: Baid

Just decrease work load on them, no special care by husbands because they are mostly out of houses, in pregnancy most common problem is pain in body (stomach, belly) and anaemia, delivery recommended in home but if complicated then prefer hospitals, After delivery received care (rest, no work) for next 30 to 40 days.

Date:14-03-2015 UC: Kakar Vill: Boriri (TBA)

Check-up by doctor with company of mother in Law, Special food for her when pregnant, decrease work load i think it is sufficient, delivery take place in home some tome hospitals, After giving birth mother in law prepared make some special food for her.

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad Arain (TBA)

Decrease workload, rest, check-up by health practitioners, increase food quantity and quality as well, delivery take place in home or with TBAs, mother in law handle all delivery related situation, not big role of husbands.

CHILDHOOD DISEASES& MALNUTRITION

Childhood diseases

- Which childhood diseases are most frequent in your community?
- In which months are they prevalent?
- How do you treat them?

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: Traditional Birth Attendant, Date: 14-03-2015

The most frequent childhood diseases in this community are diarrhoea and dehydration. It prevails in the months of June and July. They treat it with ORS and then go to doctor immediately.

Date:14-03-2015 UC: Kande chuke Vill: Baid

Malaria, Diarrhoea common in hot season from Jun-Oct months, bring hospital nearby for treatment.

Date:14-03-2015 UC: Kakar Vill: Boriri (TBA)

Fever, Flu, Diarrhoea (June to august).Honey is used for prevention or doctor when complicated medical treatment required.

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad Arain (TBA)

Malaria, Kangi, Fever, Diarrhoea (1st home treatment or take children to THs or near hospitals)

Malnutrition

(show images of marasmus / kwashiorkor)

- Are there children in your community who look like this?

If yes, which type is more frequent?

- Is it a disease like others? Why? Why not?
- Which local terms are used to describe it?
- How is it perceived in the community? Why?
- Is it a « new » disease?

If yes, since when? Why do you think this disease appeared in your community?

- Do you think that this disease is stigmatised? Why?
- How does this stigmatisation mark people's behaviour and/or community relationships?
- What are symptoms of this disease?
- What are its causes?
- What are its effects?
- Do you treat this disease?

If yes, how?

- Do you know any other treatments of this disease?

If yes, which?

- In which time of the year do children develop this disease most frequently?

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: Traditional Birth Attendant, Date: 14-03-2015

They have seen marasmus type in their community. Its not a disease like others because it is due to their mothers are careless in taking care of their children. They believe, if a pregnant women sees a human dead body then her child will born mal-nourished. They treat such malnourished children by putting him/her on one side of the scale and put slippers/shoes etc on the other side. This disease is stigmatised and community regard such parents as careless parents. Its symptoms is weakness. It is caused by improper diet and will affect child's health. She don't treat this disease.

Date:14-03-2015 UC: Kande chuke Vill: Baid

Yes this is 'KANGI' it is common from last 6 years, children weight loss in this condition, imbalance food, poverty, more children under-5 are main causes, people having child like that I think not ashamed, I can't treat but referred them to city hospitals for treatment, in summer this diseases became common due to high risk of diarrhoea.

Date:14-03-2015 UC: Kakar Vill: Boriri (TBA)

No, it is weakness in children named as (Sukhal), causes are not enough food, poverty, blood related disease etc, community hate child malnourished means stigmatized. No I can't treat this disease, it is possible in big health centres like Karachi.

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad Arain (TBA)

Yes, this is 'KANGI' it is common from many years, children weight is last in this condition, imbalance food, poverty,, I can't treat this diseases, it occurs in month of June, July and August.

AWARENESS OF CMAM PROGRAMME

- Have you heard about CMAM programme?

If yes, from whom? What did you hear?

- Do you hear about CMAM programme often? How often?
- Do you know which children are targeted by the programme?
- Do you know which treatment they receive?
- What do you think about this treatment?
- How is it perceived in the community? Why?
- What do you think about CMAM programme?
- How is it perceived in the community? Why?
- Are there any obstacles/barriers to the use of this programme?

If yes, explain.

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: Traditional Birth Attendant, Date: 14-03-2015

She have never heard about CMAM program.

Date:14-03-2015 UC: Kande chuke Vill: Baid

Yes, many times by CHW of NGO and educated peoples, they came here to measure weak children below 5 years. malnourished children receiving supplements in shape of chocolates, very familiar here Its good treat this disease by supplements, I don't know about any rejection or abandoned children.

Date:14-03-2015 UC: Kakar Vill: Boriri (TBA)

Yes (chocolate program), I saw many children under treatment by this program children eating chocolates, community like program and children are growing up by chocolates, No barriers.

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad Arain (TBA)

Yes I know this program for weak children treatment by chocolates,I attend meeting with this program staff, people like this program,

COVERAGE / REJECTION / DEFAULTING

- Are there many children in your community who benefit from CMAM programme?
- Do you know other children in your community who need this service?

If yes, why aren't they in the programme?

- Do you know any children who were rejected? Why?
- Do you know any children who abandoned the treatment? Why?

If yes, how could we motivate them to return?

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: Traditional Birth Attendant, Date: 14-03-2015

There is no one in this community who benefited from this program.

Date:14-03-2015 UC: Kande chuke Vill: Baid

Yes many children are already cured, and other who need are in program and community need this service because it is free.

Date:14-03-2015 UC: Kakar Vill: Boriri (TBA)

Yes many children are getting treatment,many others need but rejected cause not meet criteria.

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad Arain (TBA)

Yes,All community is very poor need this program,some children reffered by me were rejected by OTP site staff that admission are stop. I don't know about abandoned children in community.

SENSITISATION&SCREENING

- Who sensitises the community? How often? On what subjects?
- Do you assist in sensitisation sessions? Why? Why not?
- What do you think of those sessions? Are they interesting? Boring? Why?
- What do you think of the information shared? Is it useful? Not useful? Why?
- Do you think the sensitisation is sufficient? Why? Why not?

- How should it be reinforced?
- Are there people in your community who measure children?
- If yes, who? How often? How?

Answers:

Date:14-03-2015 UC: Kande chuke Vill: Baid

CHW- on Hygiene, Malnutrition etc, I also attend many time it is very useful because people are unaware of basic things about children health. CHW were measuring children 3 months ago.

Date:14-03-2015 UC: Kakar Vill: Boriri (TBA)

People came from NGO, subjects is health, Yes it is very useful information shared by them

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad Arain (TBA)

ACF team delivered sessions long ago, It was useful, They also measured children 5 months ago , , and I also taking MUAC of children

INTERVIEW GUIDE: HEALTH PERSONNEL, OTP NURSE, SUPERVISOR, MEASURER, IYCF, CM

PERSONAL PROFILE

- What is your role at the health centre?
- Since when have you been working in this role?
- How do you feel in your role? Why?
- Have you been given training?

If yes, when? How many times?

- Are you satisfied with the level of training provided? Why? Why not?
- Are you supervised? Does anyone follow up on your activities?

If yes, who? How? How often?

- Do you collaborate with other people/health centres integrated in the programme?

If yes, with whom? How? Why? When? How often?

Answers:

UC: Mitho Babar, Village: Gul Muhammad Chandio, Source: IYCF Promoter, Date: 17-03-2015

Her roles are admission of patients, conducting sessions and outreach in the community. She has been doing this from last 19 months. She has been trained twice and satisfied from the level of training. She has been supervised by a supervisor. She collaborates with female medical officer three days a week.

UC: KandiChukhi, Village: BHU Baid, Source: IYCF Promoter, Date: 17-03-2015

She is working here as IYCF promoter since August 2013. Her roles are conducting sessions and outreach in the community. She has been trained three times and satisfied from the level of training. She has been supervised by a supervisor.

UC: Kakar, Village: Kakar, Source: IYCF Promoter, Date: 16-03-2015

She is working in this role as IYCF promoter since August 2013. She has been trained three times and satisfied from the level of training. She has been supervised. She also collaborates with Doctor, LHW and all other staff of Government Dispensary.

UC: Kakar, Village: Kakar, Source: OTP Nurse, Date: 16-03-2015

She is working in this role as OTP nurse since August 2013. She monitors activities at the OTP site. She has been trained two times and satisfied from the level of training. She has been supervised. She also collaborates with Medical officers, dispenser and LHWs.

UC: Baid, Village: Baid, Source: Female Medical Officer, Date: 16-03-2015

She is working in this role as FMO since 2011. She consults patients and runs OPD. She has received trainings and satisfied from the level of training.

COMMUNITY PROFILE

- What are main challenges of the community where you work?
- Do they have impact on the health of the community?

If yes, explain.

Childhood diseases

- What are most frequent childhood diseases in the community where you work?
- In which months are they prevalent?
- Which therapeutic itineraries are available in the community where you work? Which are most frequent? Why?

Answers:

UC: Mitho Babar, Village: Gul Muhammad Chandio, Source: IYCF Promoter, Date: 17-03-2015

Main challenges in this community are poor hygiene practices which causes diarrhoea and other diseases. Common childhood diseases are ARI and diarrhoea which mostly arises in June and July,

UC: KandiChukhi, Village: BHU Baid, Source: IYCF Promoter, Date: 17-03-2015

Main challenges in this community are malnutrition and diarrhoea. Common childhood diseases are ARI and diarrhoea which mostly arises in autumn season.

UC: Kakar, Village: Kakar, Source: IYCF Promoter, Date: 16-03-2015

No main challenges in this community. Common childhood diseases are diarrhoea, chest infection and fever which mostly arises in June and July.

UC: Kakar, Village: Kakar, Source: OTP Nurse, Date: 16-03-2015

No main challenges in this community. Common childhood diseases are diarrhoea, malnutrition and vomiting which mostly arises in June and July.

UC: Baid, Village: Baid, Source: Female Medical Officer, Date: 16-03-2015

No main challenges in this community. Common childhood diseases are diarrhoea, skin problems and pneumonia which mostly arises in April.

Malnutrition

- Which local terms depicting the malnutrition are used in the community where you work?

- How is it perceived? Why?
- Is it a « new » disease?
- What are main causes of this disease in the community where you work?
- Do community members understand its symptoms, causes and effects?

If yes, how do they describe them?

- Which therapeutic itineraries for the malnutrition are available in the community where you work? Which are most frequent? Why?
- Do you think that this condition is stigmatised? Why?
- How does this stigmatisation mark people's behaviour or community relationships?

Answers:

UC: Mitho Babar, Village: Gul Muhammad Chandio, Ethnic Group: Saraiki, Source: IYCF Promoter, Date: 17-03-2015

The call malnutrition as Kangi and sokharo. They perceive it as a disease and needs to be treated. It is not a new disease here. Its causes are lack of food and poverty. Community can understand its symptoms and so they bring their malnourished children to the OTP site.

UC: KandiChukhi, Village: BHU Baid, Ethnic Group: Sindhi, Source: IYCF Promoter, Date: 17-03-2015

The call malnutrition as sokharo. It is not a new disease here. It is caused by low intake of food, bottled feeding and improper diet. Community can understand its symptoms.

UC: Kakar, Village: Kakar, Ethnic Group: Sindhi, Source: IYCF Promoter, Date: 16-03-2015

The call malnutrition as Kangi. It is not a new disease here. It is caused by poverty and lack of proper food. Community can understand its symptoms as weak and thin child.

UC: Kakar, Village: Kakar, Source: OTP Nurse, Date: 16-03-2015

The call malnutrition as kamzor, Kangi and nighraynatho. It is not a new disease here. It is caused due to poverty. Community know very little about its symptoms.

UC: Baid, Village: Baid, Source: Female Medical Officer, Date: 16-03-2015

The call malnutrition as Kangi. It is not a new disease here. It is caused by improper feeding, poverty and iron deficiency. Community mostly consults with traditional healers for this.

Sensitisation

- Who is responsible for the sensitisation of the community where you work?
- Do these people sensitise the community on the malnutrition?

If yes, how often?

- Do you know which subjects are addressed?
- Who is targeted by the sensitisation on the malnutrition?
- What other people should be targeted by these sensitisation activities? Why?
- Are you involved in sensitisation sessions?

If yes, why? How? How often?

If no, why not?

- Who should actively participate in the sensitisation on the malnutrition? Why?
- Is the sensitisation sufficient? Why? Why not?
- What would you change to improve the quality of sensitisation?

Answers:

UC: Mitho Babar, Village: Gul Muhammad Chandio, Ethnic Group: Saraiki, Source: IYCF Promoter, Date: 17-03-2015

OTP staff, MTMSG and CNVs are responsible for sensitisation in this community. OTP staff does it twice a week and CNV does it twice a month. They mostly address PLWs in their sessions. Other influential people like IMAMs and teachers should also be part of these sessions. These sessions can be more improved including more MTMSGs and TBAs.

UC: KandiChukhi, Village: BHU Baid, Ethnic Group: Sindhi, Source: IYCF Promoter, Date: 17-03-2015

Whole team is responsible for sensitisation in this community. OTP staff does it once a week. They mostly address PLWs in their sessions. Other stakeholders should also be part of these sessions. These sessions can be more improved by conducting more sessions at community level.

UC: Kakar, Village: Kakar, Ethnic Group: Sindhi, Source: IYCF Promoter, Date: 16-03-2015

IYCF promoter is responsible for sensitisation in this community. She do it on daily basis. She mostly targets breast feeding mothers in their sessions. Community leader and Imam should also be part of these sessions.

UC: Kakar, Village: Kakar, Source: OTP Nurse, Date: 16-03-2015

All ACF team is responsible for sensitisation in this community. They mostly address parents, caretakers, mothers and teachers. These sessions can be more improved by conducting more trainings and more IEC material.

UC: Baid, Village: Baid, Source: Female Medical Officer, Date: 16-03-2015

CNVs and ACF team is responsible for sensitisation in this community.

Screening

- Are there people in the community where you work who identify malnourished children?

If yes, who? How? How often?

- What do you think of their work? Why?
- Who should be included in this activity? Why?

Answers:

UC: Mitho Babar, Village: Gul Muhammad Chandio, Ethnic Group: Saraiki, Source: IYCF Promoter, Date: 17-03-2015

There are other people in this community who can identify malnourished children. They receive their referrals. LHWs and TBAs should also be included as they are locals.

UC: KandiChukhi, Village: BHU Baid, Ethnic Group: Sindhi, Source: IYCF Promoter, Date: 17-03-2015

Some MTMSG members and PLWs are in this community who can identify malnourished children. Community leader and teachers should also be included.

UC: Kakar, Village: Kakar, Ethnic Group: Sindhi, Source: IYCF Promoter, Date: 16-03-2015

There are other people in this community who can identify malnourished children like LHWs, CNVs, MTMSGs and TBAs. They receive their referrals and their work is good.

UC: Kakar, Village: Kakar, Source: OTP Nurse, Date: 16-03-2015

There are other people in this community who can identify malnourished children like CNVs and community groups. They are trained on referral mechanism.

UC: Baid, Village: Baid, Source: Female Medical Officer, Date: 16-03-2015

CNVs and health staff can also identify malnourished children in this community.

QUALITY OF CMAM PROGRAMME

- Do you perform systematic screening on all children who come for a consultation?

If not, why not?

- What kind of referral (CHW, auto-referral, peer referral, etc.) is most frequent? Why?
- How is screening & referral by CHWs organised?
- Who follows up on children referred by CHWs?

If no follow up is done, explain.

- How do you refer children to ITC?
- Who follows up on children referred to ITC?

If no follow up is done, explain.

- Who makes a decision to admit a child into the programme? According to what criteria?
- Do you experience any difficulties related to admissions?

If yes, what kind of difficulties?

- Do you reject children referred by CHWs or other community actors?

If yes, why? How many %?

- Who fills in the registers and/or monitoring forms?
- Do you experience any difficulties in this respect?

If yes, explain.

- How many times per month do you update the registers?
- Do children in this community abandon the treatment?

If yes, why? How many %? Which ethnic group?

- Who follows up on defaulting children? How?

If no follow up is done, explain.

- How could we motivate them to return?
- Do you experience stock breakouts?

If yes, which products are concerned? Why? What does it imply?

- Do you organise sensitisation sessions for carers of malnourished children in the programme?

If yes, how? How often? With which tools?

If no, why not?

Answers:

UC: Mitho Babar, Village: Gul Muhammad Chandio, Ethnic Group: Saraiki, Source: IYCF Promoter, Date: 17-03-2015

They perform systematic screening and they mostly receive referrals from their CNVs as they are quite active. OTP staff and CNVs both follow up on referrals of CHWs. CM follows up on children who are referred to ITC. OTP nurse decides about the admission of a child in the program. The criteria being followed is MUAC less than 115mm of children aged between 6 to 59 months of age. 2 to 3 percent of referrals are rejected due to incorrect MUAC taken by CHWs. Registers and monitoring forms are filled by OTP nurse and IYCF promoter. Register is updated on daily basis. CM follows up on defaulter tracing. They organise sensitisation sessions at community level and OTP sites with IEC material.

UC: Kandi Chukhi, Village: BHU Baid, Ethnic Group: Sindhi, Source: IYCF Promoter, Date: 17-03-2015

They perform screening and they mostly receive peer referrals. ACF staff follows up on referrals of CHWs. ACF team follows up on children who are referred to ITC. OTP nurse takes the decision about the admission of a child in the program. The criteria being followed is MUAC less than 115mm of children aged between 6 to 59 months of age. None of referrals are rejected. Registers and monitoring forms are filled by IYCF promoter and OTP nurse. Register is updated on daily basis. CM follows up on defaulter tracing. A few Balochi people have abandoned the treatment which can be sensitised again. They have experienced stock breakout before. They organise sensitisation sessions at OTP site with IEC material.

UC: Kakar, Village: Kakar, Ethnic Group: Sindhi, Source: IYCF Promoter, Date: 16-03-2015

They perform systematic screening. OTP nurse follows up on referrals of CHWs. OTP nurse takes the decision about the admission of a child in the program. None of referrals are rejected. Registers and monitoring forms are filled by OTP nurse. Register is updated on weekly basis. She organises sensitisation sessions at OTP.

UC: Kakar, Village: Kakar, Source: OTP Nurse, Date: 16-03-2015

They screen every child for early identification of malnutrition. They mostly receive peer referrals. OTP nurse follows up on referrals of CHWs. OTP nurse decides about the admission of a child in the program. There are some cases when she rejected few CHW referrals as they were out of our criteria. Registers are filled by OTP nurse. Register is updated mostly on daily basis. Outreach team follows up on defaulter tracing. They organise sensitisation/IYCF sessions daily.

UC: Baid, Village: Baid, Source: Female Medical Officer, Date: 16-03-2015

(FMO) She has seen ACF staff while screening.

PERCEPTION OF CMAM PROGRAMME

- What do you think about CMAM programme?
- What are its strengths/weaknesses?
- What would you change to improve its quality?
- How is it perceived in the community? Why?
- Are there any obstacles/barriers for the use of this service?

If yes, explain.

Answers:

UC: Mitho Babar, Village: Gul Muhammad Chandio, Ethnic Group: Saraiki, Source: IYCF Promoter, Date: 17-03-2015

Its perception is good. In order to improve the quality of the program, HR should be increased. Community also thinks very positive about this program. SFP program should be launched here.

UC: KandiChukhi, Village: BHU Baid, Ethnic Group: Sindhi, Source: IYCF Promoter, Date: 17-03-2015

Perception about this program is good. In order to improve the quality of the program, supply breakouts should be avoided. Community also thinks positive about this program.

UC: Kakar, Village: Kakar, Ethnic Group: Sindhi, Source: IYCF Promoter, Date: 16-03-2015

Perception about this program is good and requesting to continue this program. No weakness in this program.

UC: Kakar, Village: Kakar, Source: OTP Nurse, Date: 16-03-2015

Perception about this program is good. Its strengths are transparency and no compromise on protocols. Its weakness is limited HR.

UC: Baid, Village: Baid, Source: Female Medical Officer, Date: 16-03-2015

Perception about this program is good.

INTERVIEW GUIDE: COMMUNITY MEMBERS (WOMEN) BREAST FEEDING MOTHERS

PERSONAL & COMMUNITY PROFILE

Responsibilities

- What are your usual daily activities?
- Do you have any other, less regular responsibilities (week/month)?
- Does someone help you?

If yes, who? How?

- What do other family members do?

Answers:

UC: Gozo, Village: Panjani Chandio, Ethnic Group: Sindhi, Source: Breast Feeding Mothers, Date: 14-03-2015

Their usual daily activities are embroidery and stitching cloths. Other family members do farming, labour and teaching.

13-05-2015 UC ; Mitho Babar, Village ; Kathia, Ethnic Group ; Sindhi & Siraiki ,

Routine homework, no special activities. Get helping hands of mother in law, daughters n husband also.

13-05-2015 UC ; KAKar, Village ; Kakar, Ethnic Group ; Sindhi,

She is a house wife and don't have any other special or less regular activities. Family members are helping her often in hose works. Faming is familys source of income.

15-03-2015 UC ; Kolachi, Village ; Haji Qaim Khoso ; Ethnic Group ; Balochi

House wife with no other special activities, while family work is labour.

14-03-2015 UC ; Kandi Chuki , Village Jumo Shaikh, Ethnic Group ; Sindhi shaikh,

Simple housewife activities with handy craft work, and family males are farmers.

14-03-2015 UC ; kandi chuki , Village ; Baid, Ethnic Group ; Jamali

Housewife, no special responsibilities, and family men are farmers.

15-03-2015 UC ; Mitho Babar , Villlage ; Dur Muhammad Lakhair , Ethnic Group ; Saraiki

Cooking & Cleaning of house and other day to day work, family members also help in work.

Feeding practices

- What staples are available/eaten in your household? Why?
- Is there any food, which you or other family members cannot eat?

If yes, what? Why?

- Is there any food, which you cannot eat when you are pregnant/breastfeeding?

If yes, what? Why?

- Is there any food, which your children cannot eat?

If yes, what? Why?At what age?

- How many meals do you eat per day in your household? Why?
- How are meals shared among all members in your household? Why?

Answers:

UC: Gozo, Village: Panjani Chandio, Ethnic Group: Sindhi, Source: Breast Feeding Mothers, Date: 14-03-2015

The staples being eaten here are flour, milk and vegetables. During pregnancy they cannot eat cabbage and eggs. They eat 3 to 4 meals per day.

13-05-2015 UC ; Mitho Babar, Village ; Kathia, Ethnic Group ; Sindhi & Siraiki ,

Vegetables are very common food. Pulses are not likely to be eaten regularly due to babies and meal is mostly taken two times a day.

13-05-2015 UC ; Kakar, Village ; Kakar, Ethnic Group ; Sindhi,

Vegetables are mostly eaten in house. There is no food specifically which they can't eat even in pregnancy. 3 times per day meal is taken, and eat together.

15-03-2015 UC ; Kolachi, Village ; Haji Qaim Khoso ; Ethnic Group ; Balochi

Rice and vegetables are most commonly used. And there is no such food which they cannot eat. Two times a day meals are eaten together within family.

14-03-2015 UC ; Kandi Chuki , Village Jumo Shaikh, Ethnic Group ; Sindhi shaikh,

Pulses & Vegetables are common, there is no such food which one cannot eat, 3 meals are eaten a day and are shared among family members.

14-03-2015 UC ; kandi chuki , Village ; Baid, Ethnic Group ; Jamali

Vegetables are common and there is no such food which one cant eat, and 3 times a day meal is shred and eaten.

15-03-2015 UC ; Mitho Babar , Villlage ; Dur Muhammad Lakhair , Ethnic Group ; Saraiki

Vegetables, wheat and rice are common foods, there is no such food which one cant eat, and three times a day meal is shared and eaten.

Breastfeeding / weaning

- Do you breastfeed your children?

If yes, until what age? How often?

- Do you give your babies the first milk (« colostrum »)? Why? Why not?
- Do you give your babies other types of food/drink?

If yes, which? At what age? Why?

- Do you breastfeed children when pregnant? Why? Why not?
- Who advises you on breastfeeding practices?
- Do you share your experience with other mothers in the community? When? Where? Why?

UC: Gozo, Village: Panjani Chandio, Ethnic Group: Sindhi, Source: Breast Feeding Mothers, Date: 14-03-2015

They breastfeed their children till 18 months of age. They give colostrum to their babies. They give their babies other type of food after 6 months of age. They breastfeed children during pregnancy. Their mothers advises them on breastfeeding practices.

13-05-2015 UC ; Mitho Babar, Village ; Kathia, Ethnic Group ; Sindhi & Siraiki ,

Breast feeding id carried almost for 3 years, including first milk also. And are advised by mother in law or mother.

13-05-2015 UC ; Kakar, Village ; Kakar, Ethnic Group ; Sindhi,

Breastfeeding is carried on for two years from start of first milk. After some months biscuits n soft fruits are also given to babies.

15-03-2015 UC ; Kolachi, Village ; Haji Qaim Khoso ; Ethnic Group ; Balochi

Breast feeding is carried on for 2 years including colostrum, also the baby is given cow milk as food, and do not breast feed on advise of mother in law.

14-03-2015 UC ; Kandi Chuki , Village Jumo Shaikh, Ethnic Group ; Sindhi shaikh,

B/F carried on for 2 years including colostrum, B/F is also carried on during pregnancy and get advised from doctor and also shares with other mothers.

14-03-2015 UC ; kandi chuki , Village ; Baid, Ethnic Group ; Jamali

For almost two years B/F is carried on and do not B/F during pregnancy.

15-03-2015 UC ; Mitho Babar , Villlage ; Dur Muhammad Lakhair , Ethnic Group ; Saraiki

Breast feeding is started from colostrum and continued for two years 8 times a day even in pregnancy and got advised from doctor and also shares with mothers.

Pregnancy / Childbirth

- What care do you receive when you are pregnant?
- Who advises you during the pregnancy? Why? How?
- Do you experience any difficulties during the pregnancy?

If yes, which? Why? What do you do to remedy them?

- What role do fathers play during the pregnancy?
- Do you think their role is sufficient? Why? Why not?
- What change would you like to see in this respect? Why?
- Where do you give birth? Why?
- Who accompanies you? Why?
- Would you like to give birth elsewhere/differently? Where? How?
- What care do you receive after giving birth? Why?

Answers:

UC: Gozo, Village: Panjani Chandio, Ethnic Group: Sindhi, Source: Breast Feeding Mothers, Date: 14-03-2015

They receive care from mother in law and husband while being pregnant. TBA advises them during pregnancy. They experience weakness and vomiting during pregnancy for which they consult doctor. They give birth at home.

13-05-2015 UC ; Mitho Babar, Village ; Kathia, Ethnic Group ; Sindhi & Siraiki ,

Visiting doctor when feeling ill, and commonly advised by TBA and LHWs, giving birth is preferred at hospitals, after birth with good food is taken care.

13-05-2015 UC ; Kakar, Village ; Kakar, Ethnic Group ; Sindhi,

Monthly checkups are carried on,, also advised from mothers, financially supported by husband. Hospital is preferred for giving birth to a baby

15-03-2015 UC ; Kolachi, Village ; Haji Qaim Khoso ; Ethnic Group ; Balochi

Monthly check-ups and medicines are taken, and are commonly advised by doctor and mothers, and are taken by husbands to the hospitals. Giving birth at hospitals is preferred and after birth good food is taken as care.

14-03-2015 UC ; Kandi Chuki , Village Jumo Shaikh, Ethnic Group ; Sindhi shaikh,

Proper food & Rest , visits to doctor for check-up, fever is a problem during pregnancy and giving birth at hospital is preferred .

14-03-2015 UC ; kandi chuki , Village ; Baid, Ethnic Group ; Jamali

With regular check-ups and with proper food. Husband is supportive n takes care, preferred birth at hospital,

15-03-2015 UC ; Mitho Babar , Village ; Dur Muhammad Lakhair , Ethnic Group ; Saraiki

In pregnancy work load is decreased, regularly visits to doctor, and fever n weakness are a kind of difficulties, husband takes care with good food n follow ups with doctor, and hospital is always preferred for bith.

Family planning

- Do you have sexual contact with your husband when pregnant? Why? Why not?
- Do you have sexual contact with your husband after giving birth?

If yes, after what time?

- Do you wish to get pregnant after giving birth? Why? Why not?
- Does your husband wish that you get pregnant after giving birth? Why? Why not?
- Do you know means of contraception?

If yes, which?

- Do you use them? Why? Why not?

Answers:

UC: Gozo, Village: Panjani Chandio, Ethnic Group: Sindhi, Source: Breast Feeding Mothers, Date: 14-03-2015

They have sexual contact with husband during first 6 months of pregnancy and after birth they do sexual after 40 days. They don't wish get pregnant after giving birth. They know and also use means of contraception like pills and condoms.

13-05-2015 UC ; Mitho Babar, Village ; Kathia, Ethnic Group ; Sindhi & Siraiki ,

Sex is carried on till 9 months and after 1 month of birth, do not wish to be pregnant after birth due to poverty and are aware about family planning pills and injections but do not use.

13-05-2015 UC ; Kakar, Village ; Kakar, Ethnic Group ; Sindhi

15-03-2015 UC ; Kolachi, Village ; Haji Qaim Khoso ; Ethnic Group ; Balochi

Do have sexual contact during pregnancy because of husband, and after one month of birth, and do not wish to get pregnant again, while know about condoms & pills but do not use them.

14-03-2015 UC ; Kandi Chuki , Village Jumo Shaikh, Ethnic Group ; Sindhi shaikh,

Till six months sex is normal. And 1 month after birth. Don't like to be pregnant now, don't use family planning procedures.

14-03-2015 UC ; kandi chuki , Village ; Baid, Ethnic Group ; Jamali

Know about family planning but do not use ,, do not have sex after birth ,, usually do sex till six months.

15-03-2015 UC ; Mitho Babar , Village ; Dur Muhammad Lakhair , Ethnic Group ; Siraiki

carry on sex after 40 days of birth, don't use any family planning material.

Childhood diseases

- Which childhood diseases are most frequent in your community? Why?
- Which therapeutic itineraries do you use to treat these diseases? Why?

Answers:

UC: Gozo, Village: Panjani Chandio, Ethnic Group: Sindhi, Source: Breast Feeding Mothers, Date: 14-03-2015

Childhood diseases like cough and fever are common here for which they consult doctor.

13-05-2015 UC ; Mitho Babar, Village ; Kathia, Ethnic Group ; Sindhi & Siraiki ,

Diarrhea and vomiting are common and go to doctor for treatment.

13-05-2015 UC ; Kakar, Village ; Kakar, Ethnic Group ; Sindhi

Some skin infections , cough and fever are very common in children. Treated by doctor usually.

15-03-2015 UC ; Kolachi, Village ; Haji Qaim Khoso ; Ethnic Group ; Balochi

Common diseases are chest infections and fever & Cough, and taken to hospitals for treatment.

14-03-2015 UC ; Kandi Chuki , Village Jumo Shaikh, Ethnic Group ; Sindhi shaikh,

Fever and cough are common diseases of children and are treated in BHU

14-03-2015 UC ; kandi chuki , Village ; Baid, Ethnic Group ; Jamali

Diarrhea & Fever and taken to the BHU.

15-03-2015 UC ; Mitho Babar , Village ; Dur Muhammad Lakhair , Ethnic Group ; Siraiki

Cough & Fever are very common.

Malnutrition

(show images of marasmus / kwashiorkor)

- Are there children in your community which look like this?

If yes, which type is more frequent?

- Is it a disease like others? Why? Why not?
- Which local terms are used to describe it?
- How is it perceived in the community? Why?
- Is it a « new » disease?

If yes, since when? Why do you think this disease appeared in your community?

- Do you think that this disease is stigmatised? Why?
- How does this stigmatisation mark people's behaviour and/or community relationships?
- How do people describe its causes and symptoms?
- Which therapeutic itineraries are used to treat this disease? Why?

13-05-2015 UC ; Mitho Babar, Village ; Kathia, Ethnic Group ; Sindhi & Siraiki ,

There were weak children in the community and considered as dangerous disease named kangji, also it is perceived negatively. Symptoms are weakness and are treated by chocolates (RUTF).

13-05-2015 UC ; Kakar, Village ; Kakar, Ethnic Group ; Sindhi

Don't know about .

15-03-2015 UC ; Kolachi, Village ; Haji Qaim Khoso ; Ethnic Group ; Balochi

Don't know about malnutrition but weakness is a disease, and is perceived as negatively and taken to doctor for treatment. Yet is not considered as a new disease.

14-03-2015 UC ; Kandi Chuki , Village Jumo Shaikh, Ethnic Group ; Sindhi shaikh,

There are some weak children in community, and it's a disease, and is perceived seriously in community,, .

14-03-2015 UC ; kandi chuki , Village ; Baid, Ethnic Group ; Jamali

Know about child weakness, considered as a disease, and is perceived as due to poverty child cannot eat properly and remains weak, and is not a new disease, and take to the doctor.

15-03-2015 UC ; Mitho Babar , Village ; Dur Muhammad Lakhair , Ethnic Group ; Saraiki

Weakness and some child are weak, it is perceived as a disease and babies suffering from this are taken to the hospital.

AWARENESS OF CMAM PROGRAMME

- Have you heard about CMAM programme?

If yes, from whom? What did you hear?

- Do you hear about CMAM programme often? How often?
- Do you know which children are targeted by the programme?
- Do you know which treatment they receive?
- What do you think about this treatment?
- How is it perceived in the community? Why?
- What do you think about CMAM programme?
- How is it perceived in the community? Why?
- Are there any obstacles/barriers to the use of this programme?

If yes, explain.

Answers:

13-05-2015 UC ; Mitho Babar, Village ; Kathia, Ethnic Group ; Sindhi & Siraiki ,

Aware of CMAM because team had screened weak children from 6 to 59 months and is considered as good because of treatment of weak children.

13-05-2015 UC ; Kakar, Village ; Kakar, Ethnic Group ; Sindhi

Don't know about

15-03-2015 UC ; Kolachi, Village ; Haji Qaim Khoso ; Ethnic Group ; Balochi

Knows about CMAM that they treat weak children by chocolates, and is liked in community because its free.

14-03-2015 UC ; Kandi Chuki , Village Jumo Shaikh, Ethnic Group ; Sindhi shaikh,

Knew about CMAM due to ACF team, as they treat weak children with chocolate and is taken as good because of treatment of weakness.

14-03-2015 UC ; kandi chuki , Village ; Baid, Ethnic Group ; Jamali

Weak children are treated by chocolate and is good because due to this children life are saved.

15-03-2015 UC ; Mitho Babar , Villlage ; Dur Muhammad Lakhair , Ethnic Group ; Saraiki

Aware of CMAM due to acf team, as they are treating weak children of age till 5 years by chocolates, and its good because its helping and free.

COVERAGE / REJECTION / DEFAULTING

- Are there many children in your community who benefit from CMAM programme?
- Do you know other children in your community who are in need of this service?

If yes, why aren't they in the programme?

- Do you know any children who were rejected? Why?
- Do you know any children who abandoned the treatment? Why?
- How could we motivate them to return?

Answers:

13-05-2015 UC ; Mitho Babar, Village ; Kathia, Ethnic Group ; Sindhi & Siraiki ,

Some children are having benefit from CMAM and are no rejections.

13-05-2015 UC ; Kakar, Village ; Kakar, Ethnic Group ; Sindhi

15-03-2015 UC ; Kolachi, Village ; Haji Qaim Khoso ; Ethnic Group ; Balochi

Many children are having benefit from programme there are no such rejections.

14-03-2015 UC ; Kandi Chuki , Village Jumo Shaikh, Ethnic Group ; Sindhi shaikh,

Many children benefit from CMAM and are properly visiting and are no rejections.

14-03-2015 UC ; kandi chuki , Village ; Baid, Ethnic Group ; Jamali

Some weak children are treated ,, don't know any other, and are no rejections at all.

15-03-2015 UC ; Mitho Babar , Villlage ; Dur Muhammad Lakhair , Ethnic Group ; Saraiki

Many children benefit from prog. And are no such rejections.

SENSITISATION&SCREENING

- Who sensitises the community? How often? On what subjects?
- Do you assist in sensitisation sessions? Why? Why not?
- What do you think of those sessions? Are they interesting? Boring? Why?
- What do you think of the information shared? Is it useful? Not useful? Why?
- Do you think the sensitisation is sufficient? Why? Why not?
- How should it be reinforced?

- Are there people in your community who measure children?
- If yes, who? How often? How?

Answers:

13-05-2015 UC ; Mitho Babar, Village ; Kathia, Ethnic Group ; Sindhi & Siraiki ,

Community mobilizer sensitize on malnutrition and sessions are taken as positive as they are useful, but are not sufficient , should be more often.

13-05-2015 UC ; Kakar, Village ; Kakar, Ethnic Group ; Sindhi

Are sensitized by LHWs ,, overall rating for sessions are high,, appreciated.

15-03-2015 UC ; Kolachi, Village ; Haji Qaim Khoso ; Ethnic Group ; Balochi

LHWs sensitizes community once in a month, and sessions are very good for us bcz information shared is very important for us, and should be more often.

14-03-2015 UC ; Kandi Chuki , Village Jumo Shaikh, Ethnic Group ; Sindhi shaikh,

Sensitization sessions are not very often , but the information shared is very usefull and should be shared more often.

14-03-2015 UC ; kandi chuki , Village ; Baid, Ethnic Group ; Jamali

Knows that sessions are carried out but didn't participated.

15-03-2015 UC ; Mitho Babar , Villlage ; Dur Muhammad Lakhair , Ethnic Group ; Saraiki
Don't know n never participated in sessions.

INTERVIEW GUIDE: COMMUNITY MEMBERS (MEN)

PERSONAL & COMMUNITY PROFILE

Responsibilities

- What are your usual daily activities?
- Do you have any other, less regular responsibilities (week / month)?

If yes, explain.

- Does someone help you?

If yes, who? How?

- What do other family members do?

Answers:

UC: Mitho Babar, Village: Gul Muhammad Chandio, Ethnic Group: Saraiki, Source: Community Members (Men), Date: 14-03-2015

Their usual daily activities are labour and farming. Females do their household chores at home.

UC: Kolachi, Village: Haji Qaim Khoso, Ethnic Group: Sindhi, Source: Community Members (Men), Date: 15-03-2015

Their usual daily activity is farming. Females do their household chores at home.

15-03-2015 UC; Kolachi, Villlage; Bego Tewano, Ethnic Group; Tewano, Source; Community Members (Men)

Daily Activities are farming, usually milking their buffellows and cows, family members are also helping.

Date:14-03-2015 UC: Kande chuke Vill: Jumo sheikh (Community Member-Men)

Farmer, Labour work on weekly or monthly bases on need base in city, brothers help me as we are in joint family system in one house.

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad Arain (Community Member-Men)

Labour, No one for help. other family members also labour and farmers

Feeding practices

- What staples are available/eaten in your household? Why?
- Is there any food, which you or other family members cannot eat?

If yes, what? Why?

- Is there any food, which women cannot eat when they are pregnant/breastfeeding?

If yes, what? Why?

- Is there any food, which children cannot eat?

If yes, what? Why? At what age?

- How many meals do you eat per day in your household? Why?
- How are meals shared among all members in your household? Why?

Answers:

UC: Mitho Babar, Village: Gul Muhammad Chandio, Ethnic Group: Saraiki, Source: Community Members (Men), Date: 14-03-2015

Mostly they eat vegetable which is easily available in their community. They take two meals a day.

UC: Kolachi, Village: Haji Qaim Khoso, Ethnic Group: Sindhi, Source: Community Members (Men), Date: 15-03-2015

Mostly they eat vegetable, chicken and rice. They take two meals a day.

15-03-2015 UC; Kolachi, Village; Bego Tewano, Ethnic Group; Tewano, Source; Community Members (Men)
Rice, Rice flour, sometimes chicken, and milk is common, and cannot eat expensive foods, don't know about women reservations for eating while in pregnancy, normally 3 times a day meals are eaten together with family members.

Date:14-03-2015 UC: Kande chuke Vill: Jumo sheikh (Community Member-Men)

Wheat, vegetables, Everyone can eat everything, Three full meals are eating/day but children eat several time according to their need, all meals are shared on one table for all.

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad Arain (Community Member-Men)

Rice, Pulses, vegetables, Everyone can eat everything, 3 meals in a day, but children eat several time according to their need, get together on one table all family eat,

Breastfeeding / weaning

- Do women breastfeed children?

If yes, until what age? How often?

- Do they give babies the first milk (« colostrum »)? Why? Why not?
- Do they give babies other types of food/drink?

If yes, what? At what age? Why?

- Do they experience any problems when breastfeeding?

If yes, which? Why?

- Do they breastfeed children when pregnant? Why? Why not?
- Who advises them on breastfeeding practices?

Answers:

UC: Mitho Babar, Village: Gul Muhammad Chandio, Ethnic Group: Saraiki, Source: Community Members (Men), Date: 14-03-2015

Women here breastfeed children till two years of age. They give colostrum to the babies. They give other food to the baby after 6 months of age. Mothers and elder women advises them on breastfeeding practices.

UC: Kolachi, Village: Haji Qaim Khoso, Ethnic Group: Sindhi, Source: Community Members (Men), Date: 15-03-2015

Women here breastfeed children till three years of age. They give colostrum to the babies. They don't breastfeed during pregnancy. Mothers advises them on breastfeeding practices.

15-03-2015 UC; Kolachi, Village; Bego Tewano, Ethnic Group; Tewano, Source; Community Members (Men)

Women breast feed from colostrum till 2 yrs five times a day if she is not sick, and for first seven days from birth some pain is observed while breastfeeding, and breast feeding is continued for 3 months if pregnant due to concern about health, and usually are advised from mothers n mother in law.

Date:14-03-2015 UC: Kande chuke Vill: Jumo sheikh (Community Member-Men)

Yes breastfeeding is common up to two years, after 4-5 months complementary feeding start with KHEER up to 9 months, colostrums is giving by mothers in 1st hour after giving birth, yes mother facing BF problem as low secretion of milk due to low level of HB blood level. After pregnancy BF is stopped because breast feeding can affect next baby health. mother in law advise them for BF practices.

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad Arain (Community Member-Men)

Yes breastfeeding is common up to two years , colostrums is giving by mothers, children other food are **KHEER & Cerelac** after 6 months, Grandmother or Mother in law advise for BF related.pregnant women continue BF till 2nd trimester

Pregnancy / Childbirth

- What care do women receive when they are pregnant?
- Who advises them during the pregnancy? Why? How?
- Do they experience any difficulties during the pregnancy?

If yes, which? Why? What do they do to remedy them?

- What role do you play during the pregnancy?
- Do you think your role is sufficient? Why? Why not?
- Where do women give birth? Why?
- Who accompany them? Why?
- Would they like to give birth elsewhere/differently? Where? How?
- Which care do they receive after giving birth? Why?

Answers:

UC: Mitho Babar, Village: Gul Muhammad Chandio, Ethnic Group: Saraiki, Source: Community Members (Men), Date: 14-03-2015

Women don't receive any care while being pregnant. TBAs advises them during pregnancy. They support financially when their females are pregnant. Women give birth at their own village if it's a normal case. In case of any complexity they go to cities. After birth they give mothers extra food.

UC: Kolachi, Village: Haji Qaim Khoso, Ethnic Group: Sindhi, Source: Community Members (Men), Date: 15-03-2015

Women receive care while being pregnant. They go to hospital for regular medical check-up. Mostly women give birth at hospitals. After birth women receive medicine and rest.

15-03-2015 UC; Kolachi, Village; Bego Tewano, Ethnic Group; Tewano, Source; Community Members (Men)

Taken good care, bad news are avoided, not allowed to work or cook, and are advised by mothers, and prefer home for delivery, and after birth taken care with ordinary medicine.

Date:14-03-2015 UC: Kande chuke Vill: Jumo sheikh (Community Member-Men)

Decrease work load on them, no special care by husbands because they are mostly out of houses, in pregnancy most common problem is pain in body (stomach, belly) and anaemia, delivery recommended in home but if complicated then prefer hospitals, After delivery received care (rest, no work) for next 30 to 40 days.

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad Arain (Community Member-Men)

No Special food for her when pregnant, decrease work load I think it is sufficient, delivery take place in home some time hospitals, After giving birth mother are advise by Mother in law to eat more food, my role is more than I am doing but I am busy in labour work.

Family planning

- Do you have sexual contact with your wife when she's pregnant? Why? Why not?
- Do you have sexual contact with your wife after giving birth?

If yes, after what time?

- Do you wish your wife to get pregnant after giving birth? Why? Why not?
- Does your wife wish to get pregnant after giving birth? Why? Why not?
- Do you know means of contraception?

If yes, which?

- Do you use them? Why? Why not?

Childhood diseases

- Which childhood diseases are the most frequent in your community? Why?
- What are causes of these diseases?
- Which therapeutic itineraries do you use? Why?

Answers:

UC: Mitho Babar, Village: Gul Muhammad Chandio, Ethnic Group: Saraiki, Source: Community Members (Men), Date: 14-03-2015

Childhood diseases here are fever and diarrhoea and it arises in summer season.

UC: Kolachi, Village: Haji Qaim Khoso, Ethnic Group: Sindhi, Source: Community Members (Men), Date: 15-03-2015

Childhood diseases here are fever and cough.

15-03-2015 UC; Kolachi, Village; Bego Tewano, Ethnic Group; Tewano, Source; Community Members (Men)

Sex is continued after 3 months in pregnancy and after 40 days of birth, and wish to get pregnant if want to have more children, but women want 3 year break, and injections are preferred for family planning.

Chest infections, cough, diarrhea and fever are common during hot season.

Date:14-03-2015 UC: Kande chuke Vill: Jumo sheikh (Community Member-Men)

Sexual contact with wife till 6 months of pregnancy and 20 to 30 days after giving birth, Because I want to again pregnant wife because need another baby, wife also wish to be pregnant again.

Malaria, Diarrhoea common in hot season from Jun-Oct months, bring hospital nearby for treatment

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad Arain (Community Member-Men)

Ans:Not Allowed

Malaria, Diarrhoea, Fever, Kangi , (Dec, Jan, June, July)

Malnutrition

(show images of marasmus / kwashiorkor)

- Are there children in your community who look like this?

If yes, which type is more frequent?

- Is it a disease like others? Why? Why not?
- Which local terms are used to describe it?
- How is it perceived in the community? Why?
- Is it a « new » disease?

If yes, since when? Why do you think this disease appeared in your community?

- Do you think that this condition is stigmatised? Why?
- How does this stigmatisation mark people's behaviour and/or community relationships?
- How are its causes and symptoms described?
- Which therapeutic itineraries are used to treat this disease? Why?

Answers:

UC: Mitho Babar, Village: Gul Muhammad Chandio, Ethnic Group: Saraiki, Source: Community Members (Men), Date: 14-03-2015

There were malnourished children before in this community but now all of them got cured. They call it Kamzor. It is considered as a liver affected disease. Community considers weakness as a symptom of malnutrition.

UC: Kolachi, Village: Haji Qaim Khoso, Ethnic Group: Sindhi, Source: Community Members (Men), Date: 15-03-2015

There have never seen malnourished children in this community but have seen in other villages. Community don't know about its causes, effects and symptoms of malnutrition.

15-03-2015 UC: Kolachi, Village: Bego Tewano, Ethnic Group: Tewano, Source: Community Members (Men)

There were some children but are cured now, this condition is not stigmatised, and BHU are approached for treatment.

Date:14-03-2015 UC: Kande chuke Vill: Jumo sheikh (Community Member-Men)

Ans: Yes saw some children weight loss in this condition, imbalance food, poverty, diseases are main causes, people having child like that are stigmatized, I can't treat but referred them to city hospitals for treatment, in June July August.

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad Arain (Community Member-Men)

Yes, There are two children like that (Marasmus) it is a disease of weakness due, children not growing up in this condition, It is not stigmatized, causes are poverty, unhygienic water and food.

AWARENESS OF CMAM PROGRAMME

- Have you heard about CMAM programme?

If yes, from whom? What did you hear?

- Do you hear about CMAM programme often? How often?
- Do you know which children are targeted by the programme?
- Do you know which treatment they receive?
- What do you think about this treatment?
- How is it perceived in the community? Why?
- What do you think about CMAM programme?
- How is it perceived in the community? Why?
- Are there any obstacles/barriers to the use of this programme?

If yes, explain.

Answers:

UC: Mitho Babar, Village: Gul Muhammad Chandio, Ethnic Group: Saraiki, Source: Community Members (Men), Date: 14-03-2015

They have heard about CMAM program. They heard that it is for weak children. Children receive chocolate as treatment. Perception is positive about this program. They are requesting for other medical support as well.

UC: Kolachi, Village: Haji Qaim Khoso, Ethnic Group: Sindhi, Source: Community Members (Men), Date: 15-03-2015

They have heard about CMAM program. They heard that it is for 1 to 5 years of aged children. Children receive RUTF as treatment. Perception is positive about this program. Long distance is the only barrier in this program.

15-03-2015 UC: Kolachi, Village: Bego Tewano, Ethnic Group: Tewano, Source: Community Members (Men)

They knew a little bit of program, that they give biscuits and rathan, and weak children are only targeted by program. It is good because people are needy and some religious leaders have got some how reservations but community do not.

Date:14-03-2015 UC: Kande chuke Vill: Jumo sheikh (Community Member-Men)

Yes I heard from CHW about **Kangi** program for children under 5, It is good program to treat malnourished children in community, community like it mostly as it is free services for all community children.

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad Arain (Community Member-Men)

Yes from CHW we heard and also from community other people because their children were admitted in **KANGI**. It is very effective program people are attracted by chocolate program, small children are targeted in program

COVERAGE / REJECTION / DEFAULTING

- Are there many children in your community who benefit from CMAM programme?
- Do you know other children in your community who need this service?

If yes, why aren't they in the programme?

- Do you know any children who were rejected? Why?
- Do you know any children who abandoned the treatment? Why?

If yes, how could we motivate them to return?

Answers:

UC: Mitho Babar, Village: Gul Muhammad Chandio, Ethnic Group: Saraiki, Source: Community Members (Men), Date: 14-03-2015

There are children who have benefited from this program. Some healthy children were rejected from the program.

UC: Kolachi, Village: Haji Qaim Khoso, Ethnic Group: Sindhi, Source: Community Members (Men), Date: 15-03-2015

There are children who have benefited from this program. All weak children can get this service.

15-03-2015 UC; Kolachi, Village; Bego Tewano, Ethnic Group; Tewano, Source; Community Members (Men)

Many children benefit from this program, and there are some weak children but not weak as in picture, no such rejections and misconception of food voucher and program.

Date:14-03-2015 UC: Kande chuke Vill: Jumo sheikh (Community Member-Men)

Don't know because I am busy in my own responsibilities.

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad Arain (Community Member-Men)

No not such children in my knowledge

SENSITISATION&SCREENING

- Who sensitises the community? How often? On what subjects?
- Do you assist in sensitisation sessions? Why? Why not?
- What do you think of those sessions? Are they interesting? Boring? Why?
- What do you think of the information shared? Is it useful? Not useful? Why?
- Do you think the sensitisation is sufficient? Why? Why not?
- How should it be reinforced?

- Are there people in your community who measure children?
- If yes, who? How often? How?

Answers:

UC: Mitho Babar, Village: Gul Muhammad Chandio, Ethnic Group: Saraiki, Source: Community Members (Men), Date: 14-03-2015

NGO persons sensitises in this community. Those sessions are good for our knowledge and useful as well. But these sessions are not regular.

UC: Kolachi, Village: Haji Qaim Khoso, Ethnic Group: Sindhi, Source: Community Members (Men), Date: 15-03-2015

Three sensitisation sessions yearly are conducted here regarding malnutrition. It has useful information. It should be conducted on weekly basis.

15-03-2015 UC; Kolachi, Village; Bego Tewano, Ethnic Group; Tewano, Source; Community Members (Men)
Don't know about sessions.

Date:14-03-2015 UC: Kande chuke Vill: Jumo sheikh (Community Member-Men)

NGO team came for sessions 3 months ago with some pics and materials, but personally I was not as a participants, so I don't know.

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad Arain (Community Member-Men)

People came from NGO, subjects is health, hygiene, Child diseases, Yes it is very useful information shared by them

INTERVIEW GUIDE: COMMUNITY LEADERS (RELIGIOUS AUTHORITIES IMAMS, VILLAGE CHIEFS, TEACHERS OR OTHERS)

COMMUNITY PROFILE

- What is your role in the community?
- What are your main activities?
- What are main challenges in your community?
- Do they have impact on people's health?

If yes, describe.

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

He is an IMAM in this community. His role is positive sensitisation in this community. No main challenges here.

UC: Gozo, Village: Panjani Chandio, Ethnic Group: Sindhi, Source: Community Leader, Date: 14-03-2015

He is the village leader here. His role is problem resolution of individuals and community. The main challenge here is unavailability of gas. People use firewood for cooking which causes eye problems and respiratory problems in old age.

UC: Kakar, Village: Bariri, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

He is an IMAM in this community. His role is to teach Quran in this community. Main challenges here are unavailability of any Doctor and poor hygienic conditions. But these issues don't have any impact on people's health.

UC: Mitho Babar, Village: Kathia, Ethnic Group: Mallah, Source: Community Leader, Date: 15-03-2015

He is the community leader here. His role is conflict resolution in community. The main challenges here are unavailability of gas, transportation, light, drinking water and mal nutrition. No safe drinking water and poverty has impact on people's health.

UC: Kakar, Village: Kakar, Ethnic Group: Sindhi, Source: Community Leader, Date: 14-03-2015

He is the community leader here. His role is to resolve issues of the community. The main challenges here are lack of education and women are not allowed to move freely.

UC: Kandi Chukhi, Village: Jummo Shaikh, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

He is an IMAM in this community. His role is to resolve problems in this village. Main challenges here are unavailability of roads, health facilities.

UC: Mitho Babar, Village: Kathio, Ethnic Group: Sindhi, Source: IMAM, Date: 15-03-2015

He is an IMAM in this community. His role is to lead prayers and resolve conflicts in this community. Main challenges here are lack of transportation, Gas and safe drinking water and drainage problems. Among these, drainage issues and unsafe drinking water are causing impact on people's health.

15-03-2015 UC: Mitho Babar Village: Gul Muhammad Chandio Ethnic group: Siraiiki Source ; Teacher

Teacher and also a social worker, stagnant water is main cause of diseases and is a challenge for health In our community.

15-03-2015 UC: Kolachi Village: Qaim Ali Khoso Ethnic group: Balochi, Source ; Village Chief

A farmer with simple life, educational status is a major challenge and is got a lot of effects on community health.

15-03-2015 UC; Kolachi, Vilage ; Bego Tewano Ethnic Group ; Tewano, Source ; Teacher,

Basically a teacher, no other special work,

Community organisation

- How is your community organised?
- Do community members meet regularly?

If yes, for what purpose? How often? Where? At what time of the day?

- How are decisions made in your community?
- How are decisions communicated to all community members?
- What other (formal and informal) communication channels are available in your community?
- Which communication channels are most efficient? Why?
- Do community-based organisations exist in your community?

If yes, how many? What are their roles and activities? How are they perceived?

- Do you have a contact with other communities?

If yes, for what purpose? How often?

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

This community is organised into 4 ethnic groups. Soomro, Panhwar, Mallah and Burira. People in this community meet regularly. Decisions in this community are made by a CBO. Decisions are communicated in monthly meetings or by loud speakers. Monthly meeting is the most efficient communication channel here. The role of CBO is to resolve issues regarding water, education, health and medical camps. He don't have contact with other communities.

UC: Gozo, Village: Panjani Chandio, Ethnic Group: Sindhi, Source: Community Leader, Date: 14-03-2015

People in this community meet daily in Bhetak/Otaq. Decisions in this community are made by joint consensus by inviting at least one person from each household. Most efficient communication channel here is cell phone.

UC: Kakar, Village: Bariri, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

People in this community meet in weddings and death ceremonies. Decisions in this community are made jointly by representing one person from each household. Most efficient communication channel here is cell phone.

UC: Mitho Babar, Village: Kathia, Ethnic Group: Mallah, Source: Community Leader, Date: 15-03-2015

People in this community meet daily in Bhetak/ Otaq. Decisions in this community are made by joint consensus from all household representatives. Most efficient communication channel here is meeting face to face. There is no CBO in this community.

UC: Kakar, Village: Kakar, Ethnic Group: Sindhi, Source: Community Leader, Date: 14-03-2015

People in this community meet regularly in Otaq. Decisions in this community are made by landlords. Most efficient communication channel here is meeting face to face.

UC: Kandi Chukhi, Village: Jummo Shaikh, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

People in this community meet daily in Otaq in order to discuss general issues. Decisions in this community are made by jointly all community members. Most efficient communication channel here is cell phone.

UC: Mitho Babar, Village: Kathio, Ethnic Group: Sindhi, Source: IMAM, Date: 15-03-2015

People in this community meet daily in Otaq school related issues. Decisions in this community are made by inviting one person from each household and then jointly takes a decision. Most efficient communication channel here is communicating by face to face in Otaq.

15-03-2015 UC: Mitho Babar Village: Gul Muhammad Chandio Ethnic group: Siraiki Source ; Teacher

Organised community, meeting once in a week, most of the decisions are taken while gathering in a form of meeting and senior personal are authorized to take decisions, and its communicated through verbal communication. While no other CBO exists.

15-03-2015 UC: Kolachi Village: Qaim Ali Khoso Ethnic group: Balochi, Source ; Village Chief

Not very specially organised, meet daily when going to fields, decisions are made with joint discussion, and is also communicated verbally, and no such CBO present.

15-03-2015 UC: Kolachi, Village: Bego Tewano Ethnic Group ; Tewano, Source ; Teacher,

community issues are resolved with help of waderas (Land Lords) but family issues are resolved inside of home, and if community is unable to solve a problem then other communities are also contacted.

Family organisation

- How do M/W share their family roles?
- Who makes decisions for the family? Why?
- Are there any situations, in which another person can decide? Explain.
- Has there been any change in this respect in the last years? Explain.
- How would you describe intergenerational relations?
- Does young generation reproach their parents/grand-parents? Explain.
- Where do young women learn how to take care of their babies? Why?
- Do men learn how to take care of their babies? Why? Why not?
- Do you think that men should be more involved? Why? Why not?

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

Man is responsible for livelihood earning and female is responsible for household chores. Usually male member makes decisions for the family after consultation with his wife. The intergenerational relations are good in this community. Youngsters obey whatever their elders decide for them. They don't reproach their parents/grand-parents. Young women learn from TBAs, mother in laws and LHVs about how to take care of their babies as these are the only available sources to learn from. A few men also learn the same but mostly not. Men should not be more involved because they have other important things to do like livelihood earning.

UC: Gozo, Village: Panjani Chandio, Ethnic Group: Sindhi, Source: Community Leader, Date: 14-03-2015

Man is responsible for livelihood earning and female is responsible for household chores. Mostly, male member makes decisions for the family. The intergenerational relations are good and youngsters obey all decision taken by their elders. They don't reproach their parents/grand-parents. Young women learn from Doctors and LHV's about how to take care of their babies. Men aren't much involved because they have to give time to livelihood earning.

UC: Kakar, Village: Bariri, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

Male member makes decisions for the family. The intergenerational relations are good and youngsters obey all decision taken by their elders. Young women learn from elder female members of the family. Men should also be more involved because they are for the betterment of their children.

UC: Mitho Babar, Village: Kathia, Ethnic Group: Mallah, Source: Community Leader, Date: 15-03-2015

Man is responsible for livelihood earning and female is responsible for household chores. Mostly, male member makes decisions for the family. The intergenerational relations are good and youngsters obey all decision taken by their elders. Sometimes they reproach their parents/grand-parents due to improper nurturing. Young women learn from LHV's about how to take care of their babies. Men should also be more involved.

UC: Kakar, Village: Kakar, Ethnic Group: Sindhi, Source: Community Leader, Date: 14-03-2015

Man is responsible for livelihood earning and female is responsible for household chores. Head of the household makes decisions for the family. The intergenerational relations are fair. Young women learn from TV, news and other elderly women about how to take care of their babies. Men also learn the same so that they will be able to take care their babies properly.

UC: Kandi Chukhi, Village: Jummo Shaikh, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

Man is responsible for livelihood earning and female is responsible for household chores. Male member makes decisions for the family. The intergenerational relations are good. They don't reproach their parents. Young women learn from other mothers about how to take care of their babies.

UC: Mitho Babar, Village: Kathio, Ethnic Group: Sindhi, Source: IMAM, Date: 15-03-2015

Man is responsible for livelihood earning and female is responsible for household chores. Head of the household makes decisions for the family. The intergenerational relations are good. Young women learn from other elder women about how to take care of their babies. Men can't learn it because they have to give time to livelihood earning.

15-03-2015 UC: Mitho Babar Village: Gul Muhammad Chandio Ethnic group: Siraiki Source ; Teacher

Rottenly sharing each other's roles while decisions are taken by family elders (Male) sometimes with the help of some respected community member. Intergenerational relations are also good.

15-03-2015 UC: Kolachi Village: Qaim Ali Khoso Ethnic group: Balochi, Source ; Village Chief

Share each others work while only family male members are responsible for decisions, n intergenerational relations are very good, respect elders, young women mostly learn from mothers, and men are also involved in taking care of babies.

15-03-2015 UC; Kolachi, Vilage ; Bego Tewano Ethnic Group ; Tewano, Source ; Teacher,

Head of the family takes decisions and some times work is shared, and if family head is not present then women take decision but minor decisions, and theres been no major change in this regards, and orders from family head is followed and elders are given respect. young women leran from mothers to take care of children. And men should also get involve in taking care of children.

AWARENESS OF THE MALNUTRITION

(show images of marasmus / kwashiorkor)

- Are there children in your community who look like this?

If yes, which type is more frequent?

- Is it a disease like others? Why? Why not?
- Which local terms are used to describe it?
- How is it perceived in the community? Why?
- Is it a « new » disease?

If yes, since when? Why do you think this disease appeared in your community?

- Do you think that this condition is stigmatised? Why?
- How does this stigmatisation mark people's behaviour and/or community relationships?
- Do you know symptoms of this disease?

If yes, can you name few?

- Do you know its causes?

If yes, can you name few?

- Do you know its effects?

If yes, can you name few?

- What therapeutic itineraries are available in your community to treat this disease? Which ones are the most frequent? Why?

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

He has seen marasmus type mal-nourished children in this community. It is also a disease like other diseases. They call it kangi. This condition is stigmatised here as people feel bad to show their mal-nourished children but it has no impact on community relationships. Symptoms of this disease are weakness and irritative child. Its causes are low weight by birth and less intake of food.

UC: Gozo, Village: Panjani Chandio, Ethnic Group: Sindhi, Source: Community Leader, Date: 14-03-2015

He hasn't seen mal-nourished children in this community. However, he has seen it on TV and they call it kangi. They don't know any further about this disease.

UC: Kakar, Village: Bariri, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

He has seen mal-nourished children in this community. It is also a disease like other diseases. They call it kangi. This condition is stigmatised as people feel will call them as careless parents but it has no impact on community relationships.

UC: Mitho Babar, Village: Kathia, Ethnic Group: Mallah, Source: Community Leader, Date: 15-03-2015

He has seen mal-nourished children in this community. It is also a disease like other diseases. They call it kangi. It is an old disease. Its symptoms are prominent ribs, no appetites etc.

UC: Kakar, Village: Kakar, Ethnic Group: Sindhi, Source: Community Leader, Date: 14-03-2015

He hasn't heard about CMAM program.

UC: Kandi Chukhi, Village: Jummo Shaikh, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

He has seen mal-nourished children in this community. They consider it a disease like other diseases. They call it kangi. It is an old disease. Its symptom is wasted body.

UC: Mitho Babar, Village: Kathio, Ethnic Group: Sindhi, Source: IMAM, Date: 15-03-2015

There were malnourished children before in this community but now all of them got cured. They consider it a disease like other diseases. They call it kangi and its been here since long. Its symptoms are weakness and looks like an old person. It is caused by unsafe drinking water.

15-03-2015 UC: Mitho Babar Village: Gul Muhammad Chandio Ethnic group: Siraiki Source ; Teacher

Mostly knew about weakness and cause of weakness is improper food for eating, also considered as a disease,, mostly taken it as negative in a way that parents are not taking care of children. Is also assumed that if mother is weak in pregnancy then the baby born will also be weak. Basic health units are main source for treatments.

15-03-2015 UC: Kolachi Village: Qaim Ali Khoso Ethnic group: Balochi, Source ; Village Chief

No such weak child, but considered as a disease because of doctors sayings, weakness happened after floods, its called ssukkha, parents and community are aware of it n are taking care, take to hospital because it will effect childs future if not get treated.

15-03-2015 UC; Kolachi, Vilage ; Bego Tewano Ethnic Group ; Tewano, Source ; Teacher,

There are some weak children and weakness is a disease, symptoms are fever kamzori etc, and becomes weak and weak in future also .

AWARENESS OF CMAM PROGRAMME

- Have you heard about CMAM programme?

If yes, from whom?What did you hear?

- Do you hear about CMAM programme often? How often?
- Do you know which children are targeted by the programme?
- Do you know which treatment they receive?
- What do you think about this treatment?
- How is it perceived in the community? Why?
- What do you think about CMAM programme?
- How is it perceived in the community? Why?
- Are there any obstacles/barriers to the use of this programme?

If yes, explain.

- What would you change to improve its quality?

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

There is no CMAM activity in this UC.

UC: Gozo, Village: Panjani Chandio, Ethnic Group: Sindhi, Source: Community Leader, Date: 14-03-2015

There is no CMAM activity in this UC.

UC: Kakar, Village: Bariri, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

They know about CMAM program. This program is for children of 2 to 3 years of age. They give chocolates as treatment. This program is good. No obstacles here for this program. They are requesting for a doctor to be made available for females and children treatment.

UC: Mitho Babar, Village: Kathia, Ethnic Group: Mallah, Source: Community Leader, Date: 15-03-2015

They know about CMAM program. They think very positive about this program and its treatment. ACF staff are very few in number. Staff number should be increased.

UC: Kandi Chukhi, Village: Jummo Shaikh, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

He knows about CMAM program. This program is for children and women. This program is good and gives free treatment. No obstacles here for this program.

UC: Mitho Babar, Village: Kathio, Ethnic Group: Sindhi, Source: IMAM, Date: 15-03-2015

He knows about CMAM/ACF program. This program is for malnourished children. This program is good and gives injection and medicine. It's a very good treatment. People in this community also have good perception about program.

15-03-2015 UC: Mitho Babar Village: Gul Muhammad Chandio Ethnic group: Siraiiki Source ; Teacher

CMAM awareness is good and screen iss carried on in village and children are being reffered to OTP. Overall response is good because its free treatment for weak children.

15-03-2015 UC: Kolachi Village: Qaim Ali Khoso Ethnic group: Balochi, Source ; Village Chief

Aware of cmam prog, treat weak children by choclade and it is very good program, no such barriers for this program.

15-03-2015 UC; Kolachi, Vilage ; Bego Tewano Ethnic Group ; Tewano, Source ; Teacher,

Dnt know much about, as they give choclade, and ration also, if parents are weak then children will be weak,

COVERAGE / REJECTION / DEFAULTING

- Are there many children in your community who benefit from CMAM programme?
- Do you know other children in your community who need this service?

If yes, why aren't they in the programme?

- Do you know any children who were rejected? Why?
- Do you know any children who abandoned the treatment? Why?

If yes, how could we motivate them to return?

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

There is no CMAM activity in this UC.

UC: Kakar, Village: Bariri, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

They know such children in this community who benefited from this program. There are some children who need this treatment but don't know why they are skipped.

UC: Mitho Babar, Village: Kathia, Ethnic Group: Mallah, Source: Community Leader, Date: 15-03-2015

He knows such children who have benefited from this program. But no such children who still needs this treatment as all of them got cured.

UC: Kandi Chukhi, Village: Jummo Shaikh, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

He knows such children who have benefited from this program. But don't know anyone who has abandoned the treatment.

UC: Mitho Babar, Village: Kathio, Ethnic Group: Sindhi, Source: IMAM, Date: 15-03-2015

He knows such children who have benefited from this program and all of the have got cured now.

15-03-2015 UC: Mitho Babar Village: Gul Muhammad Chandio Ethnic group: Siraiki Source ; Teacher

Many children were treated under CMAM, there were no rejections at all.

15-03-2015 UC: Kolachi Village: Qaim Ali Khoso Ethnic group: Balochi, Source ; Village Chief

Many children are getting choclades, don't know anything else.

15-03-2015 UC; Kolachi, Vilage ; Bego Tewano Ethnic Group ; Tewano, Source ; Teacher,

6-7 children were benifited from this but don't know other children.

SENSITISATION & SCREENING

- Who is responsible for the sensitisation of the community?
- Do these people sensitise the community on the malnutrition?

If yes, how often?

- Do you know which subjects are addressed?
- What do you think of those sessions? Are they interesting? Boring? Why?

- What do you think of the information shared? Is it useful? Not useful? Why?
- Who is targeted by sensitisation sessions on the malnutrition?
- Who else should be targeted by these sessions? Why?
- Do you actively participate in sensitisation sessions?

If yes, why? How? How often?

If no, why not?

- Do you think the sensitisation is sufficient? Why? Why not?
- How should it be reinforced??

- Are there people in your community who identify malnourished children?

If yes, who? How? How often?

- What do you think of their work? Why?
- Who should be included in this? Why?

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

There is no CMAM activity in this UC.

UC: Kakar, Village: Bariri, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

NGO teams sensitise community on malnutrition. Local females should be added to this work voluntarily. More field visits should be done.

UC: Mitho Babar, Village: Kathia, Ethnic Group: Mallah, Source: Community Leader, Date: 15-03-2015

ACF staff sensitises this community. They conduct sensitisation sessions in which they address subjects like health and hygiene. They mostly target children in their sessions. Local language should be more used in these sessions. Other people in this community can also identify malnourished children like teachers etc.

UC: Kandi Chukhi, Village: Jummo Shaikh, Ethnic Group: Sindhi, Source: IMAM, Date: 14-03-2015

ACF teams sensitises the community here. They mostly address children and women. The session they provide are sufficient.

UC: Mitho Babar, Village: Kathio, Ethnic Group: Sindhi, Source: IMAM, Date: 15-03-2015

CNVs and ACF staff sensitises this community. They conduct sensitisation sessions after 15 to 20 days in which they address weak children. These session are sufficient. Volunteers and teachers in this community can also identify malnourished children.

15-03-2015 UC: Mitho Babar Village: Gul Muhammad Chandio Ethnic group: Siraiki Source ; Teacher

No sensitizations sessions are carried on in this village.

15-03-2015 UC: Kolachi Village: Qaim Ali Khoso Ethnic group: Balochi, Source ; Village Chief

Never attended sessions.

15-03-2015 UC; Kolachi, Vilage ; Bego Tewano Ethnic Group ; Tewano, Source ; Teacher,

Team Came n said they are here for treatment of weak children.

INTERVIEW GUIDE: COMMUNITY HEALTH WORKERS, LHWs, CNVs

PERSONAL PROFILE

- What is your role in the community?
- Since when have you been working in your role?
- How do you feel in your role? Why?
- Have you been trained?

If yes, when? How many times?

- Are you satisfied with the level of training? Why? Why not?
- Are you supervised?

If yes, by whom? How? How often?

- Do you collaborate with other community health workers?

If yes, how? Why? How often?

- Do you collaborate with other community members and/or health centre personnel?

If yes, how? Why? How often?

Answers:

UC: Gozo, Village: Panjhani Chandio, Ethnic Group: Saraiki, Source: LHW, Date: 14-03-2015

She works as an LHW here since 3 years. She feels good while doing this job. She has been trained twice. She is satisfied with the level of training which she got. She has been supervised by a supervisor. She collaborates with other community members twice a month.

UC: Kakar, Village: Kakar, Source: LHW, Date: 14-03-2015

Her role is to provide health in this community. She has been doing this since last 3 years. She has received training once.

16-03-2015 UC; Baid Village; Baji Khan Ethnic Group; Siraiiki Source; CNV

Is a Cnv from 12 months, and feeling good, for 2 times training was satisfactory, and was supervised previously but not now, don't have any collaboration with other health personnel,

17-03-2015 UC; Mitho Babar, Village; Dital Samal Ethnic Group; Sindhi Source; CNV

A shopkeeper and CNV from almost 6 months, and trained for 2 times, and also supervised, donot collaborate with other health staff, but meet them through my shop.

Sensitisation

- Do you organise sensitisation sessions in your community?

If yes, how³&how often do you organise them?

- What tools do you have at your disposal?
- Who do you target in your sensitisation sessions? Why?
- What other people should be targeted by your sensitisation sessions? Why? Why don't you target them?
- What other people should actively participate in the sensitisation of the community? Why?
- How should be sensitisation reinforced? Why?

Answers:

UC: Gozo, Village: Panjhani Chandio, Ethnic Group: Saraiki, Source: LHW, Date: 14-03-2015

She organises sensitisation sessions twice a month. She only has pictures at her disposal. She targets mothers and married women in her sensitisation sessions. She wants other community members as well to participate in these sessions.

UC: Kakar, Village: Kakar, Source: LHW, Date: 14-03-2015

She organises sensitisation sessions once a month. She targets family planning issues in her sessions. These sessions should be conducted at household level.

16-03-2015 UC; Baid Village; Baji Khan Ethnic Group; Siraiiki Source; CNV

Sensitize community by every month, also have MAUC tape and referral slip, usually sensitize all community members, but acf staff should carry on these sessions and will be more effective.

³group, door-2-door, etc.

17-03-2015 UC; Mitho Babar, Village; Dital Samal Ethnic Group; Sindhi Source; CNV
Do not sensitize.....

Screening

- Do you screen malnourished children?

If yes, how & how often do you organise this activity?

- What tools do you have at your disposal?
- How do you refer children to the health centre?
- Do health centres accept your referrals?

If not, why not?

- Who follows up on referred children? How often?

If no follow up is done, explain.

- Are there many children in your community who benefit from CMAM programme?
- Do you know other children in your community who need the treatment?

If yes, why aren't they in the programme?

- Do you know children who abandoned the treatment?

If yes, why? How could we motivate them to return?

- Who follows up on defaulting children? How often?

If no follow up is done, explain.

Answers:

UC: Gozo, Village: Panjhani Chandio, Ethnic Group: Saraiki, Source: LHW, Date: 14-03-2015

She don't screen malnourished children in this community.

UC: Kakar, Village: Kakar, Source: LHW, Date: 14-03-2015

She screens children in this community but not on regular basis. She has some images, referral cards and books at her disposal. She doesn't follow up on children whom she refer. There are some children in this community who are getting this treatment but still some children are not in the program who needs treatment.

16-03-2015 UC; Baid Village; Baji Khan Ethnic Group; Siraiki Source; CNV

usually screen every month with mauc tape. and refere with referel slip the needy children, and referrals are never refused, and many children benefit from this program,

17-03-2015 UC; Mitho Babar, Village; Dital Samal Ethnic Group; Sindhi Source; CNV

Do not screen.....

Decision-making & refusal of treatment

- Which family member do you talk to if a child needs to be referred to a health centre?
- Who makes a decision following your recommendation?
- Do both parents accept?

If not, why do they refuse? How could we avoid these situations?

- Do you sensitise parents on their child's condition?

If yes, what kind of information do you share?

Answers:

UC: Kakar, Village: Kakar, Source: LHW, Date: 14-03-2015

She talks to both the parents in case if she finds any patient but the decision is taken by their father.

16-03-2015 UC; Baid Village; Baji Khan Ethnic Group; Siraiki Source; CNV

Father or mother is contacted in case of any weak child, coz parents of child act upon suggestion, also sensitize child's parents regarding his condition and sessions as well.

17-03-2015 UC; Mitho Babar, Village; Dital Samal Ethnic Group; Sindhi Source; CNV

Usually head of that house is responsible for taking decisions, mostly are parents, and accept if its referral for admissions or if its about child condition.

CHILDHOOD DISEASES& MALNUTRITION

- What are main challenges in your community?
- Do they have impact on the health of the community?

If yes, explain.

- Which childhood diseases are most frequent in your community?
- In which months are they prevalent?
- What therapeutic itineraries are available to treat them? Which are most frequent? Why?

UC: Gozo, Village: Panjhani Chandio, Ethnic Group: Saraiki, Source: LHW, Date: 14-03-2015

There are no main challenges in this community. Childhood diseases here are diarrhoea, vomiting and chest infections. These diseases mostly appear in July and January. The most frequent therapeutic itineraries available here are ORS or being referred to a doctor.

UC: Kakar, Village: Kakar, Source: LHW, Date: 14-03-2015

Main challenge in this community is lack of education. Childhood diseases here are fever, cough and skin diseases.

16-03-2015 UC; Baid Village; Baji Khan Ethnic Group; Siraiqi Source; CNV

Water roads and washrooms are challenges, and in rains its difficult to visit hospitals. Fever , vomiting and dirrehea and skin infections are common in summer season, BHU and private doctors are basic source for treatment.

17-03-2015 UC; Mitho Babar, Village; Dital Samal Ethnic Group; Sindhi Source; CNV

No major challenges in here, dirrehea and fever are very common in summer, and BHU is main source for treatment.

Malnutrition

- Which local terms depicting the malnutrition are used in your community?
- How is it perceived? Why?
- Is it a « new » disease?

If yes, since when? Why do you think it appeared in your community?

- How do community members describe its symptoms?
- Do community members understand its causes?

If yes, how do they describe them?

- Do community members understand its effects?

If yes, how do they describe them?

- Which therapeutic itineraries are available in your communityto treat the malnutrition? Which are most frequent? Why?
- Do you think that this condition is stigmatised? Why?
- How does this stigmatisation mark people's behaviour or community relationships?

Answers:

UC: Gozo, Village: Panjhani Chandio, Ethnic Group: Saraiki, Source: LHW, Date: 14-03-2015

The local term being used here for malnutrition is Kangi. They consider it a dangerous disease.It's an old disease but they came to about it recently. It is caused due to low amount intake of food. Its symptoms is weakness in child. Community members understand its causes and effects.

UC: Kakar, Village: Kakar, Source: LHW, Date: 14-03-2015

The local term being used here for malnutrition is Kangi. They consider it a normal disease like other diseases. It's symptom is weakness but community don't know about its causes and effects.

16-03-2015 UC; Baid Village; Baji Khan Ethnic Group; Siraiqi Source; CNV

Kamzor sukhal words are commonly used for it, and perceived as very dangerous disease, and is usually described as weakness, but don't know causes nor effects, BHU is basic facility for its treatment only. Some times other children are avoided from weak children.

17-03-2015 UC; Mitho Babar, Village; Dital Samal Ethnic Group; Sindhi Source; CNV

Kangi and kamzori are words used in local terms, and is perceived as due to lack of food, and is recognised by weakness, and basic treatment is ACF team at otp site, people are worried about weakness.

PERCEPTION OF CMAM PROGRAMME

- What do you think of CMAM programme?
- What are its strengths/weaknesses?
- What would you change to improve its quality?
- How is it perceived in the community? Why?
- Are there any obstacles/barriers for the use of this service?
- If yes, explain.

Answers:

UC: Kakar, Village: Kakar, Source: LHW, Date: 14-03-2015

Perception about this program in this community is positive.

16-03-2015 UC; Baid Village; Baji Khan Ethnic Group; Siraiiki Source; CNV

It's a good program and is because of free treatment, no such barriers.

17-03-2015 UC; Mitho Babar, Village; Dital Samal Ethnic Group; Sindhi Source; CNV

It's a good program and is because of free treatment, no such barriers.

INTERVIEW GUIDE: COMMUNITY-BASED ORGANISATION / ASSOCIATIONS / COOPERATIVES / SCHOOL ESTABLISHMENTS OR OTHERS

ORGANISATIONAL & COMMUNITY PROFILE

- What is your role in the community?
- What are your main activities? How often do you carry them out?
- How are you organised?
- How are decisions made in your organisation?
- How do you communicate with the population? Why?
- How does the population perceive you? Why?
- How would you describe your community?
- What are its main challenges? Why?
- How does the community address these challenges? Why?
- How are decisions made in your community?
- Do you participate in a decision-making? Why? Why not?
- How are decisions communicated to all community members?
- What other (formal and informal) communication channels are available in your community?
- Which are most efficient? Why?

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: CBO Members, Date: 14-03-2015

Their main role in the community is to resolve the basic problems in this village. IRC helps them to make a CBO. Three members from each ethnic group are present in decision making committee. They communicate with the population in the monthly meetings. Population perceive them positively because they solve their issues.

People in this community keeps good relationship with each other. They are not facing any main challenges. Decisions are made by a committee in which they also participate. They communicate their decision to the community through loud speakers

14-03-2015 UC;Sita Road, Village; Janweri Muhallah Source; Sindhi & Balochi

a govt teacher basically, decides with help of head master, and voluntarily communicate with community, condition is very poor , no drainage system, drinking water issues, and not being addressed due to poverty, and decisions are made through village chiefs (Sardar). And are usually communicated verbally.

Date:14-03-2015 UC: Kande chuke Vill: Baid (CBO)

To provide guidance and assistance to community by meeting with community leaders, teachers to solve their problems within community, community respects the decision of CBO (Village committee), as our community is very poor and facing many problems regarding health, education etc, the decision made by village chief and communicated to other by Loud speakers or calling them on phones. Loud speaker are best way for communication.

Date:15-03-2015 UC: Mitho Babar Vill: Dur Muhammad arain (CBO)

Solving problems of community and support the community for their rights regarding village issues, As community is very poor so need our help in any decision for their benefits, village chief is the key person and he is the head of the village committee, loud speakers are used or mobiles for communications.

Malnutrition

(show images marasmus / kwashiorkor)

- Are there children in your community who look like this?

If yes, which type is more frequent?

- Is it a disease like others? Why? Why not?
- Which local terms are used to describe it?
- How is it perceived in the community? Why?
- Is it a « new » disease?

If yes, since when? Why do you think that this disease appeared in your community?

- Do you think that this condition is stigmatised? Why?
- How does this stigmatisation mark people's behaviour and/or relations in the community?
- How are its causes, symptoms and effects described?
- Do you agree? Why? Why not?
- Which therapeutic itineraries are used in your community to treat the malnutrition? Why?
- Do you agree? Why? Why not?

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: CBO Members, Date: 14-03-2015

They know malnourished children in their community. They consider it just like other diseases. They call it kamzor or kangi. It is not a new disease in this community. This condition is stigmatized for them as they feel shameful by this. There is no such impact on people's behaviour due to stigmatization. They believe that it is caused by low birth weight.

14-03-2015 UC;Sita Road, Village; Janweri Muhallah Source; Sindhi & Balochi

Weakness is pronounced as kangi, and its not a new disease nor stigmatised, and its due to carelessness with children, and are treated with good milky foods, though it should be started before disease.

Date:14-03-2015 UC: Kande chuke Vill: Baid (CBO)

Yes this is **kangi**, it is not new but different from other diseases it appear 5 to 6 years ago in our community, don't know about stigmatized, causes are poverty and lack of basic food, also unhygienic water also effect causing this diseases. I am agree these all, some treatment according to community beliefs but don't know what?

Date:15-03-2015 UC: Mitho Babar Vill: Dur muhammd arain (CBO)

Yes this 'Sukhal' or KANGI. this is due to weak health status of community, causes are diarrhoea, lack of food, mother weak. community take their children to hospital for cholera program.

Family organisation

- How do M/W share their family roles?
- Who makes decisions for the family? Why?
- Are there any situations, in which another person can decide? Explain.
- Has there been any change in this respect in the last years? Explain.
- Where do young women learn how to take care of their babies? Why?
- Do men learn how to take care of their babies? Why? Why not?
- Do you think that men should be more involved? Why? Why not?

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: CBO Members, Date: 14-03-2015

Decisions are made by head of the household in this community. Young women learn from TBA's and LHW's about how to take care of their babies as it is the only available source in this community. Men also learn how to take care of their children because they are also responsible.

14-03-2015 UC;Sita Road, Village; Janweri Muhallah Source; Sindhi & Balochi

Generally in home and in agriculture both, decisions are taken by head of family, some how head of village, and young women learn from mothers, men are not involved in taking care of children but they should be.

Date:14-03-2015 UC: Kande chuke Vill: Baid (CBO)

Men work as labour outside for full day and women daily routine work in home. decision made by father in law, Father, Husband mostly men, women not fully aware about children care, yes men role is insufficient need to be more involved.

Date:15-03-2015 UC: Mitho Babar Vill: Dur muhammd arain (CBO)

Men have power of decision and women for house work (cooking, cloth washing, baby care etc). some time mother in law make decision, women learn from LHWs or doctors that how to take care of babies.

AWARENESS OF CMAM PROGRAMME

- Have you heard about CMAM programme?
- If yes, from whom? What did you hear?
- Do you hear about CMAM programme often? How often?
 - Do you know which children are targeted by the programme?
 - Do you know which treatment they receive?
 - What do you think about this treatment?
 - How is it perceived in the community? Why?
 - What do you think about CMAM programme?
 - How is it perceived in the community? Why?
 - What would you change to improve its quality?
 - Are there any obstacles/barriers to the use of this programme?

If yes, explain.

Answers:

UC: Gozo, Village: Pejaho, Ethnic Group: Sindhi, Source: CBO Members, Date: 14-03-2015

They have never heard about CMAM program.

14-03-2015 UC;Sita Road, Village; Janweri Muhallah Source; Sindhi & Balochi

No Idea

Date:14-03-2015 UC: Kande chuke Vill: Baid (CBO)

Yes many time (3-4 times),by community leaders and CHW in meeting. designed for under 5 children of KANGI diseases, It is very useful for community, some basic medicine should be included for the children and Patti (MUAC) criteria should be increased. one barrier that admission on just MUAC.

Date:15-03-2015 UC: Mitho Babar Vill: Dur muhammd arain (CBO)

Yes the team visited villages fro many times weekly then after 2 months for screening, community need such kind of support from NGO for health status, keep it continue because its improving community behaviour as well.

COVERAGE / REJECTION / DEFAULTING

- Are there many children in your community who benefit from CMAM programme?
- Do you know other children in your community who need this service?

If yes, why aren't they in the programme?

- Do you know any children who were rejected? Why?
- Do you know any children who abandoned the treatment? Why?How could we motivate them to return?

Answers:

14-03-2015 UC;Sita Road, Village; Janweri Muhallah Source; Sindhi & Balochi

No Idea.

Date:14-03-2015 UC: Kande chuke Vill: Baid (CBO)

Yes many children need program but just age or MUAC is above criteria used by staff, they also be the part of program, Don't know about rejected children.

Date:15-03-2015 UC: Mitho Babar Vill: Dur muhammd arain (CBO)

Many community children getting benefits from program but don't know about defaulter or abandon child in this area.

SENSITISATION & SCREENING

- Who is responsible for the sensitisation of the community?
- Do these people sensitise the community on the malnutrition?

If yes, how often?Do you know which subjects are addressed?

- Are you involved in sensitisation sessions?

If yes, why? How? How often?

If no, why not?

- Who is targeted by sensitisation sessions on the malnutrition?
- Who else should be targeted? Why?
- What do you think of those sessions? Are they interesting? Boring? Why?
- What do you think of the information shared? Is it useful? Not useful? Why?
- Do you think the sensitisation is sufficient? Why? Why not?
- How should it be reinforced?

- Are there people in your community who identify malnourished children?

If yes, who? How? How often?

- What do you think of their work? Why?
- Who should be included in this activity? Why?

Answers:

14-03-2015 UC;Sita Road, Village; Janweri Muhallah Source; Sindhi & Balochi

No Idea.

Date:14-03-2015 UC: Kande chuke Vill: Baid (CBO)

Hospital staff or community health workers, community is targeted in sessions. sessions are very effective, not boring, CHW and some CNVs identified malnourished children, Satisfied their work but need to meeting with us before any activity, All the community should be included for full awareness about program.

Date:15-03-2015 UC: Mitho Babar Vill: Dur muhammd arain (CBO)

Everyone is responsible for sessions but IMAM, CHW are key persons.

Subjects: Malnutrition, Hygiene, common diseases,

This is useful for community to bring awareness because people are un educated mostly don't know how to prevent from these diseases, yes people were came many time for screening, their work ids appreciable because they did any activity at community doors steps.

INTERVIEW GUIDE: CARERS OF MALNOURISHED CHILDREN (BENEFICIARIES OF CMAM PROGRAMME)

AWARENESS OF CMAM PROGRAMME

- How did you hear about CMAM programme?
- What did you hear?
- Do you hear about CMAM programme often? How often?
- Why did you decide to come to the health centre?

If child's illness is mentioned:

- When did you notice that your child is ill?
- What symptoms /problems did you notice?
- Was your child measured at home?

If yes:

- Who measured him? How? What was said?
- After what time did you decide to come to the health centre?

If more than two weeks:

- Why did you wait so long?
- Since when have you been in the programme?
- Have you noticed a difference in the condition of your child?
- What difference?

Answers:

Date:16-03-2015 UC: Kande chuke Vill: Baid (Carers, BNF)

ACF team measured my child & referred that my child is weak, So I came here, child was admitted & from last 2 month in program, stabilization care is also given to my child, now my child gaining weight with time passing and looking active as compared before treatment, I wait here some time 20 minuits or maximum 1 hour due to patient flow in OTP site.

16-03-2015 UC; Kakar Village; Kakar Ethnic Group; Sindhi Source beneficiaries of CMAM program

Knew about program through ACF Team ,, child was ill and is in program now,, acf staff is very cooperative.

17-03-2015 UC; Mitho Babar Village; Belo Patan Ethnic Group; Balochi, Source beneficiaries of CMAM program

Heard about CMAM from CNV that it's a prog for weak children, now child is in admitted in program from 2 months becZ of weakness, and child is improving.

18-03-2015 UC; Kandi Chuki Village; BHU Baid Ethnic Group; Baloch , Source beneficiaries of CMAM program

Got info from ACF team, It's for weak children, CNV is active and regularly checking, child was weak n measured at home by CNV with a strip, and referred BHU, and visited bhu in two days.

Decision-making

- Did someone encourage you to go to the health centre?

If yes:

- Who encouraged you?
- Does this person encourage you to continue the treatment? Why?
- Does this person accompany you to the health centre?

If not, would you like to be accompanied? Why?

Answers:

18-03-2015 UC; Kandi Chuki Village; BHU Baid Ethnic Group; Baloch , Source beneficiaries of CMAM program

CNV encouraged a lot, as he is assigned by ACF team,

17-03-2015 UC; Mitho Babar Village; Belo Patan Ethnic Group; Balochi, Source beneficiaries of CMAM program

CNV Encouraged to go to otp due to weakness of child, no need to accompany to otp.

16-03-2015 UC; Kakar Village; Kakar Ethnic Group; Sindhi Source beneficiaries of CMAM program

No, I decided myself to go to program.

Date:16-03-2015 UC: Kande chuke Vill: Baid (Carers, BNF)

Yes my family members encourage me and also by calling by CHW to come for follow ups. As a responsible father mostly I took my child here for follow ups.

AWARENESS OF MALNUTRITION

- Do you know causes of your child's condition?

If yes, what are they?

- Do you know effects of this condition?

If yes, what are they?

- Do you think that it's a disease like any other? Why? Why not?
- How did you try to treat this condition before going to the health centre?
- Which words do people use to describe it?
- Does the health centre staff use the same words?

If not, what words do they use?

- Did the health centre staff explain your child's condition?

If yes:

- What did they tell you?

Answers:

Date:16-03-2015 UC: Kande chuke Vill: Baid (Carers, BNF)

Causes: Poverty, Weak, Fever, Mother is also weak, poor appetite, which effects my children health so they became malnourished, this is KANGI, hospital staff also said that this is KANGI as people describe it with same words, hospital staff explain that by this treatment KANGI will be recover very soon.

16-03-2015 UC; Kakar Village; Kakar Ethnic Group; Sindhi Source beneficiaries of CMAM program

Don't know reasons of weakness, nor effects, but it's a disease, called as kangi, acf staff explained to me the condition of my child and treated well.

17-03-2015 UC; Mitho Babar Village; Belo Patan Ethnic Group; Balochi, Source beneficiaries of CMAM program

Don't know the reason of weakness of child, but it's not a good situation, as it's a disease, don't know the name of medicine but we call it chocolate, staff explained the situation of child.

18-03-2015 UC; Kandi Chuki Village; BHU Baid Ethnic Group; Baloch , Source beneficiaries of CMAM program

Yes due to low birth weight, don't know effects, but it's a disease and is named as kamzori, otp staff explained condition and gave treatment.

QUALITY OF CMAM PROGRAMME

- How long do you have to wait before being served? Why?

- What do you do while waiting? Is it comfortable?
- How much time do you spend with the nurse during the consultation?
- Is he/she kind? Why? Why not?
- What does the health centre staff give you to treat the disease?
- Did they explain the reason for this treatment?
- Have you always received a complete ration?

If not, why not? How many times?

- Did the health centre staff explain how to use it?

If yes, do you observe their instructions?

- Does your child like to eat it?
- Does/did he/she display any symptoms after eating it?

If yes, what symptoms?

- Do you continue the treatment?
- Have you tasted the product?
- Do you share it with other family members? Why?
- What is an approximate duration of the treatment?
- Will you continue the treatment until your child fully recovers? Why? Why not?

Answers:

16-03-2015 UC; Kakar Village; Kakar Ethnic Group; Sindhi Source beneficiaries of CMAM program

I did not wait for long ,, they treated very well , they gave chocolate for treatment , and also explained how to use and showed also and child is getting healthy, and will continue treatment until complete health.

Date:16-03-2015 UC: Kande chuke Vill: Baid (Carers, BNF)

20 to 60 minutes wait generally, Consultation time with nurse is avg:3 minutes, she is kind and respect carers and children mothers, they give me chocolates for treatment, baby like it, They explain just at time of admission that how to use ration, I received full ration mention on card every time, I will continue till end of treatment because baby improving.

18-03-2015 UC; Kandi Chuki Village; BHU Baid Ethnic Group; Baloch , Source beneficiaries of CMAM program

Didn't had to wait more than 10 mins. Treated well, gave some useful info also about prog & treatment, gave chocolate never tasted but it is for weak children, don't know approx duration of treatment but its good for betterment of children.

17-03-2015 UC; Mitho Babar Village; Belo Patan Ethnic Group; Balochi, Source beneficiaries of CMAM program

We don't have to wait here staff is very cooperative, they give chocolates for treatment of children, also washed our hands before having medicine, its only for child so never tasted it, and will continue medicine till the child gets normal.

APPRECIATION OF CMAM PROGRAMME

- What do you think of CMAM programme (+/-)? Why?
- Will you refer other children in your community? Why? Why not?

If positive answer given:

- Have you already referred other children in your community? When? Why?
- What would you change to improve the quality of the programme?
- Is it easy to get to the health centre?

If not, what makes it difficult?

- What means of transport do you use?
- What is the price of the journey there and back?
- How long does it take you?
- Who takes care of your children during your absence?

Answers:

16-03-2015 UC; Kakar Village; Kakar Ethnic Group; Sindhi Source beneficiaries of CMAM program

Its good because its free and its not very far to come here.

Date:16-03-2015 UC: Kande chuke Vill: Baid (Carers, BNF)

Yes it is very positive approach for SAM children treatment, because its implemented at community level, I counselled many father's children of KANGI to bring their children for treatment. My suggestion to give some extra ration or any other food for siblings, its not easy to come here because of self transport cost 300 to 400/follow ups visit (time :Avg 2 Hours). My wife and mother take care in absence of mine.

18-03-2015 UC; Kandi Chuki Village; BHU Baid Ethnic Group; Baloch , Source beneficiaries of CMAM program

People are getting aware because its free and beneficial in improving children health. And its easy to get here, like 20 minutes ride and costs approx 50 PKR for petrol.

17-03-2015 UC; Mitho Babar Village; Belo Patan Ethnic Group; Balochi, Source beneficiaries of CMAM program

Program is very good its first time being enrolled in program, and to come here via local transport it costs 100 and 2 hours of time.

COVERAGE / REJECTIONS / DEFAULTING

- Do you know other children in your community who need the treatment?

If yes, why aren't they in the programme?

- Are these children or their parents stigmatised by any community members? Why?
- Do you know about any children being rejected? Why?
- Do you know about any children abandoning the treatment? Why?
- How could we motivate them to return?

Answers:

16-03-2015 UC; Kakar Village; Kakar Ethnic Group; Sindhi Source beneficiaries of CMAM program
Don't Know

Date:16-03-2015 UC: Kande chuke Vill: Baid (Carers, BNF)

Yes some children also need treatment, more than ten children, they are very weak, I referred them but MUAC is greater than criteria. One child I know who was abandoned but again motivated by CHW. And he is now cured,

18-03-2015 UC; Kandi Chuki Village; BHU Baid Ethnic Group; Baloch, Source beneficiaries of CMAM program

All were referred by CNV and there is stigmatisation for children, healthy children are rejected,,

17-03-2015 UC; Mitho Babar Village; Belo Patan Ethnic Group; Balochi, Source beneficiaries of CMAM program
Don't know.

