



COVERAGE MONITORING NETWC



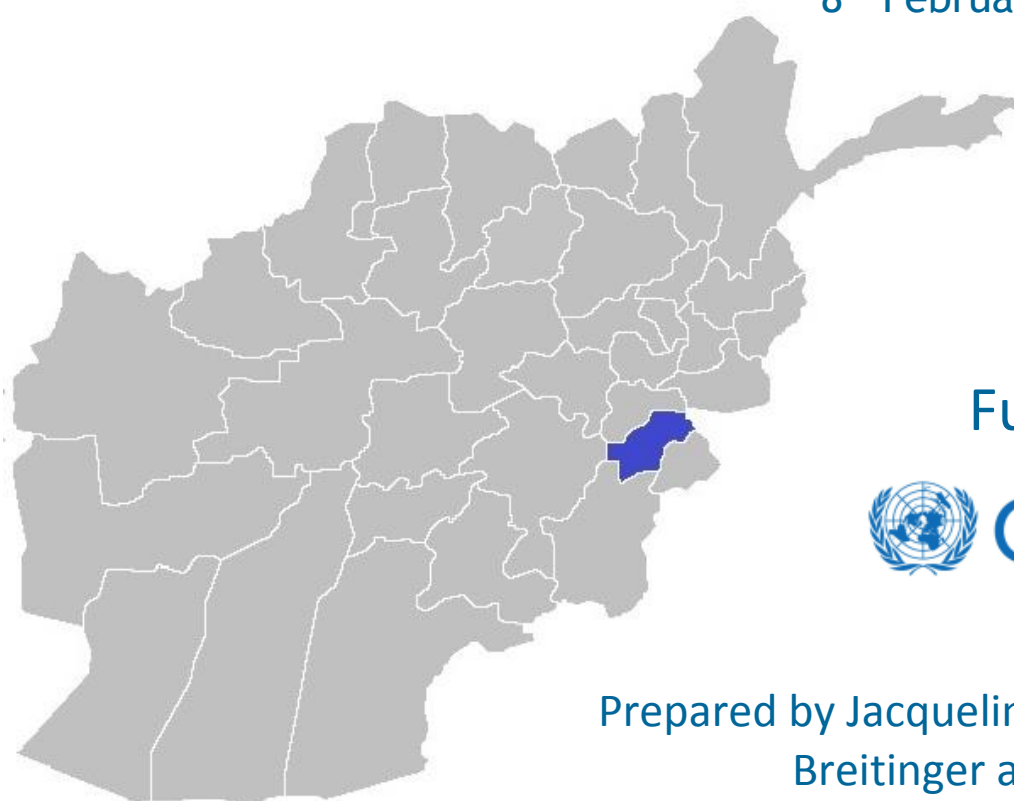
HealthNet TPO



Semi-Quantitative Evaluation of Access and Coverage (SQUEAC)

Gardez, Ahmadaba and Chamkani Districts
Paktya Province

8th February - 3rd March



Funded by:



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Action Contre la Faim

ACF is a non-governmental, non-political and non-religious organization

ACKNOWLEDGEMENTS

The authors would like to extend their thanks to the SQUEAC team from Healthnet-TPO and ACTD for their hard work and good company. Particular thanks must go to Dr Ashiqullah for his commitment to the logistics of the assessment, and to Dr Mohammad Yusuf Shoor for his hospitality at the HN-TPO nutrition office. The authors would also like to thank the Coverage Monitoring Network in London, and the ACF-Afghanistan nutrition surveillance team in Kabul, for their remote support. Finally, the assessment would not have been possible without the welcome from the communities of Ahmadaba, Gardez and Chamkani.

ACCRONYMS

ACF	Action contre la faim Action Against Hunger
ACTD	Afghanistan Centre for Training and Development
AOG	Armed Opposition Group
BHC	Basic health centre
BPHS	Basic package of health services
CBHC	Community based health care
CHF	Common Humanitarian Fund
CHC	Comprehensive health centre
CHS	Community health supervisor
CHW	Community health worker
CMAM	Community based management of acute malnutrition
DH	District hospital
EPHS	Emergency package of health services
HN-TPO	Health Net TPO
HMIS	Health Management Information System
MAR	Monthly Activity Report
MAAR	Monthly Aggregate Activity Report
MAM	Moderate Acute Malnutrition
MUAC	Mid-upper arm circumference
OCHA	UN Office for the Coordination of Humanitarian Affairs
OTP	Out-patient therapeutic programme
RUTF	Ready-to-use therapeutic food
SAM	Severe Acute Malnutrition
SEHAT	System Enhancement for Health Action in Transition Project
SMART	Standardised Monitoring and Assessment of Relief and Transitions
SQUEAC	Semi-quantitative evaluation of access and coverage
TFU	Therapeutic feeding unit
WHO	World Health Organisation
W/H	Weight for height z-scores

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EXECUTIVE SUMMARY

Health Net TPO and ACTD (Afghanistan Centre for Training and Development), with support from ACF Afghanistan, conducted a SQUEAC training and assessment in Gardez, Ahmadaba and Chamkani Districts of Paktya Province, Afghanistan in the month of March 2015. The objectives were twofold; build the capacity of programme staff in the coverage methodology and provide reliable coverage information for the SAM treatment services. The assessment would provide a coverage estimation for SAM treatment services, as well as information on barriers and boosters to access, and ultimately develop recommendations to improve coverage.

The assessment estimated a point coverage of **53.3% [CI 95%: 42.5% - 64.4%]** for the districts of Gardez and Ahmadaba¹.

The assessment identified a number of important barriers to access including: poor information about SAM treatment given to the mothers by the health facility staff, poor or no screening by the CHWs, gaps in contracts between nutrition implementers and donors causing gaps in funding, weak communication between OTP site and the CHWs, lack of motivation for the CHWs, stock outs of RUTF, carers going to private doctors who do not refer to the OTP service, alternative health seeking behaviour, the absence of mahram to escort mother to OTP services and long distance to OTP sites.

The assessment also identified positive factors effecting coverage (or boosters), such as good awareness of malnutrition in communities, good awareness of SAM treatment services in communities, strong influence of malik/mullah in communities who share nutrition messages, word of mouth dissemination about SAM treatment and malnutrition, referral to OTP by private doctors², health facility outreach (vaccinators and health educators) screening and/or referral and some passive screening in health facilities.

Based on these findings, recommendations were made under five key areas in order to overcome the barriers to access and improve coverage. First, to improve supply chain management for RUTF supplies as well as improving the timeliness of reporting on stock.

Second, since the assessment reported poor case finding and low levels of activity from the CHWs, recommendations are made to improve the effectiveness and coverage of the CHW network. This includes managing the CHW work load and recruiting more CHWs, especially females. In areas where there are no CHWs, nutrition community mobilisers should work closely with key influencers (including private doctors, mullahs and maliks) at village level. At the community level the assessment also recommends that the implementing partner develops a unified nutrition and health community mobilization plan for villages. This would involve collaborating with key influencers and all health actors (such as vaccinators) at community level.

The third recommendation area is to strengthen the reporting and data management on SAM treatment. This begins at OTP level where OTP cards and register reporting needs to be improved, and then also includes the need to do more month on month aggregate analysis of the program data in order to identify trends and gaps over time. Furthermore, it is recommended that certain SQUEAC tools (such as MUAC on admission to monitor case-finding) are integrated into routine monitoring.

Finally, the assessment recommends that alternative modalities for delivering SAM treatment services in the insecure areas are explored. A qualitative study was conducted to delve deeper into how access to health services is affected in insecure areas, highlighting the care and nuance needed in order to benefit from opportunities from access and ensure the safety of users and health care staff. Private doctors were identified as potential actors in accessing insecure areas.

¹ Chamkani was excluded from the wide-area survey for security and reasons of time. See relevant section for further explanation.

² Although referral to the private doctors who did not then refer to the OTP was a barrier, in some cases the private doctor did refer thereby acting as a booster.

1. INTRODUCTION

1.1. Context

In order to gain reliable information related to the performance of SAM treatment in Afghanistan, ACF, in partnership with OCHA, has embarked on a series of coverage assessments across the country. Targeting the areas with the highest SAM prevalence,³ ACF, in partnership with nutrition programme implementers, will be facilitating SQUEAC (Semi-Quantitative Evaluation of Access and Coverage) assessments to measure the coverage and gain an in depth understanding of the factors that affect access to SAM treatment services.

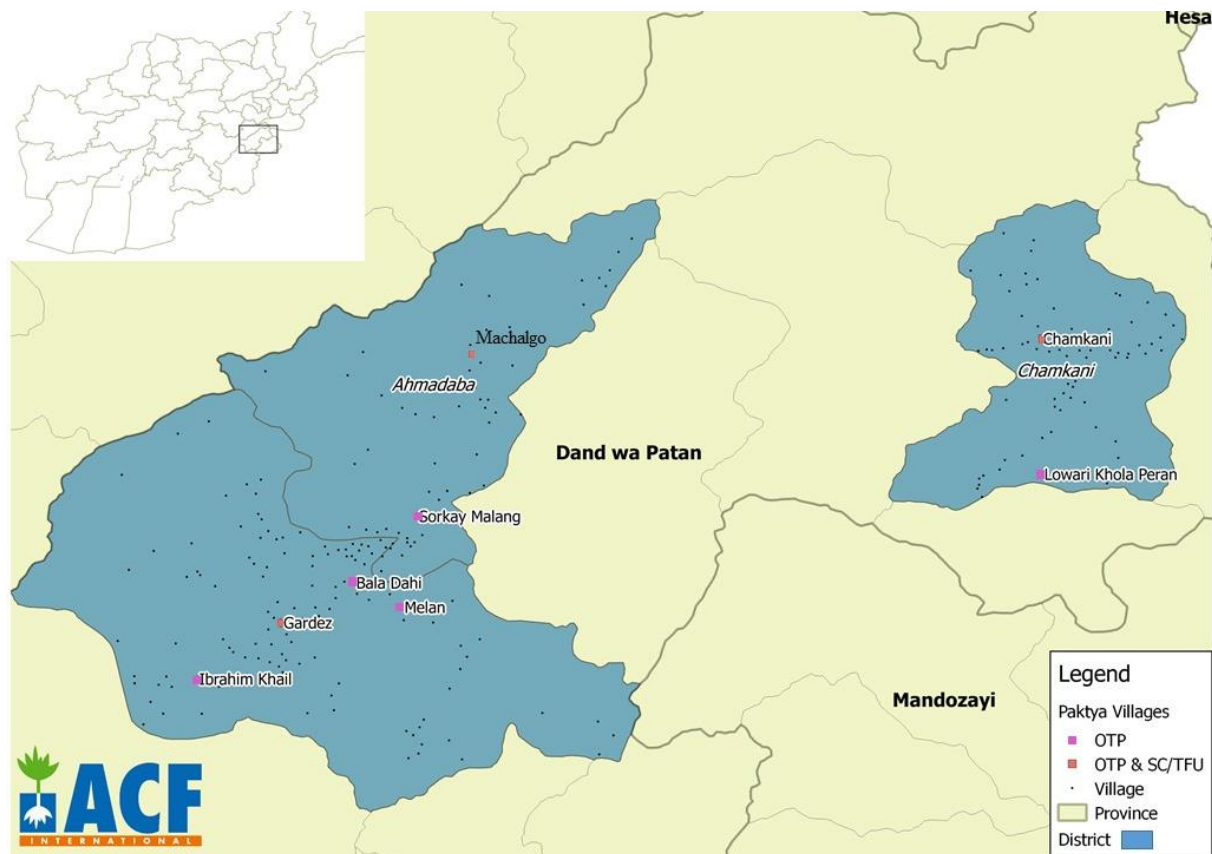
The BPHS (Basic Package of Health Services) and SAM treatment (both inpatient and outpatient) in Paktya Province are provided by the NGOs Health Net-TPO (HN-TPO) and the Afghanistan Centre for Training and Development (ACTD). Since there is limited financial provision under the BPHS contract for SAM treatment, the nutrition programmes are getting supplementary funding from the Common Humanitarian Fund (CHF). Both HN-TPO and ACTD have been BPHS implementers in the province since 2009. The current SAM treatment programme has been active since June 2014. Prior to that there were various funding arrangements that allowed SAM treatment to function at varying levels, although between January and March 2014 there was no SAM treatment due to lack of funding⁴.

Three of the 14 districts of Paktya (Gardez, Ahmadaba and Chamkani) were selected for the SQUEAC assessment. SQUEAC assessments are designed to assess access and coverage at health district level, however since there are two actors present in Paktya it was decided that at least one district from each provider should be covered. ACTD cover provides OTP services in both Chamkani and Adhmadaba districts, and HN-TPO is the provider in Gardez. Security considerations were also an important factor in determining the districts to be targeted for this assessment. See map below highlighting districts selected in Paktya.

³ See Afghanistan National Nutrition (SMART) Survey 2013

⁴ The Oxfam Novib partnership ended at the end of 2013 and the CHF contract started in March 2014

Map 1: Map of Paktya Province with selected districts, villages and health structures marked (*Paktya Province, Afghanistan, February 2015*)



1.2. Objectives

1. To assess point and/or period coverage of SAM treatment in Ahmadaba, Gardez and Chamkani districts;
2. To identify factors (boosters and barriers) affecting the access to the CMAM programme;
3. To develop specific recommendations to improve acceptance and coverage of the programme;
4. To enhance competencies of the nutrition programme staff from ACTD and HN-TPO in the SQUEAC methodology.

1.3. Methodology

The SQUEAC (Semi-Quantitative Evaluation of Access and Coverage) methodology⁵ was employed in order to determine the coverage rate in the district and to provide recommendations for improving coverage as well as a rich body of evidence to underpin them. The SQUEAC took place in the following stages:

Stage 1: An analysis of all quantitative data, collection and analysis of qualitative information and the identification of negative and positive factors effecting coverage.

Stage 2: Development and testing of hypotheses to confirm (or reject) assumptions related to areas of high or low coverage, and to ascertain whether coverage is uniform throughout the district.

Stage 3: Wide-area survey to determine district wide coverage estimate using Bayesian techniques.

⁵ M Myatt et al 2012 *Semi-Quantitative Evaluation of Access and Coverage (SQUEAC)/Simplified Lot Quality Assurance Sampling Evaluation of Access and Coverage (SLEAC) Technical Reference*. Washington, DC: FHI 360/FANTA.

The core SQUEAC team consisted of nine people from both ACTD and HN-TPOs nutrition programme teams, as well as three staff from ACF⁶. Four supplementary enumerators were recruited to boost the numbers for the fieldwork during Stage 1, and 10 during the small and wide area surveys.

The assessment took place over the course of three weeks from 8th February to 3rd March 2015⁷.

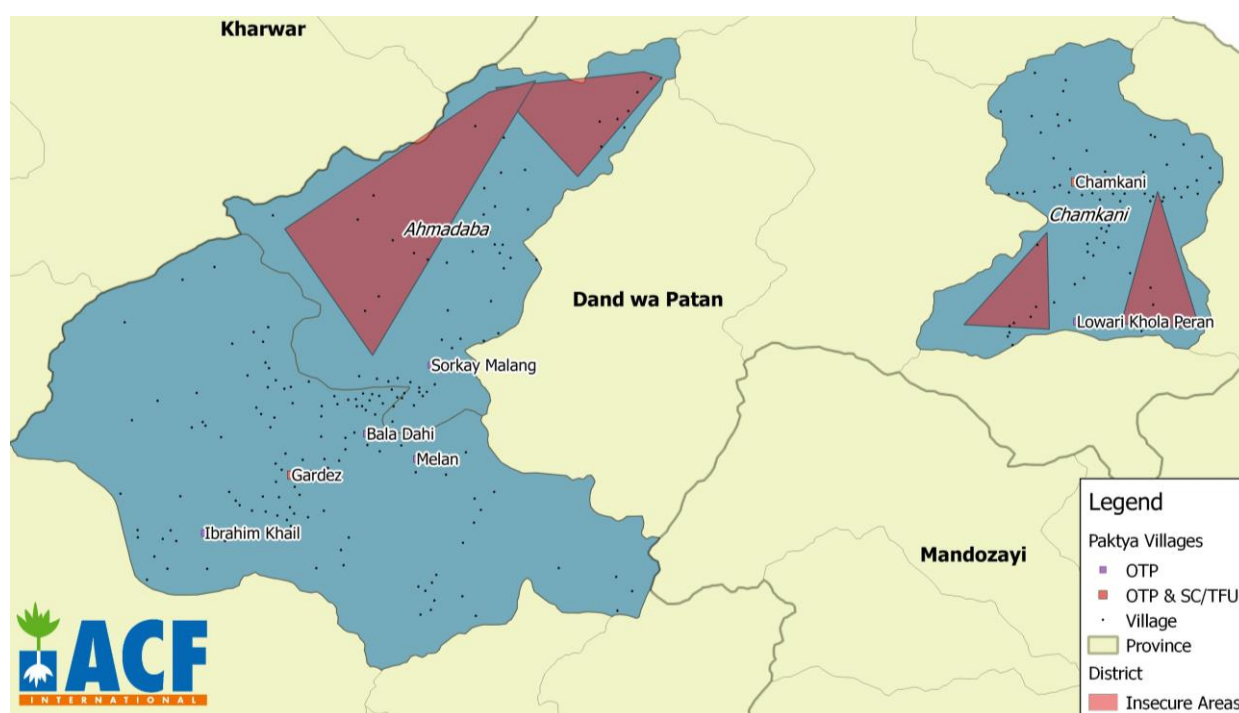
1.4. Challenges and Limitations

Insecurity

The most significant limitation to the assessment was the insecurity throughout the three districts. This meant that the expatriate members of the team were unable to travel outside of the HN-TPO nutrition office where the training took place, and also that certain areas were inaccessible for all of the team (see map below). Largely speaking these were areas in the mountains away from main towns and roads, which were not controlled by government forces. This included around 50% of Ahmadaba, large parts of Chamkani, and the southern parts of Gardez near to the border with Zurmat⁸.

Insecurity, and how it affects health services, was investigated during a Small Study in Stage 2; two incidents illustrate the risks for the assessment team quite well. On the return from Chamkani district after a day of qualitative data collection two teams were stopped at an AOG checkpoint. Although they were able to explain their movement by the fact they were private doctors, and were waved on, having continued on their journey they saw ANP rushing to the checkpoint and heard shots soon after. In a second incident (in the Ibrahim Khail area) an assessment team were told by villagers that they should leave very quickly and not come back since there were AOGs present in the village. Both incidents caused distress for the team, and demonstrate some of the risks in doing surveys in Afghanistan.

Map 2: Map showing districts and areas inaccessible by the SQUEAC team (*Paktya Province, Afghanistan, February 2015*)



Data Availability and Quality

⁶ See Annex 1 for full list of the SQUEAC team.

⁷ See Annex 2 for a full work plan

⁸ See Annex 3 for a list of the inaccessible villages.

The issue on program reporting is addressed elsewhere in the report, but data availability and reliability was a challenge for the SQUEAC team. Although there are systems in place to collect some data, there is very limited aggregation and analysis. Therefore it was down to the SQUEAC team to develop databases to do this. This was necessary for admissions and discharge data (from monthly reports), and for various other indicators (length of stay, MUAC on admission, admissions per village etc.) and analysis of OTP cards. Even with the OTP card analysis, information of reason for default was very limited. Individual CHW data was also unavailable therefore it was only possible to gauge CHW activity per health facility catchment area. A common bi-product of a SQUEAC assessment is that areas for the improvement of data management and analysis are highlighted. Therefore it is hoped that this experience will lead to strengthening the current nutrition reporting system, and developing additional monitoring processes, at both facility and management level, (to compliment the HMIS⁹) in order to yield a richer data set from the SAM treatment programme. This is dealt with in the recommendations section.

1.5. Description of Area and Population

Paktya is one of the 34 provinces of Afghanistan, located in the south eastern region of Afghanistan, and covers an area of 6259 km². The province contains 14 districts with Gardez as the provincial capital. Gardez is located 115 km to the southeast of the capital Kabul. Around two thirds of the province is mountainous or semi-mountainous terrain making it prone to natural disasters such as flash floods, extreme winter, landslides and avalanches¹⁰.

The population of Paktya is estimated at 516,000, with approximately 65,000 households, each having on average eight members¹¹. Most of population (96%) live in rural districts whilst a minority live in urban areas (4%). It also has a population of Kuchis (or nomads) whose numbers double during the winter season to almost 10,000. The literacy rate is particularly low in Paktya at 11-15% and is predominantly male¹². See Annex 4 for further information on the livelihood zone that incorporates Paktya.

The largest (91%) ethnic group is the Pashtun who has historically lived in the area for centuries, followed by a minority (9%) of Tajik. Pashtu is spoken by 97% of the population and Dari by the remainder.

Paktya is a highly volatile, AOG¹³-dominated and insecure province. The province has strategic importance because of its shared border with Pakistan and its location on the route to Kabul. It has been the scene of bitter fighting throughout the wars, falling to mujahedeen control in the 1980's and thereafter to Taliban control (1989 to 2001). After the collapse of the Taliban and the establishment of a new government, a significant number of refugees living in Pakistan returned to Paktya.

The present security situation is volatile especially in the mountainous regions, districts close to the Pakistan border, and districts where AOGs are more active¹⁴. Roadside bombings, IED attacks, kidnapping and theft are all frequent and significantly affect the daily lives of civilians.

1.6. Nutrition Situation

Despite recent congratulatory statistics related to access to health care¹⁵, there is significant evidence to suggest that access for all and good quality health care has some way to go.¹⁶ For example, in January 2015 there has been an 18% decline in patients accessing medical services due to the deteriorating security situation.¹⁷ These challenges significantly hamper efforts to respond to health needs, including SAM treatment.

⁹ Health Management Information System. This system reports on a wide range of health indicators, but only a two (number screened and number referred) related to nutrition.

¹⁰ 4,660 individuals were affected by natural disasters and 113 houses were damaged and destroyed from 2012 to 2013

¹¹ Afghanistan CSO population data 1390 (2011)

¹² Paktya Humanitarian Profile Feb 2014

¹³ Armed opposition group

¹⁴ <http://afghanag.ucdavis.edu/country-info/Province-agriculture-profiles/paktya/Paktya.pdf>

¹⁵ Newbrandera, Ickxa, Ferozb and Stanekzaic, Afghanistan's Basic Package of Health Services: Its development and effects on rebuilding the health system Global Public Health, 2014 Vol. 9, No. S1, S6-S28, <http://dx.doi.org/10.1080/17441692.2014.916735>

¹⁶ Between Rhetoric and Reality: The ongoing struggle to access health care in Afghanistan. 2014. Medecins sans frontieres

¹⁷ <http://www.1tvnews.af/en/news/afghanistan/15206-red-cross-saw-twice-as-many-dead-afghan-fighters-in-2014-fears-worse-to-come%20News>

There is no recent and reliable SAM prevalence data available for Paktya province, however a recent SMART survey in the neighbouring Nangarhar province indicated a SAM rate of 0.4%¹⁸.

The CMAM program in Paktya¹⁹ started in early 2009. Since then various implementing partners and donors have supported SAM treatment on both an inpatient and outpatient basis. Due to gaps in contracts with donors and differing funding arrangements there has at times been reductions in the number of OTPs and provision of supplies (for example between January and June 2014 when the Oxfam Novib supported programme had finished and the CHF yet to start).

SAM treatment services today are led by BPHS providers ACTD and HN-TPO. Since funding for SAM treatment is limited under the BPHS contract, CHF funds a full-scale SAM treatment programme in the province, with a total of 33 OTP sites. ACTD runs 20 OTP and HN-TPO another 13 OTPs. Table 1 lists those OTPs that are situated in the three districts to be included in the assessment.

SFP, funded by WFP, is also provided in Paktya Province, with the partner HN-TPO holding the contract. The actual implementation of the SFP however is performed by the BPHS provider (ACTD or HN-TPO). The Nutrition Nurse in each health facility is generally in charge of both the MAM and SAM treatment. This is a positive arrangement which helps to ensure that there is no miscommunication between the programmes, and that children end up receiving the appropriate treatment.

Table 1: Details of health structure and nutrition service provision in the 3 districts of Paktya (*Paktya Province, Afghanistan, February 2015*)

Name of Health Facility	District	Partner	Type	Nutrition Service
Gardez	Gardez	HN-TPO	PH	TFU/OTP/SFP
Mehlan	Gardez	HN-TPO	BHC	OTP/SFP
Balada	Gardez	HN-TPO	Sub-Health Centre	OTP/SFP
Ibrahim Khail	Gardez	HN-TPO	BHC	OTP SFP
Surkai Malang	Ahmadaba	ACTD	BHC	OTP/SFP
Machalگو	Ahmadaba	ACTD	CHC	SC/OTP/SFP
Chamkani	Chamkani	ACTD	DH	SC/OTP/SFP
Lowari	Chamkani	ACTD	BHC	OTP/SFP

1.7. Nutrition Programme Staff

The nutrition programme staff structure is essentially the same for both partners. For ACTD, the Senior Project Manager and CHF Nutrition Focal Point (both working from Kabul) lead the Nutrition Supervisor/Trainer and the Monitoring Officer at the province level. At facility level there is a nutrition nurse dedicated to SAM and MAM treatment. This nurse is supported by core health facility staff such as, the community health supervisor (CHS), health educator, midwife and medical doctor.

For HN-TPO the Nutrition Focal Point (based in Kabul) oversees the Nutrition Programme Manager at provincial level. The programme manager then supports two Supervisors and the Community Mobilisation Officer. At facility level there is a nutrition nurse and food distributor dedicated to both SAM and MAM treatment. They are also supported by health facility staff including the midwife, CHS and medical doctor.

¹⁸ ACF SMART 2014

¹⁹ From hereonhere-on Paktya will be used to refer to the three selected districts for the assessment (Ahmadaba, Gardez and Chamkani)

2. STAGE 1

The objective of Stage One is to collect and analyse quantitative and qualitative data in order to identify likely coverage and potential areas of, and reasons for, high and low coverage within the assessment area. The quantitative data analysis allows us to understand what the programme ‘thinks’ before complementing this with qualitative information from all programme stakeholders.

2.1. Quantitative data analysis

Routine programme data is collected on two levels; through the HMIS (Health Management Information System) and through a parallel nutrition reporting system. The HMIS collects only the number of children screened (by CHWs) and the number of children referred (for MAM and SAM) by CHWs. This data is reported by individual CHWs in the MAR (Monthly Activity Reports) and then aggregated by the CHS into the Monthly Aggregated Activity Reports (MAAR). Each MAAR includes the data from all CHWs attached to one health facility. Since the MAARs are stored electronically in the HMIS, they were available for each health facility however the SQUEAC team were unable to access the MARs.

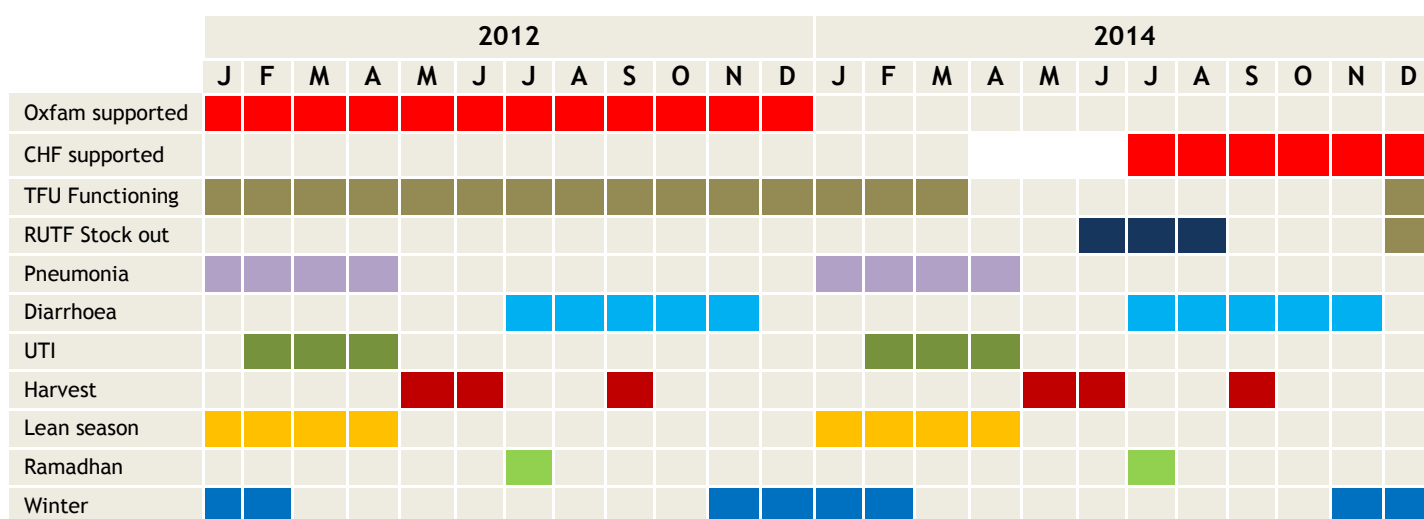
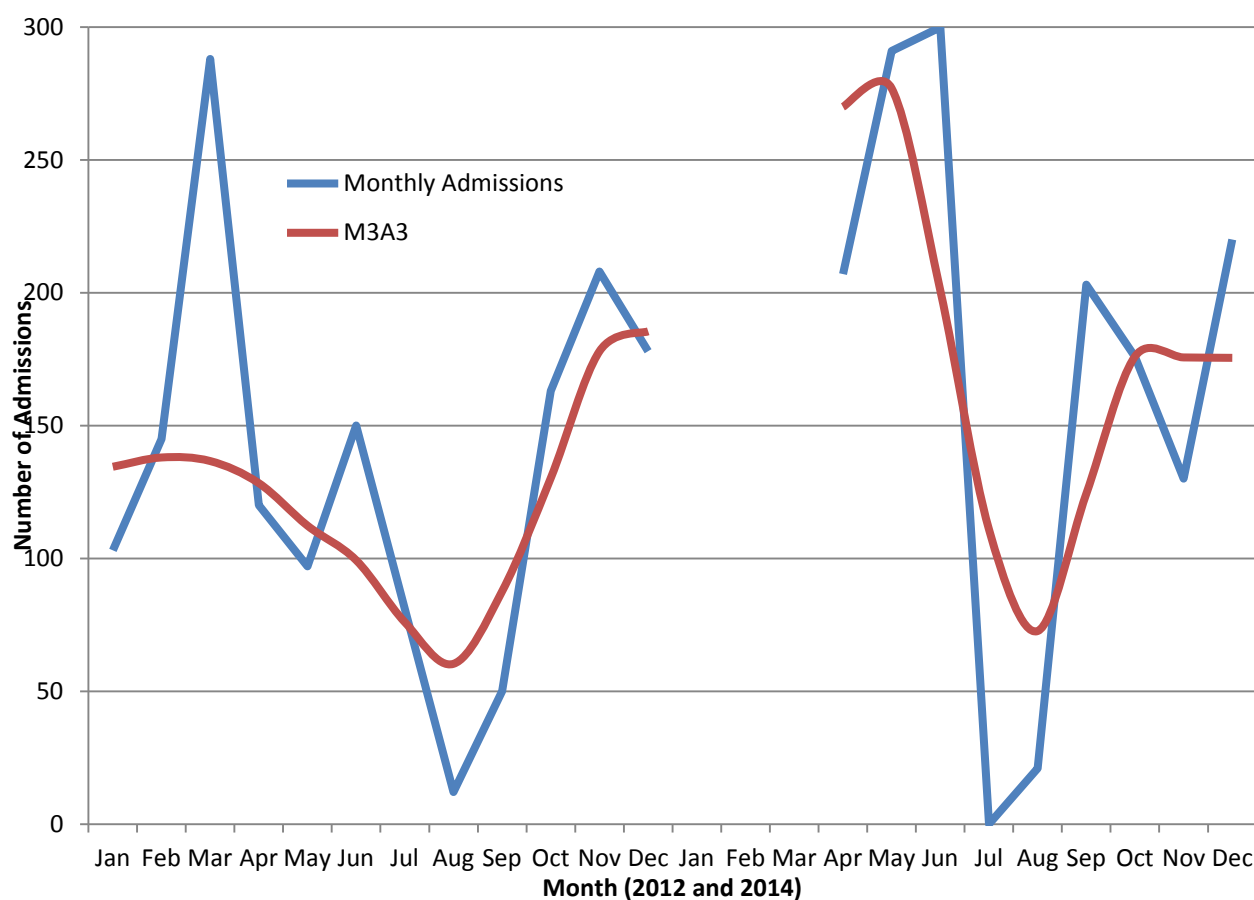
The National Nutritional Database reports OTP information from partners. Each month the nutrition nurse compiles admissions and discharges into a monthly reporting sheet. This is then entered into the National Nutrition Database by each partner. The Provincial Nutrition Officer (PNO) then reports this to the Public Nutrition Department (PND) at national level. Data entry is managed by each of the partners and later reported to the PNO and PND.

Since both reporting systems provide limited information, the SQUEAC team also analysed a sample of 1009 OTP cards (from a total of 2,763 discharges in 2014) from all eight OTPs in the period April-December 2014.

Admissions over time

Admissions data from the nutrition database from 2012 to 2014 was plotted over time. 2013 has been excluded since there is incomplete data from this time. Although there was an Oxfam Novib funded nutrition programme there is limited data available. For the month of June 2014 Gardez OTPs admissions were reduced to 300 (from 590) to avoid a severe distortion in the graph. It is likely that this is a data entry error.

Figure 1: Total OTP Admissions (MUAC, W/H and odema) over time for 2012 and 2014 with smoothing using running medians of three followed by running averages of three and seasonal calendar showing disease, food production and key events (*Paktya Province, Afghanistan, February 2015*)



Although the admissions data available is incomplete and somewhat erratic, we can notice certain patterns. Most notably we can see dips in admissions during August in both 2012 and 2014.

In both 2012 and 2014 we also see a rise in admissions after the winter period. People are reluctant to travel due to the cold weather and even unable to due to inaccessible roads, thereby decreasing admissions during those periods, but once the cold subsides access improves thereby increasing admissions.

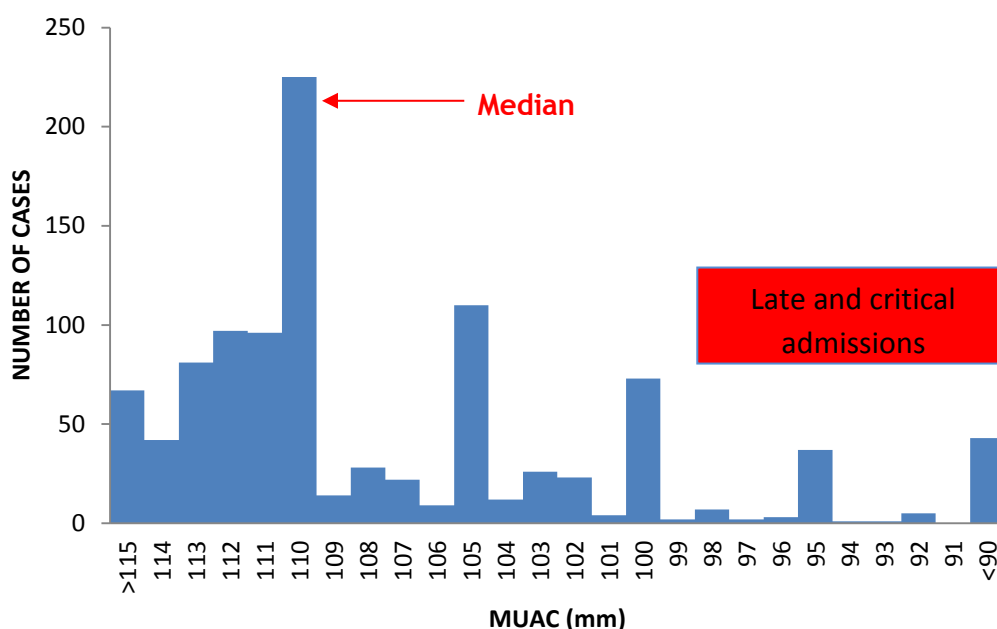
The gap in admissions between January and March 2014 can be explained by the lack of funding for OTP in the assessment during this time. Although admissions began again for April-June we see a dramatic drop in admissions once again due to an RUTF stock-out.

Finally we can observe increases in admissions during the September-October periods of both 2012 and 2014. This correlates with periods of high rates of diarrhoea. This correlation indicates that there is passive screening happening at facility level. When such screening is taking place increases in the case load of certain diseases should lead to increases in SAM admissions. This is particularly the case for diarrhoea since both conditions are closely related.

MUAC on admission

MUAC on admission analysis allows us to determine how timely SAM cases are being presented at OTPs. We can then determine whether this is due to prompt treatment seeking on the part of the community or due to strong case finding by CHWs. The OTP card analysis was used to collect this data.

Figure 2: MUAC on admission for all OTP sites (Paktya Province, Afghanistan, February 2015)



Although the MUAC on admission exercise was performed for those cases admitted on only MUAC admission criteria, some OTP cards showed cases admitted with a MUAC of >115mm. These are incorrect admissions since the admission criteria is <115mm MUAC. The data also shows a digit preference for multiples of 5mm (110, 105, 100, 95 and 90). The disproportionate amounts of cases at these MUAC measurements indicates poor accuracy of measurements by OTP staff. Both of these observations indicate a poor understanding of admission criteria leading to unreliable data.

We can also see a large number of critical admissions (MUAC <100mm). All cases admitted were over six months in age (as protocol dictates) and therefore the low MUACs are not due to the children being young (under 6 months). Therefore large number of critical admissions shows that cases are coming to the OTP having already developed into a critical case. This would indicate that case-finding in the community is non-existent or failing, since CHWs are not referring these cases earlier.

Finally, the median MUAC on admission for all OTP combined is 110mm. This does not demonstrate overall strong case-finding since significant number of cases (41%) are able to develop to a severe case of SAM (<110mm) before arriving at the OTP. When performing the MUAC on admission exercise for each individual OTP (see Table 2) we

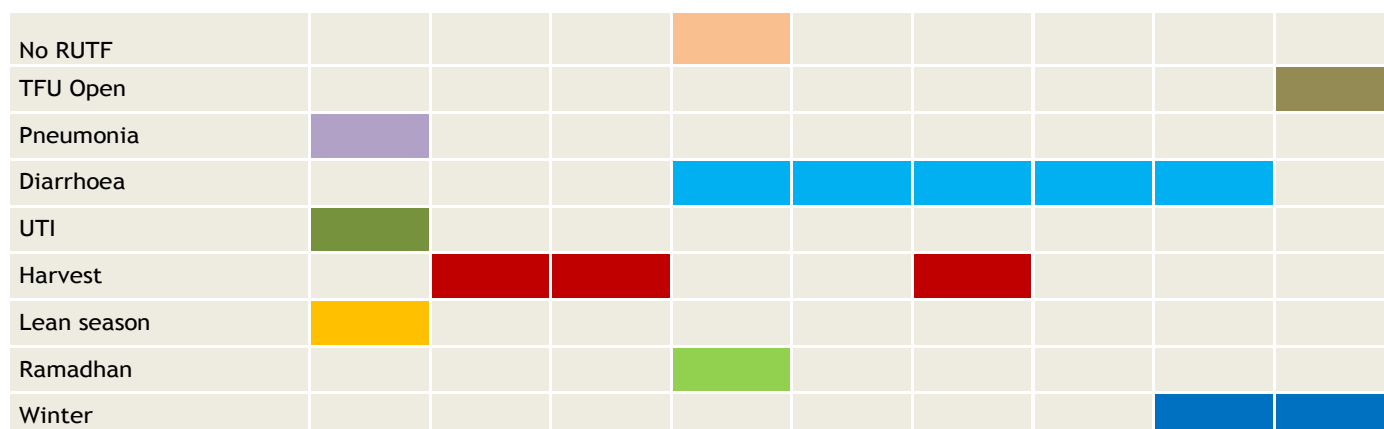
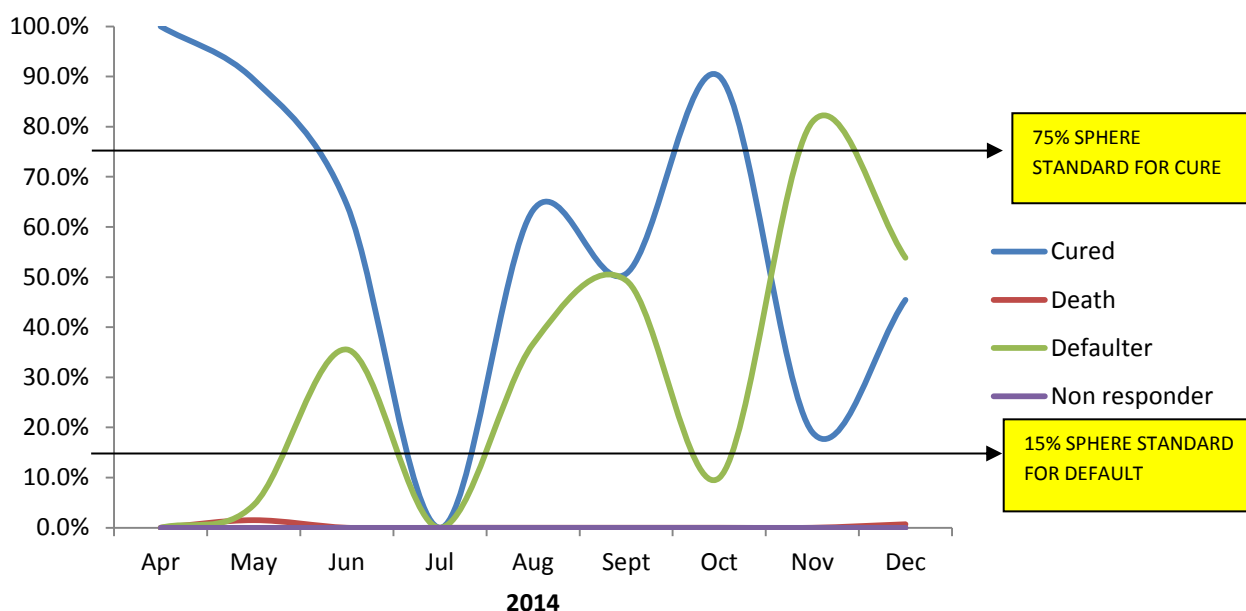
can identify OTPs that may have better case-finding (e.g. Lowari and Balada) and those that are most problematic (Gardez and Mehlan).

Table 2: Median MUAC on admission per OTP (Paktya Province, Afghanistan, February 2015)

District	Ahmadabad		Gardez				Chamkani	
OTP	Machalگو	Surkai Malang	Gardez	Mehlan	Ibrahim Khail	Balada	Lowari	Chamkani
Median MUAC on Admission (mm)	111	110	108	109	111	112	113	110

Discharge Outcomes

Discharge outcomes were analysed over time in order to evaluate the performance of the programme and identify any potential seasonal variations. The period of April-December 2014 was used since this was the most recent data available. The nutrition data base was used as the source of this data, but the OTP card sample was used to assess the reliability of the monthly data. **Figure 3: Outcome trends over time (April-December 2014) for all OTPs (Paktya Province, Afghanistan, February 2015)**



The analysis shows cure rates remain largely below the SPHERE standard (75%) and defaulter rates well above the SPHERE standard (15%) for the duration of the period. Consistently high rates of default indicate a number of potential problems with the programme that are dealt with in the section below. Findings from the qualitative research allow us to triangulate why we see this poor performance. For example, the lack of sufficient information

given to caregivers will mean that they are more likely to default, and also the limited activity of CHWs will mean that absent cases are not effectively followed up and prevented from defaulting.

Although the period analysed is 9 months and the performance erratic we can make some seasonal observations to help us understand poor programme performance. Defaulting seems to peak in the approach to winter (November and December) most likely due to roads becoming inaccessible and therefore access to the OTP. In May, June and September increased defaulting may be due to increased opportunity costs during the harvesting seasons. If there is work to be done in the fields, then the opportunity costs of attending the OTP become greater for mothers, decreasing the likelihood they will attend. All outcome indicators drop down to zero in July, during the period of RUTF shortage.

The death and non-responder rate is consistently 0%. This is a concern as it is highly likely that they are both being under reported. Information from the qualitative research showed that communication between the CHW and the OTP is weak, and it is likely that this means deaths at village level go unreported. In addition, review of the quality of data during the quantitative analysis also supports the conclusion, that deaths are likely to be under reported.

OTP Card Analysis

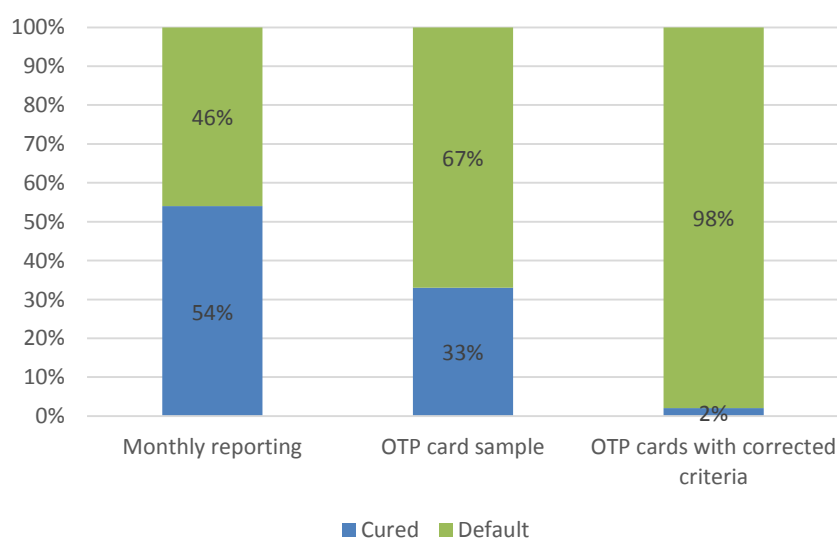
Even in programmes with a strong and reliable data management system, analysing a sample of OTP cards is an important exercise in a SQUEAC at least to validate the accuracy of the reported data. In programmes with weak and/or limited reporting, the OTP card analysis proves key in understanding the performance of the programme.

The analysis of the sample in Paktya revealed a number of important findings.

First, as with the nutrition data base we find a death and non-response rate of 0%. This is highly unlikely and therefore presents a serious concern that either these cases are being recorded as something else, or that deaths are not being recorded. This lack of clarity over the number of deaths presents a serious risk for the programme, since potentially lifesaving information is not available. The decided discharge category (cured, death, default, non-responder) was often not marked, therefore it is likely that deaths were just not recorded on the card, and then recorded as cured default in monthly reporting.

Second, comparison of the discharge outcomes from the OTP card sample with monthly reporting (from nutrition database) shows significant difference. Those cards marked cured made up 33% of the card sample as opposed to a cure rate of 54% reported in the monthly reporting for the same period (April-December 2014). This indicates poor data management from source (OTP card/register) to the data base.

Figure 4: Discharge outcomes for all OTPs per source (Paktya Province, Afghanistan, February 2015)



Third, and perhaps the most significant finding related to the use of outdated discharge criteria. Prior to the publication of the current IMAM guidelines in December 2013, the discharge criteria for MUAC admissions was 115mm for two consecutive weeks. Since December 2013, the discharge criteria has been 125mm MUAC for two consecutive weeks. However 31% of cases marked cured in 2014 (according to the OPT card sample) were discharged using the old criteria. These mean that these children were discharged before they were fully rehabilitated and therefore more prone to relapse into a state of SAM. If those cases that were discharged incorrectly in 2014 are adjusted and considered as defaulters (since they did not reach the discharge criteria before leaving the programme) then the cure rate decreases to 2%. Therefore out of 1009 discharge OTP cards only 2% were discharged cured correctly.

Finally, there were very few oedema (n=5) and weight for height (n=12) admissions. Low oedema admissions in Afghanistan are typical however that cannot be said for weight for height (W/H). The low quantity of admissions with this criteria suggests that either W/H measurements are not being taken or they are incorrectly taken. The fact that some of the 12 admissions did not even meet the correct admission criteria (W/H < -3 z-scores for both old and new criteria) suggests that competencies in W/H measurements are very poor.

Defaulting

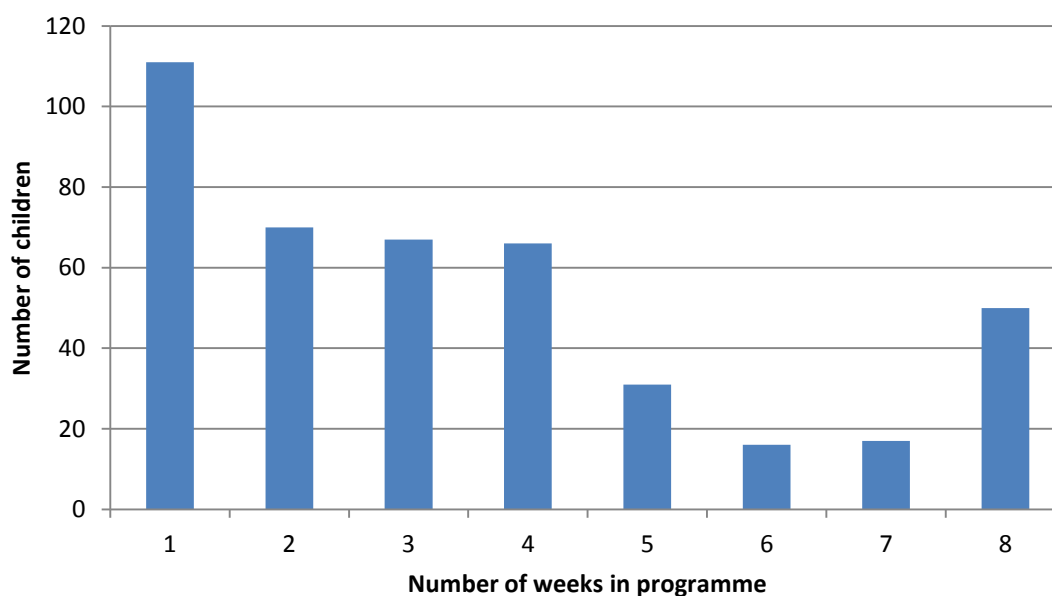
Keeping defaulting low is a key aspect in achieving good coverage for any out-patient SAM treatment programme. Therefore it is critical for any SQUEAC assessment to gain a clear picture of defaulting. We began this with data from the monthly reporting and OTP card sample.

The defaulter rate across the OTP sites was consistently high during 2014 and rarely met the SPHERE standard (maximum 15%). As detailed above, very poor data management makes it challenging to draw reliable conclusions from the data to hand. Some seasonal correlations (winter and harvest) indicate some possible reasons for defaulting.

Poor adherence to protocol (by OTP staff), demonstrated through the analysis of OTP cards, has no doubt caused cases to default and, as mentioned above, poor data management means that defaulting is much worse than reported. Due to the lack of reporting on the follow-up of defaulters, we deduce that CHWs are not tasked with reducing defaulting rates. Later on in the investigation (during the qualitative research) this is confirmed through interviews with OTP staff and CHWs.

A time to default analysis was also performed to determine when cases are defaulting from the programme. As Figure 5 shows, there are disproportionate amounts of cases defaulting after one visit to the OTP. This indicates that mothers do not know they are meant to return, or worse, that they have an unpleasant experience at the OTP. We also notice large numbers of cases defaulting after the first and the fourth visit. This, especially the important dropout rate after the first visit, indicates that mothers are not aware of the required length of stay in the programme, and therefore that they have not been sufficiently informed by OTP staff.

Figure 5: Time to default for all OTPs (Source: OTP card analysis, n= 429) (Paktya, Afghanistan, February 2015)



CHW activity

Strong community level activity is an important component of CMAM programmes. First it is important to check if there is good coordination of CHWs to ensure no villages are left without community level support. Then it is important to analyse the frequency and level of screening they perform.

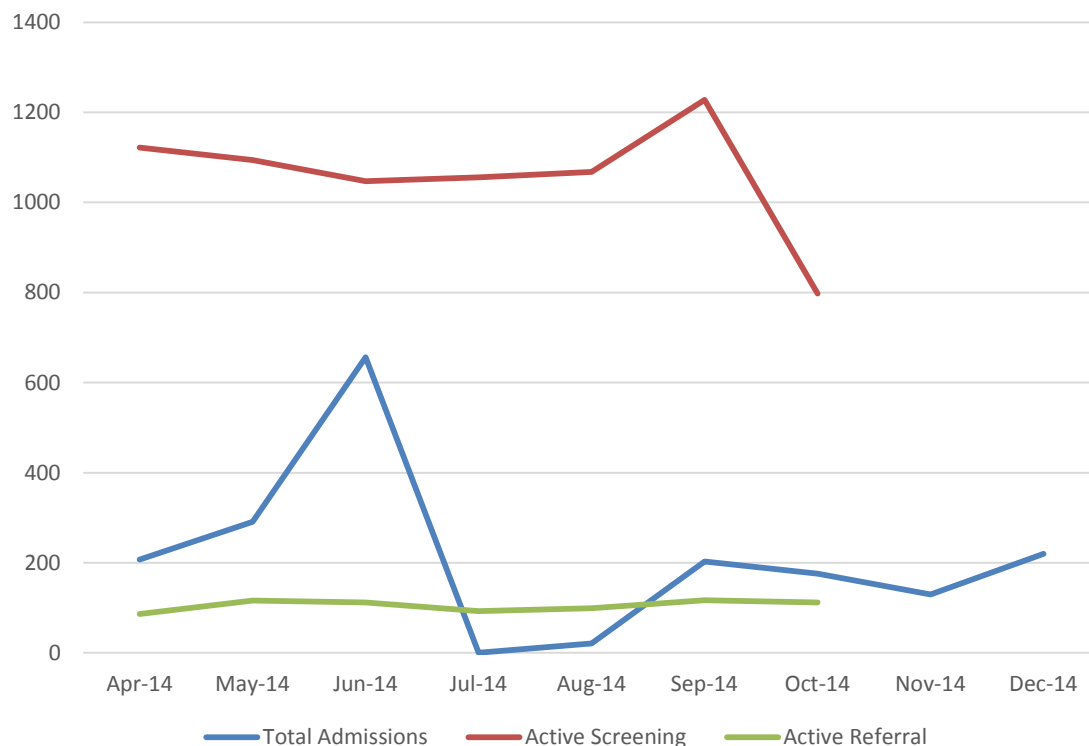
There was found to be very limited reliable data available for CHWs. A list of CHWs was provided, with limited indication of how many of these are still active. There was also discrepancies between this list and information of CHW presence gleaned from village members (especially village leaders) indicating low activity. For Chamkani, Ahmadaba and Gardez the best estimate puts the number of CHWs at 156, and since in most cases they work in pairs, this accounts for 78 villages with CHWs. With approximately 263²⁰ villages in the three districts this represents 30% coverage. It should be noted that it has been reported CHWs cover more than one village, although this is not documented, so coverage could be higher.

It was observed during the assessment that the Community Mobilization (CM) Officer for the nutrition programme does not work with the CBHC Officer who manages the CHW structure (BPHS funded). The CBHC Officer only works at health facility level managing and supervising the CHSs who in turn manage the CHWs. The CM Officer's main activities include meeting with community leaders (including Mullahs, Maliks and Health Shuras) at health facility level and informing them of the nutrition programme. Although this is clearly positive, there is also a missed opportunity in the CM Officer not working more closely with CHWs in communicating with community figures. The separation of nutrition and health community activities, is counter to attempts to integrate nutrition into the health service, and should be reviewed. The lack of clear and reliable data available on CHW presence and activity suggests poor coordination and management of the CHW network.

The graph below illustrates the number of cases actively screened and those that are referred for SAM treatment. Firstly, we notice that there is some screening that takes place, and therefore some active CHWs. Second we notice a steep decline in September 2014. This could be explained by the onset of winter. We also notice that there is not a strong correlation between cases screened and cases admitted. This suggests that admissions do not rely on active screening, and therefore that admissions are coming for other reasons. Finally we also notice a steep decline in admissions in July and August whilst referrals remain steady. The lack of admissions was due to an RUTF stockout. The fact that referrals continued to be made suggests that there is poor communication between the CHW and the OTP.

²⁰ From vaccination village list

Figure 6: Graph plotting Active screening and referrals against admissions (Source: MAAR) (*Paktya, Afghanistan, February 2015*)



2.2. Qualitative Research

Following the quantitative data analysis, some qualitative data research allowed the assessment team to understand the programme from the perspective of the programme stakeholders and investigate emerging questions. First, key informants were identified, including nutrition nurse, CHS and medical doctors (at facility level) and community elders, mullahs, CHWs, traditional healers and teachers (at community level).²¹

Second, the locations (both OTPs and villages) for the qualitative data collection were identified. OTPs were chosen based on both good and poor performance, and village locations were chosen based on distance from OTP (both far and close), number of admissions (both high and low) and high defaulters. Villages were also chosen to ensure a good spatial representation of all three districts²². Selection of villages in the insecure areas (large parts of north and east Ahmadabad and southern parts of Chamkani) was not possible.²³

Thirds, the team was trained in various qualitative research methodologies including semi-structured interviews, group discussions and case histories. Interview techniques were discussed at length to ensure the most reliable data was harvest from the qualitative research.

By the end of qualitative data collection the team had conducted 50 interviews/group discussions in 20 different locations over the course of three days. At the end of each day the qualitative research findings were organised by type of informant and added to the wall-based mind map alongside the quantitative information. The Boosters, Barriers and Questions tool was also employed in order to identify specific factors affecting coverage. Questions were also added which served to steer the investigation the next day, through the adjustment and addition over relevant questions to the questionnaires.

At the end of the qualitative research the following (Tables 4 and 5) boosters (factors effecting coverage positively) and barriers (factors effecting coverage negatively) were concluded. The sources listed are the type of informant from who the given finding was strongly triangulated (finding from at least three different informants in three

²¹ See Annex 5 for full list of interviews conducted.

²² See Annex 6 for a complete rational for the selection of each village.

²³ See Map 2 above and Annex 3 for aa full list of the inaccessible villages.

different locations). The boosters and barriers are presented in order of importance. For more clarity on their relative importance, see Table 10 where a weighting is given to each.

Table 2: List of boosters found during the qualitative research (*Paktya, Afghanistan, February 2015*)

Boosters	Explanation and Analysis	Source
Good awareness of malnutrition in communities	Good awareness of malnutrition is key to ensuring good coverage. If community members can identify malnutrition (causes, signs and symptoms) then malnourished children are more likely to be admitted. In several villages key community figures (such as maliks and mullahs) showed a basic level of understanding about malnutrition including causes. Good knowledge amongst influential figures is especially important as they are often party to any problems (including sick children) in the village. Importantly, mothers (of both SAM and non-SAM children) also showed a good knowledge of malnutrition.	Key community figures ²⁴ , mothers of SAM and mothers of non-SAM
Good awareness of SAM treatment services in communities	As with awareness of malnutrition, awareness of the services to treat malnutrition is key to ensure good coverage. The qualitative research found good awareness of the SAM treatment services across the assessment area. Knowledge of the programme was demonstrated by being able to indicate that ‘mavad’ (RUTF) was used to treat malnutrition and where it was distributed. Key community figures and mothers, again showed strong knowledge, as well as health shuras. Health shuras are community based health committees that oversee (to varying degrees) health care at community level, and therefore can be an important participant in raising awareness about the programme.	Key community figures, mothers of SAM and mothers of non-SAM
Strong influence of malik/mullah in communities and shares messages	As well as good awareness of malnutrition and the programme amongst malik and mullah, findings also indicated the disproportionate effect this awareness can have. Maliks (village leaders) and mullahs (religious leaders) tend to be the most influential figures in the community. Since they are generally aware of malnutrition and the programme (see above) this influence can have a significant effect on coverage. It was widely reported by village maliks and mullahs, that they are party to any problems in the village (OTP staff verified this). Therefore if your child is ill you visit the mullah or malik for advice before taking any other action. Thereby presenting a key	Key community figures, mothers of SAM, mothers of non-SAM and OTP Staff

²⁴ This largely refers to the maliks (village leader) and mullahs, but can include health shura (village health committee) members and other elders. Notably these informants were always men.

	moment for referring children; something that was found to happen. In addition, mullahs have been known to actively disseminate messages related to malnutrition and the programme during community gatherings (such as at the mosque), and at times work with the CHWs to do this. It should be noted that only on one occasion did a CHW discuss the importance of key community figures sharing messages related to malnutrition and the programme.	
Word of mouth dissemination about SAM treatment and malnutrition	Word of mouth is an important means of disseminating messages in most communities. Paktya was no exception, where it was found to have an important effect on increasing coverage. Mothers of SAM cases often reported that they had heard about the programme from other mothers. Although this is positive, the fact that this was a more common means of finding out about the programme and malnutrition than from the CHWs, suggests that CHW activity is weak in the assessment area.	Key community figures, mothers of non-SAM and mothers of SAM
Referral by private doctors	Although this was not a frequent occurrence, there was suggestion from some mothers that private doctors were the source of referral. It became clear during the investigation that private doctors are a significant health care provider, particularly in the remote villages, therefore key actors in ensuring SAM children receive treatment.	Mothers of SAM
Health facility outreach (vaccinators and health educators) screening and/or referral	It was reported that health facility outreach workers conducted screening and referral in parallel to additional work (vaccinating for example). Although not an official strategy (and therefore not universal nor reported) it was found to happen, and therefore represents a positive factor for coverage.	OTP staff, mothers of non-SAM and CHWs
Passive screening in health facilities	Passive (or systematic) screening should take place for all children under 5 who visit any health structure in Paktya. The qualitative research found that this practice is not universal, but it does happen in some cases and therefore without doubt contributes to better coverage. Unfortunately passive screening is limited to children under the age of 24 months, as they fall under the age for Growth Monitoring which requires that they are screened for MUAC amongst other interventions.	OTP staff and programme management staff

Table 3: Barriers found during the qualitative research (Paktya, Afghanistan, February 2015)

Barriers	Explanation and Analysis	Source
OTP/health facility staff give poor information to mothers about SAM treatment	In order to ensure the treatment is followed correctly and completed, it is important that OTP staff sufficiently inform mothers of the correct practice. Several sources showed that key messages regarding treatment are not shared effectively or at all. Quantitative data also indicated that treatment was not complete, and observations at the OTP showed that mothers were not properly informed about the length of treatment period. Other important messages such as advising against sharing, or mixing the RUTF with water were also omitted according to mothers of SAM and having interviewed OTP staff.	Mothers of SAM and OTP staff
Poor or no CHW activity	Any high coverage achieving CMAM programme has an active community component, with CHWs engaging with community and constantly screening children to ensure early admission of all SAM children. Therefore coverage assessments must look into this element of a programme. In Paktya, the qualitative research concluded that there was generally very poor CHW activity throughout the districts. In many locations screening is not happening at all, which is unsurprising considering the poor coverage of active CHWs, but even where there are meant to be active CHWs, screening was found to be at best infrequent, and at worse ineffective.	Key community figures, mothers of SAM, CHWs, OTP staff and programme management staff
Gaps in contracts between nutrition implementers and donors	Gaps in contracts between nutrition implementers (currently ACTD and HN-TPO) and donors (currently CHF) were found to have an important effect on coverage. It goes without saying that without funding, there is no programme and therefore coverage will reduce to practically zero. This does not only present challenges for the period without funding, but also has a knock on effect in terms of staff retention and development, since staff leave and find alternative work when funding ceases.	OTP staff and programme management staff
Weak communication between OTP and CHW	In order to ensure absent and defaulting cases are systematically followed-up, it is important that there is strong communication between the OTP and the CHWs. In Paktya this was found to be weak, and therefore having a negative effect on coverage.	OTP staff and CHWs
Lack of motivation of CHWs	In order for CHWs to work effectively it is important that they are motivated. In Paktya motivation among CHWs was found to be low. CHWs were found to have a long list of responsibilities ²⁵	OTP staff and CHWs

²⁵ See Annex 7 for a list of the CHW responsibilities

	(beyond nutrition) which was out of balance with their volunteer status and the level of support and training they received. This lack of motivation results in subpar work from CHWs therefore limited screening and limited follow-up, resulting in diminished coverage.	
Shortage of RUTF supply	Gaps in the supply of RUTF have an immediate effect on coverage since there is no treatment available. This was cited as a key reason for defaulting, since mothers are not able to receive treatment and so default (involuntarily). Such failures have a wider effect on coverage since mothers may be reluctant to travel if there is a chance it may be in vain, and if so, are likely to inform the wider community thereby giving the programme a bad reputation.	OTP staff and mothers of SAM
Carers go to private doctor but he does not refer	As mentioned above, private doctors are the first point of call for sick children in many villages. If the private doctor does not know about malnutrition or the programme then he will not know to refer a SAM child. Private doctors have also been known to be reluctant to refer SAM children since it would result in a loss of income. This therefore presents a barrier as the mother is likely to go on the advice of the doctor and not seek any further assistance.	OTP staff and mothers of SAM
Alternative health seeking behaviour	Investigating health seeking behaviour is a key element of a coverage assessment. In order for coverage to be high, health seeking behaviour must be directed towards the OTP first and foremost, to ensure early admission. In Paktya, we found examples of alternative health seeking behaviour. This implied that mothers initially sort treatment elsewhere including visiting the mullah or unani ²⁶ , going to a private doctor (see above) or self-medication. In some cases they may then revert to the health facility when, for example, the prayers of the mullah take no effect on the malnutrition, but this will still affect coverage negatively as there is a longer period of time when the child is not covered.	Mothers of SAM, OTP staff and mothers of non-SAM
No mahram to escort mother	The need for a mahram (male member of the family) to escort women outside of the home is a common occurrence across Afghanistan. This practice is particularly common in relatively conservative Paktya. In cases where a mahram is readily available then this need not have a negative effect on coverage. Usually this was the case, however the qualitative research found that in some cases a Marham was not available and	Key community figures and mothers of SAM

²⁶ Defined by one team member as 'a wise old women', who often engages in alternative medicine.

	therefore a cause of mothers not being able to access the OTP. In cases where the OTP was near to the mothers home, a mahram was sometimes not needed, demonstrating that this barrier is linked to distance (see below).	
Distance to OTP	Distance is a common barrier to access OTP. In Paktya this was found to also be the case, however was usually related to other barriers, rarely appearing in isolation. The distance was found to be too far or the transport was too costly, not necessarily the distance itself. Furthermore, long distances often meant a mahram was required thereby bringing on another barrier (see above).	Mothers of SAM and key community figures
Insecurity	As with many provinces in Afghanistan, in Paktya, insecurity has a significant impact on the ability of populations to access health services. The effect this has on coverage of SAM services is twofold. First, due to AOG presence and threats, mothers are unable to travel to the OTP (accompanied or not). Second, CHWs (and other outreach workers) are not permitted by AOGs to operate at community level. Generally speaking, AOGs tend to be anti-government, and since they associate health care with the government, use of these services is not permitted. That said there are examples of CHWs and mothers alike negotiating these challenges to achieve access. This issue was investigated in a small study during Stage 2 (see below).	OTP staff, CHWs and key community figures

3. STAGE 2

3.1. Small-Area Survey

The objective of Stage 2 is to test our understanding (based on findings from Stage 1) on what factors affect coverage most strongly, and if suspected, test for potential heterogeneity (or patchiness). This will be done through a Small-Area Survey where a handful of villages are purposively selected (depending on the hypothesis) and each village is sampled for SAM children to redundancy. It is determined whether each SAM child found is covered (undergoing treatment) or uncovered (not in treatment). The coverage of the sample found in each set of villages (each representing one side of the hypothesis) is then classified as acceptable or unacceptable (according to given criteria) using the simplified lot-quality assurance (LQAS) sampling method.

Evidence

The initial hypothesis proposed was that coverage is universally unacceptable (below the SPEHERE standard for rural CMAM programmes of 50%). In terms of spatial representation of coverage, distance and CHW activity were seen to be the most influential factors. As detailed above, distance incorporates three other barriers including security, the necessity to have a mahram and transport costs. Limited CHW activity was a strong finding from the qualitative research, underpinned by the large numbers of late admissions and a low MUAC on admission (110mm) both indicating poor case-finding leading to late treatment seeking. These two factors, both prominent across the assessment area, supports a conclusion that coverage is likely to be uniformly unacceptable. Although unlikely, these are also the factors most likely to cause coverage throughout the districts to be heterogeneous or 'patchy'.

The team however was not happy to accept this hypothesis for all villages. The team was adamant that coverage was likely to be better in those places that were close to an OTP, and also had a CHW. This was also supported by some evidence coming from the qualitative data. In three of the villages visited that were both close to the OTP and had a CHW (Sadique Khail, Spena Kala and Peer Kaly), community leaders demonstrated a particularly good knowledge of malnutrition and of the programme. This is only a small sample (three out of 20 locations visited) however indicates a potential correlation. Therefore the following null hypothesis was constructed:

Coverage is unacceptable in villages that do not satisfy both of the following conditions; close to OTP and have a CHW

Hypothesis definition of key words:

- ‘Unacceptable/Acceptable’ - Means coverage is less than 50% SPHERE recommended standard for rural coverage while acceptable means that coverage is equal to or more than 50% SPHERE standard.
- ‘Have a CHW’- means that CHW known to be physically located in the village and actively participating in nutrition activities
- ‘Close’ - means villages that are equal to or within 5km from the nearest OTP.

Methodology

A two-step sampling process was used to test this hypothesis. First, we selected villages (from those accessible) that satisfied the conditions of the hypothesis (two villages that are both close to an OTP and have a CHW) and villages that did not satisfy *both* of the conditions (four villages). See Table 6 for the villages selected.

Second, at village level we performed active and adaptive case-finding in order to find all SAM cases in the chosen village. Active and adaptive case-finding is a sampling method that actively searches for SAM cases by using information collected from key informants in the village to find all SAM children. These informants include mothers, village leaders and religious leaders²⁷. They were approached in order to collect information on suspected SAM cases living in the village and those already enrolled in the programme. Pashtu terms for malnutrition were used²⁸ as well as photos of malnourished children and packets of RUTF to help identify those children in the programme. When suspected cases were found they were screened using MUAC and oedema. W/H screening is generally not used during SQUEAC surveys as the equipment (height board and scales) are impractical to carry during case-finding. Furthermore, the number of W/H admissions was so small (12 out of 1009 admissions from OTP card analysis) it was felt that all SAM cases would have been identified using MUAC alone. The search continued until the whole village had been covered and the team were sure they had found all SAM cases.

When a SAM case or recovering case²⁹ was identified, it was first established if they were in the programme or not. If so, proof of admission (presence of RUTF in the household, or clear description of programme and treatment) was requested. Two different questionnaires³⁰ were then administered, one for those in the programme and one for those not in the programme. The former questionnaire allowed us to understand the reasons why children were covered (i.e. how they heard about the programme) and the later to determine why they were not in the programme (i.e. what was the barrier). Both questionnaires were translated into Pashtu, and back translated into English to ensure accuracy.

Results

A total of nine SAM cases were found in the six villages visited, four were covered by the programme and five were found to be uncovered. Those uncovered cases were referred to the OTP for treatment. Table 6 presents the cases found by village.

²⁷ See Annex 8 for a full list of the key informants identified for the active and adaptive case-finding

²⁸ See Annex 9 for the Pashtu terms associated with malnutrition used in Paktya Province

²⁹ Defined as a child that is no longer SAM (MUAC >11.4cm with no oedema present) but has yet to meet the discharge criteria (>12.4cm MUAC and no oedema for 2 consecutive weeks).

³⁰ See Annexes 10 and 11

Table 4: Results from the small-area survey (*Paktya Province, Afghanistan, February 2015*)

Village	District	<5km from OTP	CHW Present	Total SAM	SAM not covered	SAM covered
Hassan Kala	Ahmadaba	✗	✗	2	0	2
Afzail Khil	Ahmadaba	✓	✓	3	2	1
Banozai	Gardez	✗	✗	1	1	0
Woch Kwash	Gardez	✗	✗	1	1	0
Tandan	Gardez	✗	✗	2	1	1
Kalay Sursang	Gardez	✓	✓	0	0	0
	Total			9	5	4

Calculations and Conclusions

To test the small area survey results against the hypothesis, the covered cases found were compared with the target coverage value of 50%. This was performed separately for the cases found in the two sets of villages. The first set of villages were those that were close to the OTP *and* had a CHW (Afzail Khil and Kalay Sursang, total n=3) and the second set of villages were those that did not satisfy both conditions (close to the OTP *and* with CHW). These villages were Hassan Kala, Banozai, Woch Kwash and Tandan, and had a combined sample size of n=6.

The simplified LQAS method allowed us to classify coverage in each set of villages. A decision rule (d) was calculated for each sample in order to determine whether coverage was above or below 50%. To calculate the decision rule the following formula was employed:

$$d = \left\lceil n * \frac{p}{100} \right\rceil$$

d = decision rule

n= number of cases found

p= coverage standard defined

If the number of covered cases exceeds or is equal to the value the decision rule, coverage is classified as acceptable, if not, coverage is unacceptable. Table 7 presents the calculations and subsequent conclusions.

Table 5: Calculations of decision rule and results for each hypothesis in Stage 2 (*Paktya Province, Afghanistan, February 2015*)

Villages close to the OTP and with CHWs		Conclusions
Target Coverage	50%	In the case that does not equal a whole number it is rounded down; hence, this case is rounded down to 1. Therefore with 1 covered case the decision rule is met, showing that coverage in these areas meets the threshold of 50%. However since SAM cases were found in only one of the villages this finding is insignificant, therefore we cannot say that CHW presence and close
Sample size (n) n=	3+0 3	
Decision rule (d) d=	n*(50/100)= 1.5≈1	
Covered SAM cases =	1	

distance will lead to good coverage.

Villages far from the OTP and without a CHW		Conclusions
Target Coverage	50%	Since the number of covered SAM cases found in the areas that do not satisfy either of the conditions, is equal to d, the decision rule is met, therefore coverage can be said to exceed 50% in these areas as well. The sample size is strong enough to reject the null hypothesis that coverage is also acceptable in these villages.
Sample size (n) n=	6	
Decision rule (d) d=	$n \times (50/100) = 3$	
Covered SAM cases =	3	

Therefore the null hypothesis is rejected since in the sampled areas coverage has been shown to be equal 50% in villages that are far and without CHW and low < 50% in villages that are near and with CHW presence. It is evident from the analysis above that the presence of CHW's and the fact of villages being close to the OTP site does not ensure good coverage. Therefore there is no difference between villages that are considered to be far and lack CHW and those considered to be near and with CHW presence.

This could be because of a number of reasons. (1) The presence of CHW does not guarantee automatic increase in admissions. Good CHW activity was found to be wanting in Paktya where CHWs were not optimally executing their roles due to lack of support and low motivation. (2) The villages that are considered far from the OTP sites still have reported cases of children in the program and this can be attributed to the community's self-referral system that was evidenced in Paktya.

In conclusion, the small area survey data suggests that coverage is likely to be acceptable across the assessment area, but that it is unlikely to be because of CHW activity, and therefore likely to be because of another booster (such as awareness of programme and malnutrition, good community self-referral). Finally, there is nothing that indicates coverage is likely to be heterogeneous and therefore a wide-area survey would still be appropriate³¹.

3.2. Small Study on Insecurity

Background

There are large sections of the assessment area that were inaccessible to the survey team due to the fact they are controlled by AOG (armed opposition groups). Therefore it was not possible for the team to conduct qualitative research in these villages and neither was it possible to incorporate such villages in the small area survey. Therefore it was felt pertinent that in order to understand how coverage is affected in these areas a small study was conducted. Small studies are not an integral step to a SQUEAC assessment, however can be employed when there is an issue that warrants more profound investigation.

Therefore in order to understand more about coverage and access in these areas we conducted a small study. Qualitative and quantitative data analysis during Stage 1 brought us to develop the following hypothesis:

The presence of armed opposition groups in certain areas limits both access to health facilities for residents and access to communities for community-based health care practitioners (CHWs and health facility outreach teams), therefore having a negative effect on coverage of SAM services.

³¹ When a factor affecting coverage is discovered that is strong, but only effects some areas, then it is likely that this will cause coverage to be significantly different from area to area. In such a case a single coverage figure is rendered unrepresentative (for either area) and therefore has diminished utility.

Methodology

This semi-quantitative study conducted interviews with residents (of both secure and insecure areas³²) and OTP staff and compared admissions and defaulter data from insecure areas with secure areas. The overall study question was: how does insecurity affect access to health care (and in particular SAM treatment)?³³ The study had a clear limitation that we were not able to access the affected areas, however we were able to compensate by interviewing people who lived in Ahmadaba and were familiar the insecure areas, and also OTP staff who cover the affected areas (Machalgo and Surkai Malang OTPs).

The scope of the study was focussed on Ahmadaba since over 50% of the district is inaccessible, and the only two OTPs are situated in accessible areas. The inaccessible areas are largely those in the mountains, away from main towns, main roads and government forces. Although, as we found, accessibility has many nuances, the inaccessible area in Ahmadaba was not only inaccessible for the SQUEAC team but also for health care staff and even residents of the district (accessibility depending on where you are from in the district and what you are doing there).

Findings

How does 'insecurity' manifest?

The main cause of the insecurity was due to threats (to life) and harassment from AOGs. These were directed both at residents wanting to attend the health centres, as well as health staff wanting to access villages. However other fears were also cited including; fear of mines and IEDs, fear of abduction (this was largely of health workers), fear of thieves and fear of being caught between the cross fire from fighting between government and anti-government groups, as well as between other groups (such as tribes). For example, one informant explained that he has not seen some relations in a village only 30 minutes' drive away for two years since there is too much risk involved in the journey.

One informant explained how there is not only fear of being harassed by the AOGs but also by government forces (ANP and ANA). It was reported that at times residents from AOG controlled areas have been harassed for information or simply for the sake of intimidation when visiting the health facility. This is especially evident in Surkai Malang where the health facility is situated adjacent to the district governor's office, and therefore a high concentration of government forces is also present.

The close proximity of the health facility to the district governor's office also puts people at risk of being associated with the government by the AOGs, by simply attending the facility. Certain AOGs are known to be against anything that is associated with the government (education, health care, election etc.), and if the population engages with these government initiatives, then they will be targeted. This was found to be the most common reason for the harassment of people accessing health care.

Association with the government however was found to be stronger for health facility staff, community based health staff such as CHWs, and outreach workers such as vaccinators and health educators.

How does the insecurity affect functioning of the health service?

As with the rest of the districts, CHW coverage in the insecure areas is low with only 4 out of the 28 insecure³⁴ villages having known CHWs. Due to the lack of available data we are unable to gauge the level of activity of these CHWs however it is likely to be low. Interviews with OTP staff (including a CHS) revealed that CHWs are unable to work openly in AOG controlled villages, especially doing screening by MUAC and home-visits since these are more challenging to do secretly. It was reported that CHWs have been known to operate in secret. In addition, CHSs are unable to visit health posts to provide supervision and support to CHWs, although CHWs are at times able to come to the health facility for monthly meetings (although often at great risk).

Since CHWs are community-based, the level of access they have to the communities is much better than that of outreach workers (health educators and vaccinators). AOG controlled areas are almost completely out of bounds for

³² one mother from an insecure area was interviewed at the OTP

³³ See Annex 12 for full study outline.

³⁴ The insecure villages were highlighted during the interviews and can be found in Annex 3

these outreach workers, as they bear the brunt of AOG suspicion. As with CHWs they are considered government workers and often accused of spying for the government.

Another noteworthy observation is that AOGs often also object to the type of health care support that is provided by CHWs, which therefore affects all of the services they provide. This is particularly the case for family planning advice and the distribution of contraceptives.

The qualitative research revealed two different approaches of AOGs to health care and health care workers. Broadly speaking it was found that foreign armed groups (often from Warizstan in Pakistan) were more inclined to object to government initiatives (as detailed above) however localised armed groups, are often more accepting of any policies that improved the lives of the local population, and therefore allow programmes such as SAM treatment. In these cases good coordination and relationships with different actors is essential - a time consuming operation not without its risks.

How do residents from insecure areas overcome these challenges to access health care?

Barriers to access health care related to insecurity are complex and nuanced. Residents are therefore, in some cases, able to find strategies in order to receive treatment. Throughout the SQUEAC we have seen the prominence of private doctors. This was found to be particularly apparent in the insecure areas, as it means that the need for travel to the health facility is reduced. However we also found that private doctors are often unaware of malnutrition and available treatment. Communities have also been known to send residents to collect medication and vaccines from the health facility and take them back to the communities for distribution. Of course there is a risk for the intermediary; however it is reduced to them rather than all patients. Finally, alternative treatments (for malnutrition and other ailments) are resorted to if the journey is determined to be too hazardous and other treatment is unavailable. However, as we found elsewhere in the SQUEAC, if such treatments are unsuccessful recourse to the health facility is often sought. In which case a balance between the severity of the condition and the risk of the journey is determined by the carer and her family.

In such cases deceit is often required. For example, a mother was interviewed who explained that she is forbidden by AOGs for attending the health facility to receive SAM treatment for her child. Fortunately she has relatives in Machalgo town, so is able to explain to AOGs that she is visiting them in order to collect the treatment. In this case, and in others, RUTF rations for two weeks of treatment are given in order to reduce the number of visits required and therefore the risk.

The qualitative research showed that villages identified in Ahmadaba as insecure³⁵ are insecure all year round, and therefore these issues are present throughout the seasons. That said it was also strongly triangulated that during the winter fighting between government and AOGs and offensive activity is reduced, although the control of the areas and therefore threats remain continuous.

An analysis of admissions and defaulter rates in the insecure areas enables us to further determine what effect this insecurity had on the programme. Table 9 allows us to compare defaulter and admission levels for the insecure villages of the Machalgo and Surkai Malang catchment areas, with the secure parts.

Table 6: Table comparing number of admissions, defaulters and CHWs in insecure areas with secure areas (Paktya, Afghanistan, February 2015)³⁶

	Surkai Malang	Machalgo	Totals
Total # of villages	89	38	127
# of insecure villages	7	21	28
% villages insecure	8%	55%	22%

³⁵ See list in Annex 3

³⁶ Admissions and defaulting data is taken from the OTP card analysis. Numbers of insecure villages are taken by matching named insecure villages (during qualitative work) with total number of villages from vaccination list (also used in the wide-area survey)

# of admissions	143	105	248
# of Admissions from insecure areas	48	15	63
% of admissions from insecure areas	34%	14%	25%
Total # of defaulters	31	29	60
% of defaulters from all areas	22%	28%	24%
# of defaulters from insecure areas	6	5	11
% of defaulters from insecure areas	19%	17%	18%

Since the proportion of villages in insecure areas for the Surkai Malang catchment area is so small (8%) we are unable, and unlikely in any case, to see a variation in admissions and defaulters. However for the Machalgo catchment area 55% of the villages are deemed to be insecure. Despite this we only see 14% of admissions from this area. This indicates that insecurity is likely to have an important effect in terms of coverage in these areas. It is possible that the villages in the insecure areas are very small and therefore are likely to have lesser admissions. Unfortunately this cannot be verified due to the lack of population data from these villages. In any case, alongside the qualitative data, it strongly indicates that coverage is likely to be very low in these areas.

For both Surkai Malang and Machalgo we do not see an above average level of defaulting. This is likely to be because if access from these villages is difficult, patients will not have the ability to attend the programme and therefore are unable to default. In addition, due to the lack of data on reasons for default we are unable to determine if the defaulters from these areas are due to insecurity or other factors.

Conclusion

The small study shows that insecurity has a significant effect on the ability of certain populations to access health care and SAM treatment. Therefore our hypothesis is confirmed. These challenges significantly limit the ability of patients to receive treatment on time. However, we can see that access is not impossible and is at times achieved despite the dangers. CHW activity, as in most areas, is very low, however unlike other areas, outreach work is non-existent, which presents an immediate concern for the health of populations. The Small Study also presented some opportunities for improving coverage, such as working more closely with private doctors. The partner should investigate alternative ways of improving coverage in these areas, and collaborate with key community figures and mothers. Great care should be taken for the safety of mothers and health care staff.

4. BUILDING THE PRIOR

An integral part of a SQUEAC survey lies in the building a prior belief of coverage. The prior incorporates all the evidence collected during Stages 1 and 2³⁷, and illustrates a belief of what coverage is likely to be, based on this evidence.

Two different methods were selected to develop prior mode (or most likely coverage value): simple scoring of boosters and barrier, and then weighted scoring, both yielding a prior mode. The average of both prior modes was then taken as the final prior mode. Table 10 lists the boosters and barriers identified during Stage 1 and the scores for both methods. Further explanation on each method and the calculations are presented below.

Table 7: List of positive and negative factors used to inform prior belief on coverage with triangulation and weighting (*Paktya Province, Afghanistan, February 2015*)

Positive Factors (Boosters)	Simple	Weighted	Negative Factors (Barriers)	Simple	Weighted
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³⁷ Including both the small-area survey and the small study.

Passive screening in health facilities	5	2	Distance to OTP	5	1
Good awareness of malnutrition in communities	5	4	Lack of motivation of CHWs	5	3
Good awareness of SAM treatment services in communities	5	4	Poor or no CHW activity	5	4
Strong influence of malik/mullah and shares messages about the programme and malnutrition	5	5	Shortage of RUTF supply	5	3
Word of mouth dissemination about SAM treatment and malnutrition	5	3	Gaps between contracts between nutrition implementers and donors	5	3.5
Referral by private doctors	5	1	Insecurity	5	5
Health facility outreach (vaccinators and health educators) screening and/or referral	5	2	No mahram to escort mother	5	2
			OTP/HF staff give poor information to mothers about giving treatment	5	4
			Weak communication between HF and CHW	5	3.5
			Alternative health seeking behaviour	5	2
			SAM children go to private doctor but does not refer	5	3
Totals	35	21		55	34

4.1. Simple Scores

The simple scoring method sees the same score (in this case 5) allocated to each of the boosters and barriers. In this case the prior mode is only influenced by the number of positive and negative factors affecting coverage, not their relevant importance. The total scores for the positive (35) and the negative (55) factors were calculated and then used to calculate the prior mode, as follows:

$$100\% - \text{sum of negative factors} = 100 - 55 = 45$$

and

$$0\% + \text{the sum of positive factors} = 0 + 35 = 35$$

$$= \frac{45\% + 35\%}{2}$$

$$= 40\%$$

4.2. Weighted Scores

In the weighted scores method, a weight was given to each factor that represented the relative effect it has on coverage. The team worked together having analyzed all the evidence from Stage 1 and 2 to allocate a score that represented the relative effect that factor has on coverage. The team considered the following questions: How prevalent is this issue? Does it relate to only certain areas or is it applicable across the entire assessment area? How much of an effect does the factor have on coverage? How strong is the evidence? The team reflected on all the available evidence to allocate a suitable score. Using the total scores of the negative factors (66) and the positive factors (21) the prior mode was calculated, as follows:

$$100\% - \text{sum of negative factors} = 100 - 34 = 66$$

and

$$0\% + \text{the sum of positive factors} = 0 + 21 = 21$$

$$= \frac{66\% + 21\%}{2}$$

$$= 43.5\%$$

The average of the two prior modes was then taken as the final prior mode:

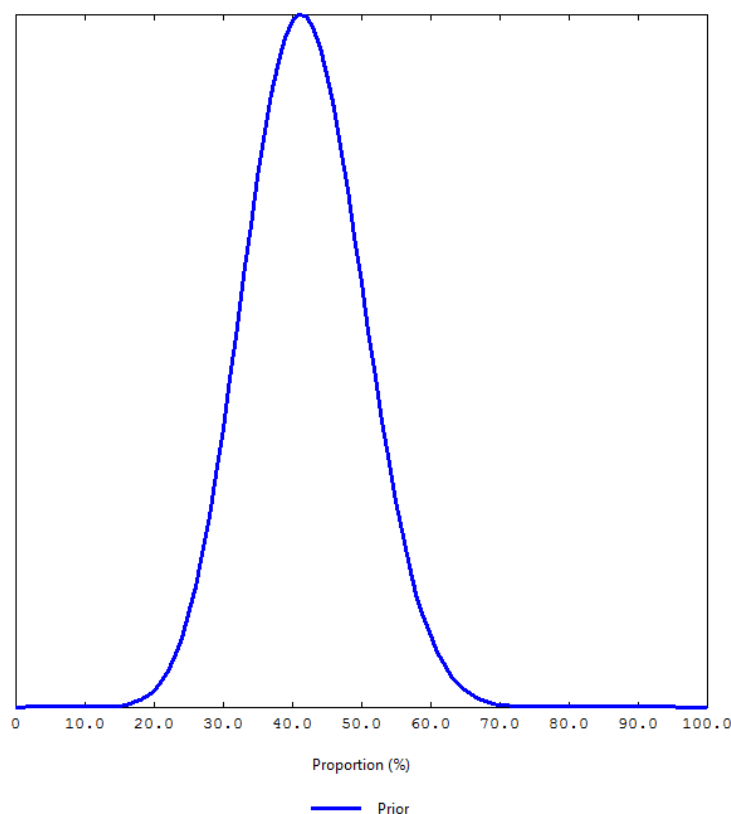
$$\text{Prior Mode} = \frac{43.5\% + 40\%}{2}$$

$$= 41.75\%$$

The standard formulas³⁸ were then used to calculate the shape parameters, in order to illustrate this prior information as a curve. The minimum and maximum possible values used were 25% below and above the prior mode. The SQUEAC Technical Reference recommends that 25% certainty is used during the first SQUEAC a programme conducts since there is relatively low certainty about the prior mode. If there was more information on coverage, as there would have been if there had already been a SQUEAC assessment conducted, then a high certainty (such as 20%) can be used. A mode of 41.75% and credibility interval of 25% gives the following shape parameters: $\alpha=14.2$ and $\beta= 19.83$, which are represented by the following curve.

Figure 7: A representation of the prior belief of coverage using the BayesSQUEAC Calculator (*Paktya Province, Afghanistan, February 2015*)

³⁸ See SQUEAC Technical Reference



$$\alpha = 14.2 \text{ and } \beta = 19.83$$

5. STAGE 3

Stage 3 is conducted with objective of estimating coverage in the assessment area. Building on the prior information collected during Stage 1 and 2, collects further quantitative data during wide-area survey, in order to provide reliable coverage estimation. The wide-area survey also collects some qualitative information shedding further light on barriers to access SAM treatment.

5.1. Building the likelihood - the wide-area survey

In Paktya wide-area survey was conducted in 24 villages across Ahmadaba and Gardez districts in order to build on the information presented in the prior.

A decision was made by the SQUEAC team to exclude Chamkani from the wide-area survey for a number of reasons. First, Chamkani was over 2 hours' drive from the base in Gardez, and the time allocated for the wide-area survey would not have allowed us to cover an acceptable number of villages if Chamkani was included. Second, there were serious security concerns with the road to Chamkani. During Stage 2 one of the teams was aggressively questioned by an AOG on return to the base. Third, with the travel time removed, the teams had more time to do good quality case-finding in a smaller number of villages. Finally, we had no evidence (from Stage 1 and Stage 2) to suggest that there were any factors affecting coverage unique to Chamkani and so felt comfortable extrapolating findings from the other two districts to Chamkani. Therefore it was concluded that there was not significant added-value on covering a third district in Stage 3.

Sampling framework

Once entered into the BayesSQUEAC calculator the above prior yielded a target sample size of 55 SAM cases (for a precision of 10%). With the required sample size determined, a two-step sampling process was used in order to identify this number of SAM children, and to ensure that the villages sampled were spatially representative. For the wide-area survey it is critical that the sampling method is random and produces a spatially representative sample.

Step One

The following formula was used to calculate the likely number of villages that we would need to visit in order to achieve the required sample size.

$$n \text{ villages} = \left\lceil \frac{n}{\text{average population per village} \times \frac{\% \text{ population 6 – 59 months}}{100} \times \frac{(\text{prevalence of SAM})}{100}} \right\rceil$$

Table 8: Estimations used for calculation of n villages (*Paktya Province, Afghanistan, February 2015*)

	Value
Required sample size (n)	55
% population 6-59 months	17% ³⁹
Prevalence of SAM	1.5% ⁴⁰
Average population of each village	707 ⁴¹

Using the formula above and estimations presented in Table 11, the calculation was as follows:

$$\begin{aligned} & \frac{55}{707 \times 0.017 \times 0.015} \\ &= 30.5 \\ &= 31 \end{aligned}$$

In order to ensure the 31 villages were selected both randomly and were spatially representative of the two districts the spatially stratified sampling (or 'list') method was employed. In this case, villages are listed by OTP catchment area, and after calculating a sampling interval (number of villages (263) divided by number of Villages

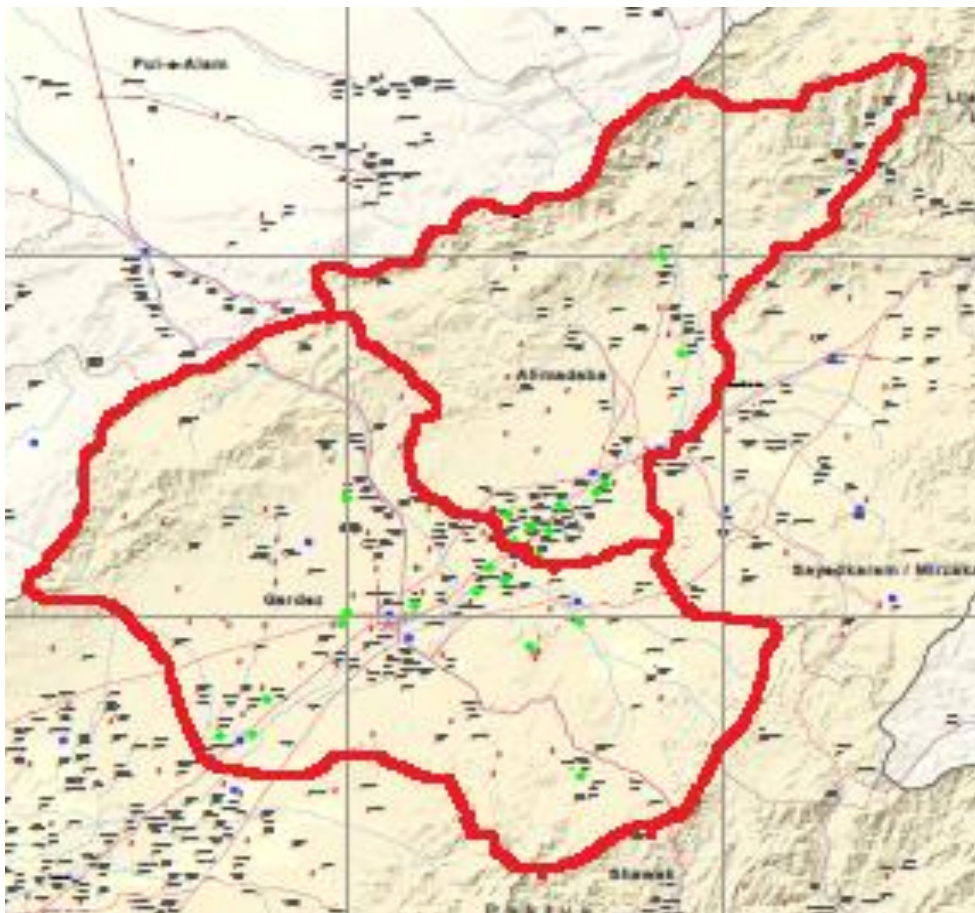
³⁹ Provided by programme staff in core assessment team

⁴⁰ In the absence of reliable prevalence data, 1.5% was used to estimate expected case load. First, the number of cases found during the small area survey was low and therefore using a lower estimate would mean we would need to go to a greater number of villages and therefore reduce the risk of not meeting the minimum sample size. Second, 1.5% gave us the maximum number of villages that we were able to visit during the 4 days of wide area-survey.

⁴¹ Average village size was calculated using the population list (2014) used for the vaccination campaigns - the most reliable and up-to-date population data available. Extreme values (<200 and >4000) were excluded in order to ensure the result was as representative as possible, and ensure the village size was not over-estimated adding to the risk of not meeting the sample size. A map (from OCHA) was available but after discussions with the team determined that the villages marked were incomplete, and the list was more reliable.

(31) to be sampled), the required number of villages (31) is selected⁴². See Annex 13 for the full list of selected villages. The map below indicates the selected villages with a green dot.

Map 3: Map of Ahmadaba and Gardez districts with boundaries and villages sampled for the wide-area survey marked (Paktya Province, Afghanistan, February 2015)



Three of the selected villages were in the insecure areas of Ahmadaba. Whereas it would have been more suitable to omit these villages from the original sampling process, we were still able to find an adequate number of SAM children in the other sampled villages. We also felt that the factors affecting coverage in these areas was suitably represented in the prior, largely from the Small Study on insecurity, therefore we can be confident that the final coverage estimation has been adequately influenced by factors in these areas.

Step Two

At village level active and adaptive case-finding was employed in the same fashion as detailed in the Stage 2 section above. The main concern with active and adaptive case-finding is ensuring high quality, i.e. the finding of all SAM children within a clearly defined primary sampling unit (village). This is particularly the case in Afghanistan where close supervision is limited. In Paktya the following approaches were employed in order to increase the quality of active and adaptive case-finding:

- Strong and repetitive explanation of method and emphasis on exhaustivity
- Utilisation of an 'Overall Data Form'⁴³ to ensure certain pieces of information were obtained from the village leader at the beginning, and that number of households visited and children screened were reported.
- Survey teams phoning the survey leaders having established village population and boundaries, and conferring if further segmentation of the village was required⁴⁴. And then finally phoning the survey leaders once the teams believed they had reached exhaustivity.

⁴² See SQUEAC Technical Reference page 102 for more information

⁴³ See Annex 14

- Interrogation and verification of activity and all data having returned to base.

6. COVERAGE ESTIMATE

The wide-area survey found a total of 41 SAM cases. This was short of the target sample size of 55, yet still allows us to estimate coverage with a precision of 11%. The total cases found are presented in Table 12 below and by village in Annex 13.

Table 9: Total SAM cases found during the wide-area survey (Paktya Province, Afghanistan, February 2015)

Type of case	Number found
Total SAM cases	41
SAM cases not in the programme (non-covered)	26
SAM cases in the programme (covered)	15
Recovering cases (in programme with MUAC >11.5cm)	7

A point coverage estimator was deemed the most appropriate representation of coverage in the target area due to the programmes poor case-finding identified during Stage 1. Period coverage (which includes recovering cases) is more appropriate for programmes that have good case-finding and short lengths of stay, since in such a programme point coverage would not reflect high performance and cases loads will be lower (since they are being efficiently treated). Point coverage can be calculated with the following formula:

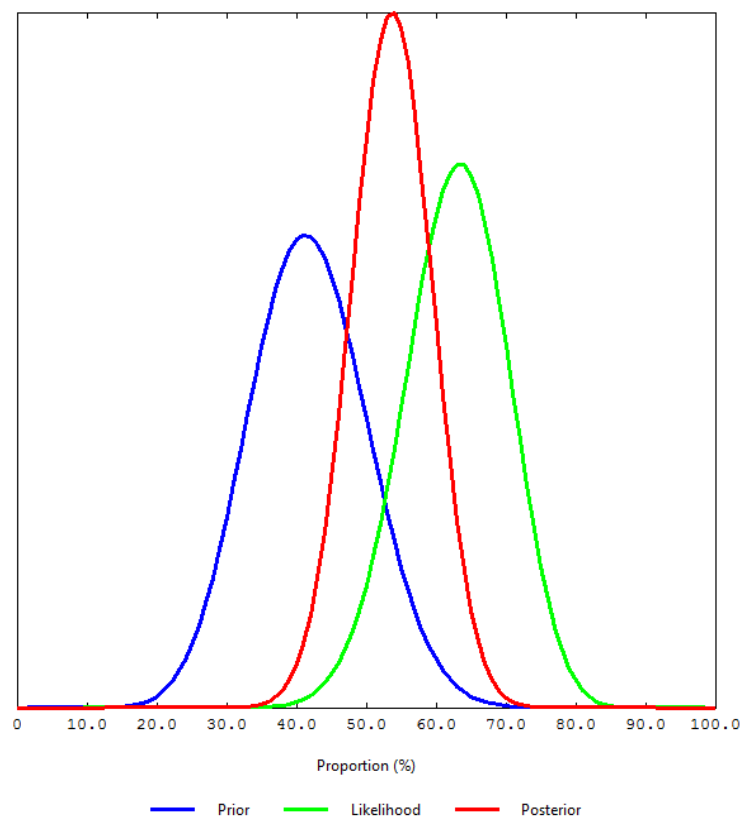
$$\text{Point Coverage} = \frac{\text{number of SAM cases in the programme}}{\text{total number of SAM cases in the community}}$$

Point coverage was calculated through the BayesSQUEAC calculator by combining the prior and the likelihood with a conjugate analysis to produce the posterior. The likelihood is constructed using the data collected during the wide-area survey. The following coverage estimation was calculated which is also presented graphically in Figure 7:

$$53.7\% [CI\ 95\%: 42.5\% - 64.4\%]$$

⁴⁴ In the cases where the population data we have underestimates the actual village size and the team sent to survey is not large enough to complete the village in one day.

Figure 8: Graphic representation of the point coverage estimate including the prior, likelihood and posterior information (*Paktya Province, Afghanistan, February 2015*)

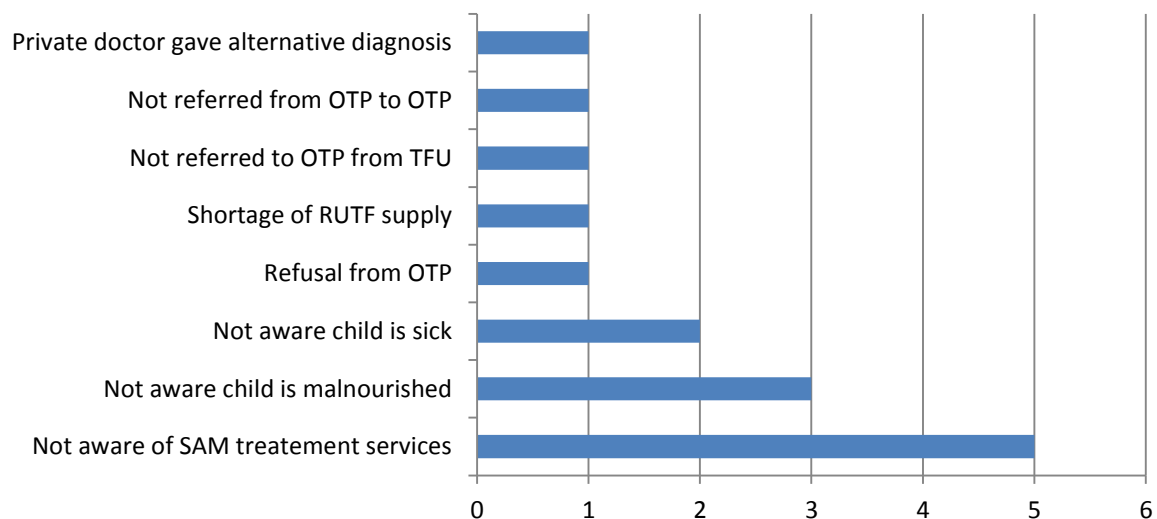


The graphic representation of the coverage estimate demonstrates significant overlap between the prior and the likelihood, therefore are not in conflict ($p=0.06^{45}$). Therefore we can accept that the prior and likelihood are not in conflict. Since the likelihood survey brought back a higher coverage than was estimated with the prior information it is possible the strength of the barriers were over-estimated and those of the boosters under-estimated.

The same questionnaire used in the small area survey was administered to each SAM child that was not in the programme ($n=15$) in order to determine reasons why. Analysis of the data collected through the questionnaires revealed eight different barriers, with those related to awareness ($n=10$) were most prominent. This data suggests that any remedial action to improve coverage should first and foremost focus on awareness. Recommendations related to community mobilisation and sensitisation are presented in the Recommendations section.

⁴⁵ The p value is statistical measure of how complementary the prior and likelihood information are to each other. For example if the prior estimates a coverage mode of 20% but the wide-area survey delivers a coverage mode of 80% then the prior and likelihood will be in conflict and therefore not complementary. The prior and likelihood are said to be complementary if the $p > .05$

Figure 9: Pareto chart showing reasons for non-covered cases found during the wide-area survey (*Paktya Province, Afghanistan, February 2015*)



7. CONCLUSIONS

The SQUEAC assessment recorded a point coverage of **53.3% [CI 95%: 42.5%-64.4%]** which represents a coverage rate over the SPHERE standards of 50% for the coverage of CMAM programmes in rural settings. This is a good achievement, and the assessment was able to identify the main drivers of good coverage. In addition the assessment was able to highlight the most important barriers to access that are preventing the programme from achieving better coverage.

The assessment highlighted a number of factors that contributed to the coverage achieved. The most important of these related to awareness of malnutrition and the programme. The qualitative research found that the knowledge of the programme was good. Since nutrition programming is somewhat integrated into the health system, it is difficult to separate awareness of the nutrition programme from other health services. In any case, since the nutrition services are located in the health facilities, knowledge of the health services was adequate to ensure SAM children received treatment. As well as good awareness of the programme, various programme stakeholders showed good awareness of malnutrition. This was indicated by the ability of informants to associate causes and symptoms to the condition. This good awareness however was not attributed to specific activities of the nutrition programme.

CHWs cannot be said to contribute to the awareness of malnutrition or the programme since there is nothing to suggest CHWs operate effectively (limited screening/referral, no discernible effect on admissions, weak links between OTP and CHWs) and the data suggests limited CHW presence and limited activity when present. There are many other factors that are likely to have contributed to the good awareness, such as health facility outreach activities, strong presence of village elders in each village, good coverage of health centres and high awareness of available health services.

Certain activities of the health system did however contribute to good coverage. First, passive screening in the facilities made a contribution to the coverage achieved, although it was likely to have been limited since passive screening was only performed systematically for children those eligible for growth monitoring (under 24 months). Second, outreach workers (health educators and vaccinators) were reported to screen children when in the community. Although reported during the qualitative research since this is not recorded, we were unable to triangulate quantitatively.

Two other significant factors included the strong influence of community leaders and word of mouth dissemination. The fact that the mullahs and maliks tend to know about what is going on in the village (including sick children) proved to be a key driver in ensuring children get to the programme. This goes to show that if CHWs systematically engaged with maliks and mullahs across the programme area, then much high levels of coverage could be achieved. The same goes for the booster related to word of mouth. Since this is so strong, active engagement with key influencers (those that can spread messages) can lead messages being shared related to malnutrition and therefore to better coverage.

The private doctor was found to be an important actor in the provision of health care in Paktya. There are many private doctors active in the province⁴⁶, and are critical providers particularly in the insecure areas where staff from the health facilities are unable to access. However, in terms of influence on coverage the data on their role was mixed. There was evidence that private doctors refer children to the OTP and therefore was considered a booster to coverage. However it was also found that private doctors sometimes do not refer malnourished children. Whether this is intentionally, or because they are unaware of the service, it represents a barrier to access. In conclusion, the assessment showed the importance of private doctor as a health provider and therefore the importance in engaging them in SAM treatment in order to achieve better coverage.

A number of barriers to access were also identified during the assessment, one of the most significant was the lack of (or at best limited) level of CHW activity. To start with, the number of active CHWs was estimated to be very low, therefore the geographical coverage of CHWs is very poor. But even in cases where there was a CHW present (according to the implementing partner) the qualitative research (and questioning of village leaders during the

⁴⁶ The exact number is unknown

small and wide-area surveys) showed that activity was very low. Low activity means, infrequent screening, lack of home visits or follow-up of absent cases and limited engagement with key community figures.

It became clear during the assessment that both partners (ACTD and HNTPO) each effectively run two parallel community systems, one funded by the BPHS contract and another funded by the nutrition programme. Each of these are then headed up by a different manager, the CBHC Officer (BPHS) and the Community Officer (nutrition), with little collaboration between the two. In the case of HN-TPO the Community Officer for nutrition worked on communicating with key community figures (in the health facility) and the CBHC Officer managed the CHWs, but with little engagement with nutrition affairs (aside from screening). This meant that there is no real integration between the two approaches to community mobilisation.

Weak communication between the OTP and CHW, as well as the lack of motivation of CHWs were also highlighted as barriers. These three barriers (including low level of CHW activity) are of course connected. The motivation of CHWs is hampered since they have too many responsibilities, too many villages to cover and not enough support, and are required to work as volunteers. Volunteerism must be treated with care, and that includes not overworking the volunteers since this will lead to low quality work and low levels of retention. This low motivation leads to low activity (when they are present), including poor communication with the OTP, in relation to absent and defaulting cases. This onus with this barrier is however not only on the CHW since OTP staffs need to also engage in such exchanges.

Although the biggest gains in achieving better coverage will be made through improving the community component (CHWs and community mobilisation), there were other barriers that if overcome would contribute to sustain good coverage. These included the shortage of RUTF supply and gaps in contracts between the nutrition implementers and the donors, distance to the OTP and the lack of a mahram to escort the mother to the OTP.

The most significant factor reducing coverage is insecurity. Large swathes of Paktya are insecure, meaning that mothers are unable to access health services and that health services (e.g. CHWs) are unable to access SAM cases. The small study showed that insecurity manifests itself in various ways, and therefore needs to be treated with the requisite nuance and care. If a simple 'AOG areas insecure, government areas secure' analysis is made then potential access could be denied, and dangers overlooked. This understanding is critical if health services are to increase coverage in the insecure areas. Due to the risks in access some areas for outsiders, locally based private doctors present a potential opportunity for treating SAM cases in insecure areas. Although not without its risks, dialogue with armed actors has also been proven to be successful in negotiating access to AOG controlled.

The SQUEAC assessment also highlighted the poor quality of data management in both the HN-TPO and ACTD programmes. This is most pronounced at OTP level, where OTP cards were often incomplete and regularly did not specify the chosen discharge outcome. First this means that cases are not clearly tracked from admissions to discharge, and if default, suitable protocols are not taken. This also makes it very difficult to report on a monthly basis and to track the performance of the programme reliably. At management level, analysis of monthly data across the districts and of each OTP is also very limited. This makes it difficult to identify gaps and lulls in performance and inform remedial action.

Since each OTP has at least one dedicated nutrition nurse, there should be the capacity to have accurate reporting. Despite this, one of the likely reasons for high coverage is the fact that each OTP has dedicated nutrition resource. This means there is in theory always someone to provide SAM/MAM treatment when a child is admitted. This also presents a significant opportunity for improving coverage. The quality of the service provision will not do it alone, but coupled with a stronger community component, and link between CHW and OTP, better quality service provision will mean that more children are effectively treated.

8. RECOMMENDATIONS

Preliminary recommendations were developed with the SQUEAC team during the last day of the assessment. During this day the team reflected on all the findings and evidence from the assessment and then, in groups according to recommendation area, developed recommendations and specific actions. All actions were initially given a level of priority as 'Medium' and then adjusted to 'High' or 'Low' if relevant.

	Recommendation	Findings	Evidence	Actions to be taken	Responsible organisation /people	Level of priority
SUPPLY	1. Link UNICEF supply contracts with BPHS and nutrition contracts to ensure supply is available when the programme is running. 2. Improve supply chain management and contingency planning for RUTF supplies 3. Improve timeliness of reporting on stock and supply requests (automatically link with monthly reporting)	Limited supply during some months Poor reporting on commodities	No admissions in the months with stock outs Qualitative data from key informants reporting regular stock outs	Lobby UNICEF to provide supply contracts in line with BPHS/nutrition contracts.	UNICEF	High
				Improve communication on supply between partner, PND and UNICEF (including supply levels and admissions numbers)	PND/Partner /UNICEF	High
				UNICEF to supply 6 months stock at a time	UNICEF	Low
				Lobby UNICEF for timely supply of RUTF	PND/Partner	Medium
				Submit supply request to UNICEF 3 months in advance of supply ending	PND	Medium
				Link supply automatically to monthly reports (partner to PND)	PND/Partner	Medium
COMMUNITY MOBILISATION	4. Expand the coverage of the CHW network, increase the quality of screening and community mobilisation	Limited coverage of CHWs	Low admissions from villages with and without CHWs	Increase number of CHWs including females.	PND/Partner	High
		Low motivation of CHWs	Qualitative research revealed low level of CHW activity (screening, home visits, coordination with community members)	Integrate BPHS and nutrition community components, using the same CHWs and single training plans, monitoring, community mobilisation and coordination.	Partner/donors	High
		Infrequent and poor quality CHW activity		Manage CHW work load by allocating CHWs according to number of households not villages. CHWs reasonably could cover more than one village, but only a certain amount of households. In cases where there is no CHW,	CHS	Medium
		Limited interaction between some CHWs and key community				

		figures	Discrepancies between referral slips received from CHW and referred admissions at health facilities.	partner to engage with key community figures (as a bare minimum).		
				Develop an absentee and defaulter tracing mechanism for CHWs, ensuring reasons for default are recorded.	CHS/CHW	Medium
			Little evidence of community mobilization by the CHWs	Uphold MoPH guidelines related to CHW selection (selected by villagers, known by villagers etc.)	PND/Partner	High
				Ensure CHWs remain properly equipped with working tools (drugs, MUAC, guidelines, referral sheets etc.)	PND/Partner	Medium
				Improve support and supervision of CHWs, including both reporting and practice. Annual training plans should be put in place, giving CHWs security and nurturing commitment. This should include formal and on-the-job training	CHS/Partner	High
				Strengthen monitoring of individual CHW and communication with OTP	CHS/CHWs	Medium
				Ensure adapted support for illiterate CHWs is always provided (e.g. pictorial refer sheets, pictorial tally sheets)	PND/Partner	Medium
				Organise mass screening days (especially at villages not covered by CHWs) where remuneration is considered for CHWs on these days. Villages with no CHWs and limited outreach are likely to have a high number of cases	CHW/CHS	High
				Ensure CHWs and outreach workers (health educators and vaccinators) coordinate activities.	Partner	Medium
MANGEMENT AND REPORTING	5. Begin month on month aggregate analysis	Lack of monthly analysis of program performance	No analysis of the monthly data done	Commence analysis of monthly data over time. Including the analysis of admissions, referrals, screening and discharge outcomes, by province, district and at OTP level.	Partner	High
	6. Improve recording at source (OTP card) to allow follow up, analysis		Lack of some activity			

	and recording of defaulters	Poor quality reporting at OTP level	reports, e.g. supervision reports, screening reports	Documentation and reporting of all the nutrition activities at all levels	PND/CHS/C HW/Partner	Medium
	7. Use current OTP Card (from IMAM guidelines) that does not include transfer to SFP and is in Pashtu	Use of dated (old CMAM guidelines) protocols and tools	Wrong discharges from the program as cured using the wrong	Train all health workers (clinic staff and CHWs) to use latest IMAM guidelines	PND/Partner	High
	8. Use mapping to analyse spatial spread of admissions, defaulters and CHW activity (large map provided to HN and ACTD after SQUEAC)	Poor monitoring of the program admissions	Erratic recording of OTP admissions with extreme high and low	Map CHW coverage to ensure even allocation of CHWs across the province	CHS/CHW	Medium
	9. Improve interface between TFU and OTP including reporting and transfers	High defaulting	Defaulting in the program above the SPHERE standards of <15%	Reconcile admissions with referrals from CHWs, ensuring that all referrals are recruited in the programme, and if not, they are followed up by CHW	CHS/CHW	Medium
	10. Implement regular use of SQUEAC tools (e.g. MUAC on admission) to monitor programme performance			Integrate certain SQUEAC tools into routine monitoring including MUAC on admission to test timeliness of case-finding and small area surveys to perform targeted coverage assessments.	Partner	Low
SECURITY	11. Explore alternative modalities for delivering SAM treatment in insecure areas	Insecure areas have minimal or no nutrition related activities ongoing	Low admissions recorded from insecure areas, qualitative data reported limits to movement.	Build on evidence from small study and conduct further investigations into potential solutions (such as engaging private doctors). Where possible engage key community figures.	Partner	Medium
SQUEAC	12. Ensure learnings from implementing this SQUEAC are documented and take forward to future SQUEACs in Afghanistan	Insecure areas cannot be omitted from all SQUEAC surveys.	N/A	Conduct Small Study on coverage in insecure areas for all SQUEAC assessments	ACF	Medium
		Limited supervision requires more		Ensure quality assurance mechanisms (detailed in Stage 3 section) for small and wide area surveys are used		

		creative methods for quality assurance		Allocate more time to qualitative research (minimum 5 days) and prior formulation (minimum 1 day)		
		Qualitative research requires ample time for collection and analysis		Document Paktya experience in 'Coverage Learning Document'		

9. ANNEXES

Annex 1: SQUEAC Team (Paktya, Afghanistan, February 2015)

Name	Position
Dr Ashiq ullah (Safi)	Nutrition Programme Officer (ACTD)
Dr Islamudin “Danish”	Nutrition Programme Supervisor (HN-TPO)
Dr Abdullah Farooq	Monitoring Officer (ACTD)
Abdul Qayum	Nutrition Community Mobilisation Officer (HN-TPO)
Dr Noorullah (Ulfat)	Nutrition Focal Point (ACTD)
Jacqueline Fernandes Breitingner	SQUEAC Officer (ACF)
Sayed Rahim “Rastkar”	SQUEAC Deputy (ACF)
Nikki Williamson	SLEAC Officer (ACF)
Ben Allen	Global Coverage Advisor (ACF)

Annex 2: SQUEAC Work Plan (Paktya, Afghanistan, February 2015)

Date	Activity
4 th -8 th February	Preparation
9 th February	Travel to Paktya
10 th February	SQUEAC and Coverage Training
11 th February	Quantitative Data Analysis + getting to know the programme
12 th February	Qualitative Research Training
13 th February	Preparation for Qualitative Data Collection
14 th -16 th February	Qualitative Data Collection and Analysis
17 th February	Formulation of Hypothesis and planning for Stage 2 + training of enumerators
18 th -19 th February	Stage 2: small area survey
20 th February	Day off
21 st February	Hypothesis analysis and Formulation of Prior
22 nd February	Preparation for Wide Area Survey (Sample, Log etc.) + training enumerators
23 rd -27 th February	Stage 3: Wide area survey
28 th February	Development of Posterior, Recommendations and Action Plan
2 nd March	Travel back to Kabul
3 rd March	Debriefing

Annex 3: Villages listed as insecure during Small Study on Insecurity (*Paktya Province, Afghanistan, February 2015*)

Village	Triangulation	Distance from OTP (km)	Admissions	Defaulters	Machalgo or Surkai Malang	CHW?
Alaf Kala	!	9	0	0	M	
Ata Kala	!		0	0	SM	
Baba Kari	!		0	0	M	
Buraki	!	40	0	0	M	
Burgai Kala	!	15	0	0	M	
Fazil Khail (2)	!!!!	9	0	0	M	
Feroz Khail	!	6	25	1	SM	
Gharak (2)	!!!!	11	8	4	M	x
Haider Khail	!	12	1	0	SM	
Jender Khail	!		0	0	M	
Kargi Khail	!	10	0	0	M	
Kawgan Zawara	!		0	0	M	
Khwajer Khail	!	6	2	0	SM	x
Madu Khail	!	12	3	0	M	
Mia Khail	!!	15	1	0	M	
Nisti Kut	!!!!	7	6	1	SM	
Ramak Khail	!		0	0	M	x
Remau	!	7	0	0	SM	
Sawi Kaly	!!!	10	0	0	M	
Seori	!		0	0	M	
Separi	!	10	2	0	SM	
Shagi Kala	!	15	0	0	M	
Sudyan	!	10	1	0	M	x
Talkhan	!		0	0	M	
Usman China	!	13	0	0	M	
Woch Shakh	!		0	0	M	
Zarin Khail	!	8	0	0	M	
Zowandi Khail	!		0	0	M	

Annex 4: Livelihood Zone Profile for Paktya taken from, FEWSNET Livelihoods Zoning ‘Plus’ Activity in Afghanistan (February, 2011)

Livelihood Zone 7: Eastern Deep-Well Irrigated Agriculture		
Characterization of Food Security The zone is considered at little risk of food insecurity when climate performance is normal.		Most of the zone residents are congregated in the irrigated areas of central Paktia and western Paktika. The Kandahar-Kabul road transects this flat zone connecting it to the larger regional and national markets. The distinctive feature of this zone is the large land holdings (approx. 30 <i>Jeribs</i>) and the dependence of deep-well pump irrigation systems. Livelihoods depend on the irrigation for fruit cash cropping and its associated agricultural labor opportunities. Orchard fruits such as apples, grapes and pomegranates are the main cash crops, followed by potatoes and wheat. The costs associated with the crop production in the zone are directly influenced by the cost of fuel and fertilizers. Most households till their land with tractors and those that don't own tractors must rent them at 400 Afghans per hour. Food is obtained through a combination of majority purchase and minority own production or sharecropping payment. The majority of poor households have limited access to or no land holdings and therefore must engage their better-off neighbors in various social arrangements such as <i>dekhani</i> and in-kind labor payment to obtain food. Despite these arrangements the amount of food earned often falls short of meeting all of the poorer households' needs. Wheat, rice and mung beans imported from India and Pakistan are purchased from the market as reserves subside. Labor migration to Pakistan and the Gulf States is an important source of cash for the poor. Locally cash labor opportunities, specifically the harvesting of maize (October) and the cultivation (May-June) and harvesting (September) of potatoes. Construction labor opportunities are also abundant in April/May and July through September. Cash crops, such as fruit and potatoes, are bought by traders at the farm gate and transported to the main zone markets. From the main market fruit are exported to Pakistan and India via Khost while potatoes are bound to Kabul, Khost, Jalalabad and Pakistan. Better-off households also travel to Pakistan to buy sheep and goats when prices are low (April to August) and then sell to butchers in the main zone markets.
Key Livelihoods Activities		
Poor Labor Agriculture production	Better-off Agriculture production Livestock husbandry	
Staple Foods and Sources*		
Poor Wheat: 6mths <i>dekhani</i> /in-kind, 6mths purchase Rice: 3mths purchase Livestock products: 3mths own produce Beans: 3mths purchase	Better-off Wheat: 10mths own produce, 2mths purchase Rice: 12mths purchase Livestock products: 9mths own produce Maize: 4mths own produce	
Key Income Sources		
Poor Migrant labor Local on- and off-farm labor Firewood sales	Better-off Crop sales (fruits) Remittances Livestock trading	
Main Markets Gardez Sharan Zurmat		
Shocks and Hazards Increased fuel prices Crop diseases and pests		
Key Early Warning Indicators Poor rainfall Water table Increase in fuel cost Food price spikes Conflict		

Annex 5: List of focus-group discussions and semi-structure interviews done during Stage 1 (Paktya Province, Afghanistan, February 2015)

Date	Village	Place	Type	Type of informant	# people
14/02/2015	Mehlan OTP	BHC	FGD	Mothers	2
14/02/2015	Mehlan OTP	BHC	FGD	Mothers	7
14/02/2015	Habib Kala	C	SSI	Mother of child in the programme	1

14/02/2015	Habib Kala	C	SSI	Mother of child in the programme	1
14/02/2015	Ibrahim Khail OTP	BHC	SSI	NN	1
14/02/2015	Ibrahim Khail OTP	BHC	SSI	CHS	1
14/02/2015	Ibrahim Khail OTP	BHC	SSI	Mother BNF + more mothers not BNF	7
14/02/2015	Sadique Khail	C	SSI	CHW	1
14/02/2015	Sadique Khail	C	FGD	Mallik + 8 men	9
14/02/2015	Surkai Melang OTP	BHC	FGD	Mothers BNF	4
14/02/2015	Surkai Melang OTP	BHC	SSI	Vaccinator	1
14/02/2015	Surkai Melang OTP	BHC	SSI	Midwife	1
14/02/2015	Surkai Melang OTP	BHC	SSI	NN	1
14/02/2015	Feroz Khail	C	FGD	Teacher + Mullah + Malik	3
14/02/2015	Feroz Khail	C	FGD	Elders	2
15/02/2015	Ghafor Khail	C	FGD	Malik + others x2	3
15/02/2015	Ghafor Khail	C	FGD	Mother of child in the programme + other women	+5
15/02/2015	Samad Khail	C	FGD	Mullah + Malik + elders x3	5
15/02/2015	Samad Khail	C	FGD	Mothers + girls + older women	10
15/02/2015	Samad Khail	C	SSI	Mother of child in the programme	1
15/02/2015	Spahi Khail	C	FGD	Malik + elders x4	5
15/02/2015	Spahi Khail	C	SSI	Man	1
15/02/2015	Balada	C	FGD	Health Shora + elders x3	4
15/02/2015	Balada	C	SSI	Shopkeeper	1
15/02/2015	Balada	C	SSI	Mullah	1
15/02/2015	Rabat	C	SSI	School teacher	1
15/02/2015	Rabat	C	FGD	People in village including women	20
15/02/2015	Askari Family	C	FGD	Father of child in programme + men	15
16/02/2015	Gardez OTP-SFP	PH	SSI	Nutrition Nurse	1
16/02/2015	Gardez OPD	PH	FGD	Pediatric doctor + Growth monitoring person	2
16/02/2015	Machalgo OTP	CHC	FGD	Health Educator Nutrition Nurse + midwife	3
16/02/2015	Machalgo OTP	CHC	SSI	Vaccinator	1
16/02/2015	Machalgo OTP	CHC	SSI	Mother	1
16/02/2015	Machalgo OTP	CHC	SSI	CHW	1
16/02/2015	Machalgo OTP	CHC	FGD	Mother of child in the programme + mothers	8
16/02/2015	Spena Kala	C	SSI	CHW	1
16/02/2015	Spena Kala	C	FGD	Malik + others x2	1

16/02/2015	Chamkani OTP	DH	FGD	Health Educator + Food distributor	2
16/02/2015	Chamkani OTP	DH	SSI	Nutrition Nurse	1
16/02/2015	Chamkani OTP	DH	SSI	TFU nurse	1
16/02/2015	Chamkani OTP	DH	SSI	Midwife	1
16/02/2015	Chamkani OTP	DH	FGD	Malik	1
16/02/2015	Peer Kaly	C	FGD	CHW	1
16/02/2015	Peer Kaly	C	SSI	Mullah	1
16/02/2015	Mada Khail	C	FGD	Malik + mullah + Elders	9-15
16/02/2015	Speena Kotay	C	FGD	Mullah + mallik + elders + doctor	18
16/02/2015	Surkai Melang OTP	BHC	FGD	CHS+head vaccinator	2
16/02/2015	Machalgo OTP	CHC	SSI	Vaccinator	1
16/02/2015	Machalgo OTP	CHC	SSI	CHW	1

	Key
BHC	Basic health centre
CHC	Comprehensive health centre
PH	Province hospital
DH	District hospital
C	Community
OTP	Outpatient program
FGD	Focal group discussion
SSI	Semi-structured interview
OPD	Outpatient pediatric unit

Annex 6: List of villages chosen for qualitative research and reasons (Paktya, Afghanistan, February 2015)

Village/OTP	OTP Catchment	District	Reason for choosing
Mehlan OTP	Melhan	Gardez	Poor performance according to OTP card analysis
Surkai Malang OTP	Surkai Malang	Ahmadaba	Best performing OTP according to OPT card analysis
Habib Gala	Melhan	Gardez	Relatively high admissions and defaulters, and with no CHW present.
Sadique Khail	Melhan	Gardez	Good admissions.
Freozkhail	Surkai Malang	Gardez	Relative high admissions
Rabit Camp	Ibrahim Khail	Gardez	High admissions and high defaulters. Camp setting.
Askari Family	Gardez	Gardez	High admissions and high default (almost 100%)
Supahi Khail	Mehlan	Gardez	Far from OTP, no admissions
Baladda	Balada	Gardez	High admissions and has a sub-health centre with OTP

Ghafor Khail	Gardez	Gardez	Far from OTP with no admissions
Samad Khail	Gardez	Gardez	Far from OTP with no admissions
Machalgo OTP	Machalgo	Ahmadaba	Long length of stay (from OTP card analysis) and highest defaulting for an OTP.
Spena Kala	Machalgo	Ahmadaba	Close to an OTP, moderate admissions
Spen Kote	Lowre	Chamkani	In between two OTPs (Chamkani and Lowre)
Madakahil	Lowre	Chamkani	Good admissions and high default
Peer Kaly/Gul	Chamkani	Chamkani	Close to an OTP and no admissions
Chamkani	Chamkani	Chamkani	High number of defaulters after 1 or 2 visits.

Annex 7: Annex 8 List of CHW responsibilities in Afghanistan (Paktya. Province, Afghanistan, February 2015)

This list is taken from the HMIS system and details the indicators used to monitor CHW activity, which gives an idea of the responsibilities of CHWs.

of Children Screened with MUAC
of Meetings with Health Committee
of Normal Deliveries Referred by CHW
ARI
Chloroquine
Oral Pills (cycle)
Total Number of Family Visited
Referred for EPI (<1y)
Number of Weighing Sessions
of Children Referred for Malnutrition
of Obstetric Complications Referred
Acute Diarrhea
Condoms (dozen)
Cotrimoxazole
Women Referred for TT
Number of FHAG Active
Number of Children Weighted
Injectibles (injection)
Malaria
Number of Maternal Death
Oral Contraceptive
Referred for TB
Number with Adequate Weight Gain
Number of Neonatal Deaths
ORS
ANV at Home
Zinc Tablets
PNV at Home
Vitamin A
Died at Home

Annex 8: Key informants at community level identified for active and adaptive case-finding (Paktya Province, Afghanistan, February 2015)

Pashtu	English
Da kor mashran	Community elders
Ustad/Malim	Teacher
Mullah	Religious leader
Malak	Village leader
Da sehi Shura ghari	Health committee members
Tolanez sehi karkawonkai	Community Health Worker
Da kali doctor	Village doctor
Unani	Traditional healer
Nahi	Barber
Sehi karkawonki	Health facility staff
Morani (Mor)	Mothers
Dahi	Wise old lady'

Annex 9: Local terms used for malnutrition in Paktya Province (Paktya Province, Afghanistan, February 2015)

Pashtu Word	Pronunciation	Meaning	Literal Meaning
مواد	Mawad	RUTF	Material
بيسکټ	Biscut	RUTF	Biscuit
مواد ماشومانو د	Da Mashomano Mawad	RUTF	Children's material
پټی	Patay	MUAC	Belt
ډنگر	Dangar	Marasmus	Skinny
کمزوری	Kamzoray	Marasmus	Weak
ضعیف	Zaeef	Marasmus	Weak
شوی په سوری	Soray pa shawy	Marasmus	Under shadow of ghost
موری وچ	Wach moray	Marasmus	Early weaning (due to close pregnancies)
خوارخواکه	Khwarzwaka	Mulnutrition	Weakness
مانده	Mandha	Mulnutrition	Skinny
ضعیفتیا	Zaeefiya	Mulnutrition	Weakness
پرسیدلی	Parsedaly	Oedema	Kawshiorkor
شان په سري زړ د	Zor sari pa shakal	Monkey face	Old man face

Annex 10: Questionnaire for covered cases (in Pashtu) found during the small and wide area surveys (Paktya Province, Afghanistan, February 2015)

په پروگرام کې د شامل شديد ځواکونو ماشومانو سوالنامه

نېټه: _____ د ماشوم نوم: _____
 ولسوالي: _____ MUAC: _____
 کلی: _____ Oedema? (+, ++, +++) _____
 جنس: _____
 د سروې کوونکي نوم: _____ عمر (مياشت): _____
 په ثبوت يې کړی چې ماشوم په پروگرام کې شامل دی. (مثال: د موادو پاکت/ راشن کارډ/ نور تشریحات): _____

1. تاسو څنگه پوهه شوی چې ماشوم مو ځواکونه وو؟

2. د پروگرام په اړه څنگه خبر شوی؟

3. مخکې له دې چې ماشوم مو کلنیک/OTP ته راوړی کوم نور علاج مو ورباندې کړی ده؟

4. په ټولنه کې مو داسې ماشومان شته چې ځواکونه وي؟

5. ستاسو په نظر ولې ماشوم وکولای شو چې پروگرام ته لاسرسی وکړي؟

Annex 11: Questionnaire for covered cases (in Pashtu) found during the small and wide area surveys (Paktya Province, Afghanistan, February 2015)

د پروگرام نه پاتې د شديد ځوارځواکو ماشومانو سوالنامه

نېټه: _____ د ماشوم نوم: _____
 ولسوالي: _____ MUAC: _____
 کلی: _____ Oedema? (+, ++, +++) _____
 جنس: _____
 د سروې کوونکي نوم: _____ عمر (مياشت): _____

1. آیا فکر کوی چې ماشوم مو مریض دی؟
☐ هو، ستاسو ماشوم څه مریض لري؟ ☐ نه ← پس

2. آیا فکر کوی چې ماشوم مو ځوارځواکه دی؟
☐ هو ☐ نه ← پس

3. آیا پوهیږی چې د خپل ځوارځواکه ماشوم درملنه چیرته وکړی؟
☐ هو، د هغه پروگرام نوم څه شی دی او چیرته دی؟ ☐ نه ← پس

4. خپل ماشوم مو ولې کلنیک ته نه دی وړی؟

5. آیا د خپل ماشوم علاج مو مخکېنې په کوم OTP, SFP یا په TFU کې کړې ده؟ (د لاندې څخه یو په نښه کړی)
☐ هو، اوس ولې په پروگرام کې نشته؟
☐ 1. د پروگرام نه ورک شوی دی (Defualter): کله؟ _____ ولې؟ _____
☐ 2. روغ له پروگرام څخه خارج شوی: کله؟ _____
☐ 3. ناروغ له پروگرام څخه خارج شوی: کله؟ _____
☐ 4. نورې وجې: _____

مننه ترې وکړی او د ریفر کاغذ ورته ورکړی چې خپل ماشوم کلنیک ته یوسي.

ستاسوپه نظرولی ماشوم په پروگرام کې نشته؟

Annex 12: Small Study on insecurity: Study outline and findings (Paktya Province, Afghanistan, February 2015)

Study Outline

Hypothesis: *The presence of anti-government groups in certain areas limits access to health facilities for residents and access to villages for health facility staff (e.g. outreach teams and CHSs), therefore having a negative effect on coverage.*

Overall Question: How does insecurity affect access to health care (and in particular SAM treatment)?

Specific Questions:

1. What is the nature of the insecurity?
 - 1.1. Fear of IEDs?
 - 1.2. Threats from armed groups?
 - 1.3. Travelling through unknown areas?
 - 1.4. Fear of travelling in 'opposition' areas? (different tribes, or different allegiance)
 - 1.5. Is it criminals out to steal?
 - 1.6. Or anti-government out to control?
2. How does insecurity affect access to HFs for users?
3. How frequently does security affect access?
4. If community members cannot access the HF due to insecurity, what do they do for health care instead?
5. Which villages are affected by 'insecurity'? (Provide list from Rahman, do they agree?)
6. How is CHW activity (including allocation) affected in the 'insecure' areas?
7. Does insecurity affect the functioning of health service (SAM treatment precision)
8. At health facility level? (for example, provision of supplies or access for staff)
9. At community level (supervision of CHWs (access of CHWs to HFs), provision of outreach services, vaccination campaigns)
10. Do we have admissions from 'insecure areas'?
11. At what time of year/season does insecurity affect access to HF most, in the area/Ahmadaba/Paktya?

Methodology

In this Small Study we interview health facility staff (in whose catchment area the inaccessible villages fall) and residents (from nearby accessible villages).

Qualitative

- Literature review on insecurity in Afghanistan and how it affects access to health care
- Interviews with key informants
- 6x OTP staff (of all types)
- 3 x men from Ahmadaba
- 1 x mothers

Quantitative

- Analysis of CHW reports from affected villages (this will tell us if CHWs are present and give us an understanding of how active they are and if they are adequately supervised/supported). These need to be accessed from Machalgo and Surkai Malang HFs.
- Analysis of admissions and defaulters from affected villages, and comparing this with unaffected villages.

Annex 13: SAM and recovering cases found during the wide-area survey by village (Paktya Province, Afghanistan, February 2015)

	Village	Total SAM (Point)	SAM IN	SAM NOT IN	SAM IN TFU	RECOVERING CASES (IN <11.5cm)
1	Baghaka (Ibrahim Khail)	2	0	2	0	0
2	Speena Kala Payen	1	0	1	0	1
3	Baghaka (Gardez)	1	0	1	0	0
4	Momin Khail	2	0	2	0	0
5	Karmashi	3	2	1	0	1
6	Alyar Khail	3	3	0	0	0
7	Shekhan (Ibrahim Khail)	1	1	0	0	0
8	Terawal Totakhail	0	0	0	0	1
9	Darah Zor Kaly	0	0	0	0	0
10	Resi Khail	3	3	0	0	0
11	Mahajerin Dawlatzai	4	0	4	0	1
12	Lewan	3	2	1	0	0
13	Madukhail	0	0	0	0	0
14	Hajiyan Kalay (Porta)	2	1	1	0	0
15	Zargar Kaly	2	2	0	0	0
16	Shekhan (Mehlan)	1	0	1	0	1
17	Bahaiy Kalai	3	2	1	0	1
18	Shali Kalai	1	1	0	0	0
19	Muhammad Alai Khail Essa Khail	1	1	0	0	0
20	Mula Ajab Kalai	0	0	0	0	0
21	Bato Khail	1	1	0	0	1
22	Sha Alam Khail	4	4	0	0	0
23	Muhammad Alam Kalai	1	1	0	0	0
24	Feroz Khail Payen	2	2	0	0	0
		41	26	15	0	7

Annex 14: Overall Wide Area Survey Data (Paktya Province, Afghanistan, February 2015)

Date:	
-------	-------

Enumerator team:		
Village:		
Population:		
Distance from HF		
CHW (yes or no?)		
COUNT OF:		
CASES SCREENED:		
HOUSEHOLDS REFUSING ENTRY:		
SAM CASES	COVERED	
	UNCOVERED	

	RECOVERING CASE (>11.5<12.5 cm MUAC in SAM programme)	
--	---	--