Assessment ofBarriers that delay forAcute Malnutrition Treatmentamong Caregivers having under-five children inLay Gaynet,NorthwestEthiopia: 2020.

By: Habtemariam Abate Meshesha

A thesis submitted to Addis Ababa University, School of public health, Department of Behavioural health Science, in partial fulfillment of the requirement for Master of Public health in Health Education and Promotion.

Nov. 2020
Addis Ababa, Ethiopia

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ASSURANCE OF PRINCIPAL INVESTIGATOR

The undersigned agrees to accept responsibility for the scientific ethical and technical Conduct of the research project and for provision of required progress reports as Per terms and conditions of the Research Publications Office in effect at the time of Grant is forwarded as the result of this application.

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Approval of the Advisor/s

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College of Health Sciences

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Approving by the examining board

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Addis Ababa, Ethiopia

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Abbreviations and Acronyms

AM	Acute malnutrition
AMC	Acute malnutrition care
AMT	Acute malnutrition treatment
AMTS	Acute malnutrition treatment service
MUAC	Mid Upper Arm Circumference
SAM	Severe Acute Malnutrition
MAM	Moderate Acute Malnutrition
SFP	Supplementary Feeding Program
OTP	Outpatient Therapeutic Program
SC	Stabilization
UNDAN	United Nation Decade of Action on Nutrition
SDG	Sustainable Development Program
EDHS	Ethiopian Demographic and Health Survey
MEDHS	Mini Ethiopian Demographic and Health Survey
GDP	Gross Domestic Product
ETB	Ethiopian Birr
GMP	Growth Monitoring and Promotion
“P”	Promotion
CMAM	Community Management of Acute Malnutrition
MTC	Malnutrition treatment
UNICEF	United nation children’s fund
NG	Nasogastric
AM	Acute malnutrition
CSAE	Central Statistical Agency of Ethiopia
WFH	Weight for Height
WFL	Weight for Length
TSFP	Therapeutic Supplementary Feeding Program
IRB	Institute of Ethical Review Board

Abstract

Background:about 55 million children under the age of five suffer from acute malnutrition.The problem is aggravated by acute malnutrition treatment delay due to different barriers.As pointed out in Nigeria, about 39% of the population access health facility within one hour walk during the dry season and it decreased to 24% during the wet season(1). Likewise, evidences showed that there was a high admission rate for under-five children in Ethiopia. However; evidences in the study areawere rare to explore the barriers for early treatment.Thus, exploring barriers that delay for acute malnutrition caresof under-5 children qualitatively to have detail understanding and evidence-based interventions in a holistic approach are vital.

Objectives: The objective aimed toexplore the barriersthat delay for acute malnutrition treatment servicesamong parents/caregivers having under-five children from June 01/2020 to August 28/2020.

Methods:A descriptive qualitative content analysis study with a purposivesampling technique were employed to conduct in-depth interview and key informant interview.The data was collected by twotrained research assistants from6 parents/caregiversfor in-depth interviewsand16participants for the key informant interview withobservations of the practice.Open code version 4.02 software was used for data managementduring analysis. Coding and codebook were prepared. There were simultaneous data collection and initial analysis to grasp what was said and how it was said by memoing; verbatim transcription was undertaken. A qualitative content analysis method was hired to conduct the analysis process.**Result**: Parents faced lack of health seeking behaviour: lack of awareness, perceptions of illness behaviour,poverty, workload and traditional beliefs; poor infrastructures and difficult geographical setup, the travel distance, inaccessibility of the service,and lack of organized treatment facility, COVID-19 pandemic, lack of sustainable interventions, lack of skilled and committed health worker, lack of health worker training, discontinuity of stock supplyand long waiting time to receive the treatment were identified as the barrier for early prevention and treatment of under-5 child acute malnutrition. **Conclusion**:The health education and promotion on social behaviour change communication (SBCC) had to be strengthened, and monitored along with health workers skill development and successive trainings. There should be strong and close monitoring and evaluation of the impacts of the service provision and inter-sectoral collaborations among different sectors. It also needs to evaluate the impacts of projects in the area on SBCC for AMTS.

Key Words: under-five child acute malnutrition, acute malnutrition treatment barrier, under five children, Treatment delay, Lay Gaynet, Amhara, Ethiopia

1. Introduction

1.1. Background

Thewide-ranging, quality acute malnutrition treatment health care services is important for promoting and maintaining under-five child health, preventing and managing hasty recent weight loss and growth faltering,morbidity and premature death(2).In the year 2016, 80,060 of 400, 000 estimated severe acute malnutrition (SAM) children had faced medical complications and it was time for the need of intensive lifesaving medical treatments in health facility-based therapeutic feedings; alongside, 1.7 million moderate acute malnutrition (MAM) pregnant and lactating mothers were in need of access to emergency health services though they delay(3). Globally, about 55 million children under the age of five suffer from acute malnutrition; 19 million of these suffer from the most serious type of severe acute malnutrition. Every year, 3.1 million children die of malnutrition(4).

The problem of acute malnutrition treatment delay is aggravated by poor infrastructure and accessibility of treatment services. As pointed out in Nigeria, about 39% of the population access health facility within one hour walk during the dry season and it decreased to 24% during the wet season due to poor infrastructure which accounts for 90% non-paved road to access the treatment services(1). Due to this and different factors, in 2015, it was estimated that 50 million under-five children were affected by acute malnutrition globally and the highest rates of undernutrition are reported in Africa, Asia and Oceania(5).

Although Ethiopia had designed a new guideline for acute malnutrition treatment in the year 2019 to increase the access and coverage of the services (6), evidences showed that only 3 out of every 10 of all episodes of underweight received proper health attention for treatment which articulates the treatment service was low and it contributes for 24% of all child mortality (7). Additionally, evidences showed that there was a high admission rate for under-five children in Ethiopia(8).Thus, exploring barriers that delay parents/caregivers for acute malnutrition treatment can contribute to disclose the barriersand provide evidence-based decisions in a health structure andthe community that can help to scale-up the access and coverage of acute malnutrition treatment services(9).

1.2. Statement of the problem

The trends of global prevalence of childhood underweight areestimated decreasing in all parts of the world. However, the case is projected in increasing fashion in Sub-Saharan, Eastern, Middle and Western Africa. This trend alerts the world and Africa that are not in track of achieving malnutrition reduction(10).It is evidenced that twelve African countries have very high levels of childhood underweight which contributes for insignificant change of child malnutrition reduction in that Ethiopia is one of the affected country with high level of childhood malnutrition(10).

Similarly, the service provision for acute malnutrition treatments among under-five children are bare and Amhara regional state accounts high prevalence under-weight and poor nutritional status.Thehigh admission rate, bed occupancy and length of staywhich indicates the higher the delay or the lower cure rate for treatment (11–13).Lay Gaynet is also one of highly affected district by nutritional problems in the region that Growth Through Nutrition project is running to reduce malnutrition problems though the problem is not significantly reduced yet (14).

There are different concurrent and conflicting perspectives on the problem and it was the clinical assortment that consideredas a disease perception in the community rather than viewing undernutrition as a disease. In thatcase, parents/caregiverswere unlikely behaved to consult health workers if the child was lonethin(15–17). Again, parents/caregivers'health-seeking behaviour onaccessing the service of acute malnutrition is also poor(18).The provision of health education and promotion, counselling on beliefs, motivation and awareness creation(15), linear child growth interpretation had not guided by nutrition and health system programming which had dominated by community norms; additionally, there is a need for early identification of acute malnutrition (16,18).Despite the fact that the services for acute malnutrition in every allopathic health facility had said to be delivered, the attendance for treatment remains low in the country(19).Though studies assured the low service utilization quantitatively, still there is a huge gap in knowing barriers of acute treatment in health facilities(20–23).

Again,qualitative research is rarely done to explore the barriers in the study area.Consequently, knowing the detail is critical to have evidence-based intervention against the barriers for missing the mark on acute malnutrition treatment among under-five children.

Thus, this studyaimed to explorebarriers that delay for acute malnutrition treatment among under-five children in Lay Gaynet, Northwest Ethiopia.

1.3. Significance of the study

In spite of the fact that exploring barriers for acute malnutrition treatment/care delay among parents/caregivers having under-five children (0-59 months) is a key factor for the reduction of acute malnutrition, morbidity, and mortality, little is known about the current factors influencing the utilization of acute malnutrition treatment services early in allopathic health facilities.Although different factors were identified for the reason of care delay, most of the studies werequantitative studies, they were not done in the study area, they might be different in socio-economic, cultural and other related issues, availability of the service and understandings of the problem might be different. Again, qualitative research is rarely done to explore the barriers in the study area. Similarly, this qualitative study was conducted from time and place context of acutemalnutrition treatment Therefore, to have detailed understandings of the reason for treatment delayand to intervene the problem with evidence-based approach this qualitative content analysis study was done. Consequently, knowing the detail is critical to have evidence-based intervention against the barriers for missing the mark on acute malnutrition treatment among under-five children.

This qualitative study is, therefore, aimed for filling the gaps, by attempting to explore details of the barriers for acute malnutrition treatment/care services delay among parents having under-five children.Therefore, different stakeholders could utilize the finding of this study for a holistic approach and designing their evidence-based intervention strategy foradvocacy, health education and promotion, nutritional counselling and community mobilization.

2. Literature review

2.1.The magnitude of Under-five child Acute malnutrition

The 2018 report on global nutrition reaffirmed that acute malnutrition aggravated by different factors and it accounts for a burden of 7.5% (50.5 million) wasted under-five children worldwide(24).Though the commitment to end all forms of malnutrition by spending more financing for nutrition intervention in different nations had being got emphasis and data gathered from 25 countries in the world indicated an increased expenditureof 24.4% for nutrition-sensitive and 9.8% nutrition-specific programs, there is unacceptable change and slow progression(24,25). A study conducted on Coverage of Community-Based Managementof SAM Programmes inTwenty-One Countries from 2012-2013; in which most of the review were from Sub Saharan Africa, ascertained that 33 of 44 coverage assessment review failed to meet the context of specific internationally agreed minimum standard coverage(26).

2.2.Causes for Barriers to access acute malnutrition services

2.2.1. Socio-demographic Factors for Under-five children Acute malnutrition

The burden of acute malnutrition was reinforced by different sociodemographic factors: maternal educational status, sex, and preterm babies(27). Community networks: wider family and social support networks were considered an important aspects of care in acute malnutrition treatment and management(16).

2.2.2. Health Care Services and Quality of Care

According to evidence from a prospective study conducted in India on progress of child with severe acute malnutrition (SAM) in the malnutrition treatment (MTC) rehabilitation program, multiple morbidities were common and 50% of the study participant children were had two or more episodes of illness;68% of the had cough and cold, 40% had fever and 35% had diarrhoea(28). Similarly, reports from UNICEF and works of literatureconducted in Ethiopia showed that there is limited access to health care services, poor access to water, sanitation,a recurrent outbreak of preventable diseases and internal displacementthat contributes to the distressing challenge of acute malnutrition treatment/care (25,29).Likewise, lack of focus on

nutrition and documentation in nursing homes, home care, and home nursing, the self-perceived views of the primary care workforce study conducted in Denmark; had identified lack of uniform and system communication which affect nutritional care; experience-based knowledge among the primary workforcethat influences the daily clinical decisions, different attitude towards nutritional careand differences in organizational culture create differences in quality of care and lack of clear nutritional care responsibilities and clinical leadership and priorities affect how daily care is performed and makes nutritional care invisible(30).Again, a study conducted on community health worker perceptions of structural

barriers to quality of care and community utilization ofservices in Bangladesh, irregular supply of medicine from health facilities was another challenge for quality service delivery(31).

2.2.3. **The healthcare workforce**

A gap in health workers' training and focus of caregivers on clinical symptoms lack of noticing malnutrition until it becomes severe were among the barriers to treat acute malnutrition and contributes toa decrease in treatment service utilization(16,32). Similarly, a study conducted in the performance of low-literate community health workerstreating SAM in South Sudan discovered that lack of training hinders understanding of treatment protocols and reduce accessing treatment services due to poor quality service(33).Likewise, a study conducted in Kenya showed that health care providers at health facility face challenges in placing intravenous lines for dehydrated children and they believed that nasogastric (NG line) was not effective for rehydration; knowledge and training regarding to guidelines and availability of NG was found as their concern to deliver the treatment for acute malnutrition(34).

2.2.4. **Financing to acute malnutrition management**

A study conducted in Senegal; on inpatient and outpatient treatment for acute malnutrition among under six-month infants identified affordability was one of the barriers for accessing the treatment services(35). Correspondingly, high opportunity cost, inter-program interface problems, and previous rejections were identified problems for accessing acute malnutrition services(22). Again, a study conducted in Bangladesh identified that community poverty constraining the recommended uptake of practices(31).On the other hand, a qualitative study conducted in rural Bangladesh on perceptions of acute malnutrition and its management in

infants under 6 months of age identified that perceived causes of infant malnutrition were underlying illness, poor feeding practices, poverty and local misconception(16).

The neglection of the community component of health systems and dedicated funding for community component for integrating acute malnutrition treatment with the national health system, provision of equitable services delivery, and feasibility of mechanisms to effectively reduce barriers were identified by a comparative study conducted in Pakistan and Ethiopia(22).

2.2.5. **Perceptions of Service providers**

Health workers perception to barriers and limited abilities to access and utilize the services were a gap recognized forquality of care according to a study conducted on Sometimes they fail to keep their faith in us': community health worker perceptions of structural barriers to quality of care and community utilization of services in Bangladesh(31).

2.2.6. **Perceptions of Beneficiaries**

According to a study conducted in Marsabit County, Kenya: on Stigma as a barrier to treatment for childhood acutemalnutrition had identified women's time and labour, odds of reporting shame as a barrier to access health care and stigma were the most common barrier to access the child health care services and under-recognized barrier(36). The poor quality of care for community health workers' referrals sent to the health facility and community trust on community health workers are identified behavioural barriers in the study conducted in Bangladesh(31). On the other hand, lack of awareness about acute malnutrition management program, knowledge of the service, knowledge of malnutrition and child's refusal of utilizing supplementary food were gaps to access acute malnutrition treatment services and contributes for the burden of acute malnutrition(22,26).Perception on views and preferences of treatment for acute malnutrition on hospitals and doctorsas the best treatment offering facility; perceiving health care workers as second important treatment provider and need of care of the caregiver/mother along with infants were identified and lower cost, greater accessibility of community-based care were perceived and appreciated but they worried about the quality of care in a qualitative study conducted among under six-month infants in rural Bangladesh(16).

1. OBJECTIVE

1.1. General Objective

To explore barriers that delay for acute malnutrition treatment/care among parents/caregivers having under-five childrenin Lay Gaynet, Northwest Ethiopia.

2. Methods and materials

2.1. Study setting and period

The study was conducted from June. 01/2020 to August28/2020 in Lay Gaynt, South Gondar Zone, in Amhara regional state which is a Northwest Ethiopia; above 735km from Addis Ababa. The study area wasa vulnerable study setting forunder-five childhoodacute malnutrition. The area was identified as one of the priority areas for growth through nutrition (GTN) and sustainable undernutrition reduction in Ethiopia (SURE) project nutrition intervention with social behaviour change communication approach (SBCC). There was one primary hospital, nine health centres and forty health posts throughout the district as per the interviewobtained from the district health department on June 22/2020.

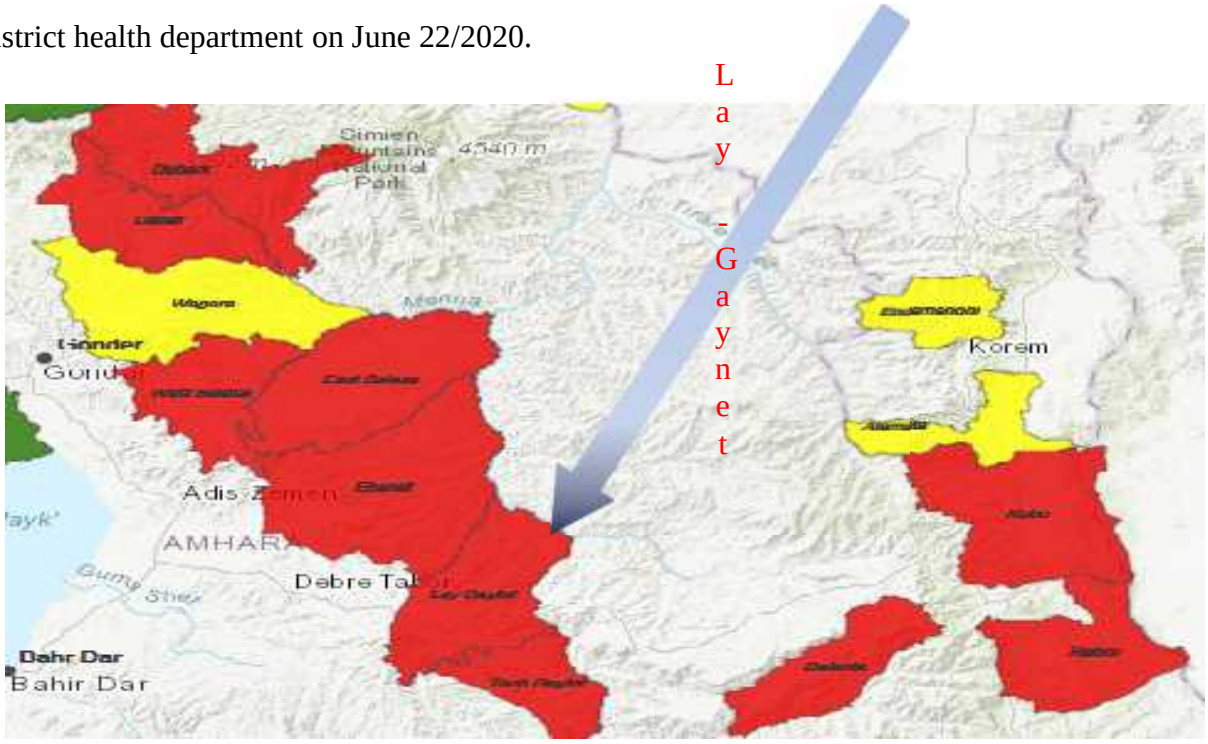

Figure 1: Geographical map of Lay Gaynet, South Gondar Zone, Northwest Ethiopia, 2020.(14)

2.2. Study approaches/design

A descriptive qualitative content analysisstudyapproachwas employed to conduct the study on barriers that delay for acute malnutrition care of under-five children to obtain a full understanding of barriers for missing the mark in health facilities.

2.3. Study participants

There were 22 study participants recruited. The study participants wereparents/caregivers having under-five children with acute malnutritionwho were delay for acute malnutrition treatment and admitted in inpatient care, health care providers (health administrative bodies: head/coordinator/medical director of health facilities, district health department, zonal health department and regional health bureau),NGOs key personnel and health workers working in acute malnutrition ward.Parents/caregivers with acutely malnourished child and who did not visit health facilities for acute malnutrition treatment werealso participants.

2.4. Study participants Recruitment Technique

The study participants were recruited by mixed non-probability sampling technique. A maximum variation purposive and snow-ballsampling technique were used to recruited the right participants.

Hence, everyone did not have the same level of experience or engagement withall issues or concepts; they did not expect toequally adept at reflecting upon or articulating their experiences anddue to the need to go where we could get data to work withto recruit participants who were ‘information-rich’;parents/caregivers with under-five children who suffer from acute malnutrition and/or admitted to inpatient carewere selectedpurposively until information redundancy was reached. Snow ball sampling was employed to reach those parents/caregivers who have had acutely malnourished child but that did not come to health facilities by requesting those parents/caregivers’ that already attended the treatment whetherthey knew parents/caregivers who have/had acutely malnourished child in their neighbour and/or influential communityleaders if there were practices of traditional healer preference than treatments in allopathic health facilities.

2.5.Data collection Process

The data was collected by trained two research assistants usingsemi-structured interview guideand observational check list with close follow up and full engagement of the principal investigator in interviewing. One of the research assistants had experience in qualitative data collection.

On the other hand, participants were interviewed using interview guides contained queriesproving factors that delay the use of acute malnutrition care services at different levels in the study area. The interview guides werepiloted and the questions were modified based on the findings from the pilot finding.

There wasa day-to-day debriefing to discuss on progress of data collection, identify saturation levels, refine queries and support the quality of the research process with PI and the research assistants. The interviews were carried out in the usual work settings of participants: hospital, health centres andhealth post. The in-depth interviews were conducted using the interview guide prepared considering the logical order of asking a warming-up questions, cool off and closure sequencing approachand with precautions not to present leading questions.

TheIDIs and KII were conducted by one interviewer, and a research assistant. All the data collection was recorded by audio recorder.

Observational Data collection

The observation was conducted related to acute malnutrition includingremarking the type of care provided in each health institutions, the weighing technique, the intimacy/linkage/ relationship of parents/caregivers' approach with health workers and how the treatment was done and records was filled. The observation was held on reviewing child health cards, register books, weighing skills and counselling techniques whether there was intimate link with greeting, asking, listening, identifying, discussing, recommending, accepting and appointing (GALIDRAA Approach) was based on observation check list.

2.6.Operational definitions

Under-Five children: children whose age is 0-59 months under parents/caregivers' care.

Barriers:are those factors at least one hinderance existed (cost of care, opportunity costs, Inadequate or no insurance coverage, lack of availability of services, Lack of culturally competent care/acceptability of care)which could be the respondents wanted to see health professionals but not and/or respondents not seeking and utilizing health care services totally for acute malnutrition care.

Treatment/careServices: are activities designed to assist the person to maintain or improve behavioural functioning, emotional,physiological functioning, and to prevent conditions that would present barriers to a person's functioning. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.

Allopathic health facilitiesis a system in health facilities: health s and hospitals that have or plan to have acute malnutrition treatment services:outpatient therapeutic program and therapeutic supplementary feeding program services provided for individuals with SAM or MAMand healthcare professionals (such as senior nurses, health officers, nutritionists, and physicians) provide the service to treat symptoms and diseases of acute malnutrition for children less than 5 years.

2.7. Trustworthiness

2.7.1. **Credibility of the study**

In regard to credibility there was prolonged engagement until information redundancy was obtained. There wasinsistent observation and searching for negative cases, peer debriefing, re-reading of the transcribed data for familiarization, member checking and data triangulation to have clear understanding the local contexts of the problem(37).

2.7.2. **Transferability of the study**

The study had a thick description of time, place, context and culture so as to have applicability of the ontology and epistemology derived from this qualitative study to other situations depending on the similarity between the study's context and the reader's context(38).The study tried to have representative participants from different levels. Therefore, the readershadjudgments of the transferability of the finding of this study.

2.7.3. **Dependability of the study**

The dependability of this study wasassured and made sense by making it clear why the study was done, what was done, and why it made sensegiven the data. There was codebook (organized list and definitions of themes), codes (shorthand notation for themes), topics and concepts preparationafter intense reading and memo to index the data set. One-third of the data were used to develop the data and developing codes was stopped when it was reached at saturation level(39).

2.7.4. **Confirmability of the study**

The study findingconfirmability were guaranteed with the research supported by the data collected, and triangulated at the ground data gatheredwith authenticity considering fairness to represent all views adequately, evocation of emotional or intellectual impacts of the work with mental-map/memory of the process and outcome and critical change of conscious-raising among participants to empower them in participating in the study which could be confirmed by other research auditors by tracing back the data gathered(38,40).

2.8.Data analysis

All of the audio-records were transcribed verbatim and translated from Amharic into English by an experiencedtranslator for analysis. We provided both the transcriber and translator with a brief description aboutthe research scope and objectives of the data to enhance their understanding of the subject matter.The transcripts and translations were cross-checked for consistency. The analysis was done from verbatim transcripts, memos, and opinions taken from participants considering what was said and how it was said was focused andthe content analysis approach was hired. Qualitative content analysis was done which is appropriate analysis approach for recorded human communications that enables, with conceptualanalysing and relational analysis for analysing the relationships of concept with manifest (observable content) and latent content (underlying meaning of the content) in the data gathered from interviews.Open code version 4.02 wasused for qualitative data management during the analysis.The collected data was read and re-read, memos was taken using memo notes, & codes were developed, the inter-coder agreementwere prepared. The entire data set was also coded and analytic tools were used to describe socio-demographics, different barriers, compared with others and categorize into their level of influence for acute malnutrition treatment delay. Finally, there were a validation of findings with data accordingly to build an explanation and theory for barriers of acute malnutrition treatment delay in government allopathic health facilities. The analysis had a thick description based on the breadth, depth, context and nuance of barriers for acute malnutrition treatment delay among participants' perspectives.

2.9.Ethical consideration

The basic study protocol was approvedby Addis Ababa University College of health scienceethical review board.This study's code of research ethics addresses the participants' autonomous rights and maleficence, clarify the benefits, and disclosepossible harms that might

suffer during the research. The participant selection process and the study area were clearly stated in the information sheet with clear and detail descriptions of the study purpose. The research also respects for justice and fidelity in the consent form to assure confidentiality. After approval of ethical issues,ethical clearance andletter of permission and support were received from Addis Ababa University, school of public health Ethics review Board (IRB).

Again,Support letter and permission was obtained from Amharapublic health institute, zonal health department and district health office.

Finally, consent was taken from correspondent participants after the information sheet has read and clarified for the respondent by their understanding language.Written informedconsent wasobtained from respective participants.

2.10. Dissemination of results

The result of the study is believed to be a key input and brings the attention of policymakers and interested groups to work on under-five childhood acute malnutrition in the study area. Therefore, the result will be presented in multi-dissemination system like submission/report to for regional health bureau, zonal health department, presented in annual health and education conference, ministry of health, Amhara development organization which works on social security and development of Amhara, organization for rehabilitation and development of Amhara and women and child affairs bureau of the region for intervention to alleviate the problem of malnutrition among under-five children based on evidence, submission for publication of the result on peer-reviewed journals.

3. Result

3.1. Sociodemographic Background information

There were twenty-two study participants for in-depth and key informant interviews.One of the participant'schild was aged above four years; stunted, wasted and unable to go. The other three participant children were aged less than one year and one participant child was three years of age.

The parents range from 28-38 years of age while the health worker participants were aged from 25-35 years and administrate aged 28-41 years of agewith educational level from level III-to-post graduate level. There were only two mothers who were literate. One of the literate mothers was a primary school teacher and the other mother was grade eight complete housewife-mothers. The participants' family size ranges from three to a maximum of six family members.

The following table summarises the socio-demographic information.

Table 1: Background information of the study participants for barriers that delay for under-five children acute malnutrition treatment, Lay Gaynet, 2020.

Level	Participants involved	Profession/occupation	sex	Technique	No. of participants
Community	Parent/Caregiver/s/	5 farmers 1 teacher	4females 2 males	IDI	6
	Community leader	Farmers	Female	KII	1
Health professionals	Focal/assigned Health worker/s for acute malnutrition care	3 nurses 1 paediatric nurse 1 physician 1 health officer	3 females 3 males	KII+ Observation	6

	Health Extension Worker	Health extensionworker	female	KII	1
Facility	Health service coordinator/head/medical director at hospital/health	1 health officer 1 nurse 1 physician	male	KII	3
	Hospital Manager	Health officer	male	KII	1
Administrative	AMTS program coordinator/head at district	Health officer	male	KII	1
	AMTS coordinator/head at zonal health department	Nutrition unit coordinator	male	KII	1
	AMTS coordinator/head/regional health bureau	Malnutrition reduction project coordinator	male	KII	1
	NGO coordinator	SBCC nutrition officer	male	KII	1
Total	**Ten type of participants**				**22**

3.2. Delays in decision making for health seeking Behaviour

3.2.1. **Parents' awareness**

The awareness of parents was found at grass root level. They did not aware about acute malnutrition treatment and consequences of malnutrition. The nutritional health education and promotion program under gone in the district health facilities were observed missed and priority was not given in practice though it was perceived implementing along with other health education sessions. A parent who had got three times relapse of undernutrition for the under-five child stated the scenarios;

> *"……..there are health extension workers. They did not give us health education in the institution. They told us to give food but there is no nutritional health education session while I stay here." /Father IDI: PI1/*

> *The mother said that "… hence, **we are farmer**, we did not get cabbage,**to get balanced diet**." /Mother IDI: PI2/*

Unless a child of under-five ceases eating, got high febrile, lose weight accidentally and diarrheal disease observed simultaneously, parents did not recognize that the need for well-child visit and they did not relate their children's illness with malnutrition. The wasting and skinniness of their children were considered as natural and especially, if the child was born wasted and inactive, they would be painstaking it as a dissension of GOD.Thirty-eight years of age mother stated that,

> *"……..it is the penalty of GOD that is taken their health like this of my child. I do not know out of this.I go to health facility and for the wholly water **when my child gets ill**."*/Mother IDI: PI4/

3.2.2. **Parents' perception towards ill-role behaviour**

The parents of under-five children did not have ill-role behaviour towards their child unless their child got weakened and slept due to ailment. The delay for early treatment was strongly related with their perception of their child was not ill or well while the under-five child has been playing. If the child gets out of home for those children started going, playing, did not get high fever, faced emergency accident and did not cry differently from the normal trend, then the child will not bringforwell-child visit.

"It is when my child is ill that I come to health institution for my child treatment.……..……..…….." /Father IDI: PI1/

"Unless my child is ill why I come to health facility; I did not come to health facility unless my child is ill. ***But for my child vaccination****, I bring my child to health worker timely. ……., I did not go for well-child visit to health facility." /Mother IDI: PI2/*

3.2.3. **Traditional Beliefs**

Concerning to beliefs, though there is a change in traditional beliefs, there is still valuing traditional beliefs among the parents towards their under-five children. The parents believed that the health of their under-five child can be harmed by traditional beliefs like "evil eye".

"Some parents believe "evil eye". When their child becomes sick, they come to health institution for treatment but occasionally, they raise a new idea and stand to go to home saying 'there is unfinished issue left undone at home that we should have to go to home.' They believe in "evil eye". ……for traditional treatment. They believe that if a child is affected by "evil eye",……the child has not been injected with needle (IV) for treatment. ……..."/Health worker KII: PI8/

Traditionally, there is a medicine prepared by themselves as a healer for healing and/or identifying "evil eye". As woman from community health development described the medicine preparation and utilization as follows:

"even when it is 'evil eye', the child will be brought to wholly water; there is 'altit, onion and 'tenaadam' spices which will be grinded, mixed and tied with cotton cloth then wet with water and knead dough it with finger; finally smelling to the child. If it is evil eye, the child will be annoyed, crying severely. Then the child will be brought to wholly water and there is spiritual book that will be read and the wholly water will be spray on the child or baptized; there is no witch doctor now a days;/Community leader KII: PI14/

3.2.4. **Workload**

Mothers also claim workloads at home; cooking for food, take caring of other children and their husband were among the indicated prioritized tasks for them as community norm. Bringing a child for health care was perceived as the child got severe illness or the child's life is in between surviving and dying. In this case, the mother has to piggyback her under-five child to take to heath facility or wholly water.

"…….. I gave close births and I could not find who can take-care of my small children. However; if my child got ill, I leave all things and I bring to health facility. ……..…..I may not get a supporter that coordinate and give food for my family members, my child; ……..……" /Mother IDI: PI2/

3.2.5. **Poverty**

They produce cereals and legumes once or twice a year. There were no expanded irrigational activities in the area and the people rarely producing fruits and vegetables. The people had low varied agricultural production.The people seek aid for basic needs. They claimed lack of money, different agricultural products: lack of different types of cereals, legumes, fruits and vegetables for their under-five child malnutrition. To diffuse different agricultural production the government in collaboration with non-governmental organization has had selected model nutrition villageto show variety of agricultural production for farmers. However, the initiative was not actively functional yet. Parents faced economic crisis and got their under-five children malnourished; denied of early treatment.

A mother who worried whilethinking of the distance, geographical set up, lack of money for transportation and opportunity cost stated as follows;

"it is incapacity; ……. Economic issues, there is lack of money to treat early though I found collecting or debiting a loan for mandatory treatment of my child illness. It is poorness which is the main challenges."/Mother IDI: PI2/

3.3. Delays in reaching for acute malnutrition treatment services

3.3.1. **Difficult geographical location**

The topography of the district was mountainous, gorge, plateaued and butte with lack of transportation. There are jungles, rivers and farm lands in a wide spread phenomenon. The onerous type of topography hinders parents for early reaching their under-five children to treatment centre.Due to the topography the households were sparsely populated and difficult for health extension workers and health workers toreach the parents with under-five children and vis-versa.

"…….. the travel distance makes my heart weaken and I become tired off when I think of the travel.……" /MotherIDI: PI3/

"The area is unreachable; it is wide area, it is remote area to travel, there is challenge of coverage. The health extension worker cannot go to very remote area because there is river, jungle, and distance. So, if you order health extension worker to there, she will not." /Health worker KII: PI10/

3.3.2. **Distance from health facility and Transportation system**

In this category, the parents with under-five children faced long distance travel for accessing under-five child malnutrition treatmentthattook above 80km.There were places that took 10:00 hours travel on bare foot or by stretcher carried by humans.Health extension workers also went to work by travelling a distance that took at least 3:00 hours bare foot travel.

"…… there is afeared of rape for mothers to travel alone; …… even we go for vaccination and community service for a distance of about 3:00 hour bare foot travel being two and above..……"/Health worker KII: PI13/

Among the nine health centres five of the health centres did not have accessible transportation. The road was onerous, full of dusty, gravel, crinkum-crankumand undulation due to the areas' mountainous topography. Those at the farthest distance have relapse of the case or they did not come totally for treatment.

A mother of 43 days age child who came travelling more than 2:00 journey carrying her child on her back responded that:

"It is incapacity: the transport, family case; I am a mother of children, I did not get a person that coordinate and givefood for family members, my child and the travel distance make me my heart weaken and I become tired when I think of the travel" /Mothers IDI: PI2/

3.4. Delays in receiving for acute malnutrition treatment services

3.4.1. **Lack of organized treatment facility**

The health institutions did not organizein a way of organized treatment rooms, continuous stock supply, skilled health worker and committed monitoring and evaluation of the programs.There was only a single bed observed in one health institution and a mattress without bed in another two health facilities.

"…… lack of rooms for under-five child malnutrition treatment……the health workers know its consequences on quality of care." /health worker KII: PI7/

3.4.2. **Quality of care and skills of Health workers**

The health workers who were assigned as a focal person and those who were working at under-five child malnutrition did not have full recognition and skills on under-five child acute malnutrition management.

> *"I have no enough awareness. I observe the prescription /order/ of F-75, or transition to second stage, F-100, then I will provide the order and gentamycin and antibiotics will be given based on the order. ……I did not know the updated guideline but I give care and treatment based on the order/prescription of the physician."/Health worker KII: PI8/*

> *"……malnutrition treatment needs proper management due to its complications of the management……the main problem for quality service is lack of compassionate and kindness which is lack of commitment among health workers. There is also poor quality of health worker graduates ……On the other hand, trained health workers are not committed to serve and they are not different from untrained health workers for screening, counselling and treating properly which is a challenging barrier for under-five child malnutrition care and treatment."/Managers KII: PI15/*

3.4.3. **Nutritional Counselling and education**

The role of nutrition education and counselling was missed and miss managed in health facilities and it did not provide in organized and planned way.

> *"A nurse health worker was treating a 43 days of age infant in a health; she receives the mother and told the father to stay outside the room; then she invited the mother to take a sit on a chair and she started asking what happened to her infant. The mother then responses that her infant did crying and decreased breast feeding…… for the questions of the nurse. The nurse, after taking the history; she told to the mother to breastfeed her child and refers to OTP without anthropometric measurement (No MUAC andWeight) and recognitions of under-6 month of age child treatment protocol. /Under-five child care unit Observation: OPI1/.*

There is a gap from parents' side to ask health workers about their child health, what to do, how to do and they perceived that every treatment would be given by the health worker and they did not have a right to ask rather they had to implement what the health worker orders them. They did not understand that there might be miss-understanding and management of the case by the health workers. Parents draw health workers the doer and actor of everything.

> *"……there is haggling at the beginning. The health workers are good; I did not get a challenge. Otherwise, if they refuse to treat my child, I will go back to home without getting the treatment and my*

child may die. I come here for a third time due to my child illness. In the first visit I stayed for a week,for second timedue to relapse it was five days I stayed admitted, and for third time it is my third day of admissionnow while I come here." /Father: at Hospital: IDI; PI1/

The health workers did not recognise the counselling process is an on-goingway and that could be used for feasible course of action in the treatment process of under-five child malnutrition, they did not use job-aids for counselling of parents. They did not give emphasis for the counselling rather they treat under-five children and communicate to the parents in unscientific accustomed way ofarbitrarily GALIDRAA approach counselling.

"……..; we did not follow the procedure of GALIDRAA approach; ……... hard for me to say that we followed the procedure. To say that I have to say welcome; introduce name, I have to sit and discuss every activity; If I say that,I did those of everything, it will be lie; …… /Health worker KII: PI7/

The barriers for the delay of parents of under-five children with acutely malnourished child for early treatment from perspectives of the participants were viewed in the following diagram.

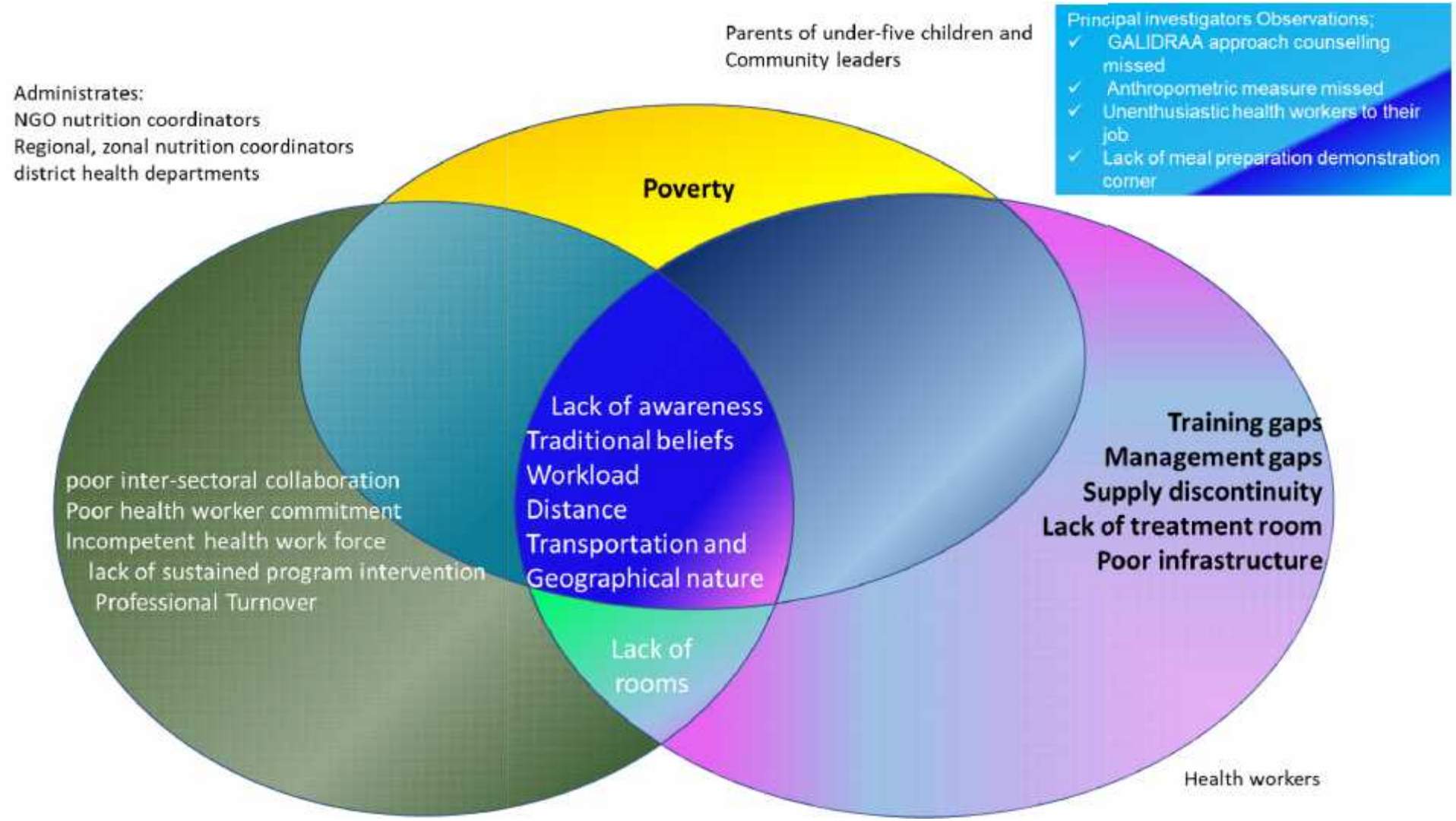

Figure 2: The barriers of under-five child acute malnutrition early treatment in Lay Gaynet, South Gondar, Northwest Ethiopia, 2020.

4. Discussion

In regard to under-five children acute malnutrition, as depicted by many scholars, recent weight loss, with and without medical complication, was an issue that the developing world was not in a track of achieving prevention of it due to different barriers(41,42).The participants had attitude of classification of acute malnutrition as non-case unlesstheir child had complications: diarrheal diseases, high fever, stop breast feeding and meal due to lack of knowledge about child malnutritionwhich is allied with other studies (16,43).

Parents conveyed that their decision on early acute malnutrition treatment was influenced by their low level of awareness and lack of knowledge about under-five child acute malnutrition.Like other findings thisstudy found that unless their child got ill and faced a chance of dying or living they did not aware about early treatment(44). This might be due to limited sources of information and poor coverage of the service. On the other hand, a malnourished childwith complicationwould not be brought to health facility leaving the rest of family members which also related with burden of workload.

The perception of under-five child's parents towards ill-role behaviour (illness behaviour undertaken and perceived as ill and seeks relief) was when their child had faced acute malnutrition with complication(45).There was a difference between literate mothers, illiterate but consistently trained mothers by health extension workers and illiterate mothers regarding to perceptions of child acute malnutrition which implies to strengthen health education and promotion. This finding was comparable to aqualitative study on perceptions of childhood undernutritionamong rural households on the Kenyancoast and health care seeking behaviour in Ethiopia(17,46).

Traditional belief was one of the finding that the parents of under-five children had delayed for under-five child acute malnutrition treatment. While parents had wait for natural recovery, supernatural regaining like baptizing with wholly water/spy and true-cross body lapping, traditional healing and beliefs of "evil eye", their child got acute malnutrition with complication(47). A study conducted in South Africa on a mother's choice founds similar findingon beliefs in the treatment of their under-five children(48).The parents' uncertainty and delay regarding to their under-five child malnutrition treatment might be due to low diffusion of

social behaviour change communication, low coverage of health education and nutritional counselling.

The existence of rivers, jungles and crinkum-crankums had made parents tired off and they had preferred not only delay for treatment but also absent for modern treatment. This study was consistent with a qualitative study conducted in Jimma and West Harrerghe zone(21). Although the evidence was limited, parents also exposed for rape virulence and they, parents, raised difficulty of travelling alone. To solve this, mothers had to request males, husband and young child/adolescents, during farm season to go with them.

The other factor was distance and coverage that the clients from the nearby health facility and poor coverage was remained the main challenging barrier which was consistent with a study conducted in Southwest Ethiopia on health care seeking behaviour(49). There were no easily accessible transportation system and transport infrastructure(50). There were areas which did not have transportation that exacerbates the problem. This might also contribute to high child morbidity and mortality from acute malnutrition.

In our study we had found that the treatment for under-five child acute malnutrition was not arranged in organized and standard way which had a deviance from the national guideline of acute malnutrition treatment(6). As we found in our study, there was no service availability and readiness treatment facility. This might indicate the gaps andloosen link hat could not trigger parents to have consistent follow up.

Regarding to quality of care and skilled personnel, though the service of acute malnutrition treatment was delivered; it was a great challenge for the district and unsolved problem yet. The poor quality of care and the low level of skilled health workers, lack of consistent problem identification and intervention to identified problems to deliver under-five child acute malnutrition treatment service were identified barriers like other studies(31).There was lack of adequate training, nutritional health education and promotion, nutritional counselling based on GALIDRAA approach to have effective acute malnutrition treatment and for teaching parents on early treatment of under-five child acute malnutrition. There were health workers who did not want to work in under-five child acute malnutrition due to their incompetency to treat the case. There was also complains on training provision for health workers and their claim was not fair

when selecting a health worker to be trained though the training provision was rare and inconsistent. This might be one of the causes for poor commitment of health workers and this could lead to poor quality care that enforces parents to delay and stay home.

On the other hand, the service was challenged with supply continuity, mainly under-five child acute malnutrition supplementary foods: F-75, F-100, ReSoMal, Plumy nut and antibiotic medicines were identified with not significant problem from participants' perspective. However; a one-day meal miss could bring a child under treatment delay in recovery and increased hospitalization.Regarding to supplies, there was no incessant supply in the health facilities. This study was identified similar challenge like a study conducted in Bangladesh on Challenges and opportunities of integration of community-based management of acute malnutrition into the government health system(31,51).

The other issue was nutrition counselling and nutritional health education which was missed in the study area, was reported as the main challenge to be implemented in the right way of GALIDRAA approach. Health workers under the unit of under-five child acute malnutrition treatment ward/unit were testified underling the here and there counselling rather than following the right procedure of counselling so as not to miss the necessary message.Nutritional health education was delivered by mainstreaming it with other health issues. Although mainstreaming nutritional health education with other health issues had to increase awareness about the relation between nutritional problemswith other diseases,provision of nutritional health education for unsegregated audience might not bring successful effective communication and behavioural change. There was also no health promotion on meal preparation demonstration for parents.

As indicated in the study, the sustainability of under-five child acute malnutrition treatment was in misgiving. Though the issue had a great devotionand it had thought that the issue had given great devotion, it was not true in practical scenario due to incapability to have strong inter-sectoral collaboration, lack of ownership among governmental sectors, poor coverage of the service and emergencyand seasonal public health problem events that enforced to change the focus area from under-five child acute malnutrition. This might cause parents to be exposed for poor quality care, poor treatment outcome and long hospitalization that could trigger them to prefer other healing choices, to decrease their trust on modern care. This might also one of the

causes for their delay from early treatment, lack of behavioural change for malnutrition treatment.

4.1.Strengths and Limitations of the study

Although the study unable to conduct a focus group discussion considering group variation among parents (fathers and mothers), and health workers among focal persons and health workers working with focal persons in the under-five child malnutrition department and due to the extremely time consuming nature of content analysisit was tried to participated different participants in in-depth and key informant interview with more than one interview/having repeated interview with participants expected to unanswered questions during analysis that might had influence on delay for under-five child acute malnutrition treatment.Again, participants with a consideration of maximum variation, debriefing and triangulations were done to have the right information from place, time and cultural contexts so as to avoid subjectivity in coding.

5. Conclusions

In conclusion, delay in under-five child acute malnutrition treatment among parents in lay Gaynet district was visible that needs immediate intervention. The parents with under-five child acute malnutrition did not visit health facility early due to poor awareness, lack of positive perception towards illness behaviour, traditional beliefs, poverty, parents workload, geographical situation, distance and transportation system, service availability and readiness, poor quality care, lack of supply continuity, lack of nutritional counselling and health education and unsustainability of intervention for under-five child acute malnutrition were those major barriers that delay parents from early treatment.

6. Recommendations

There should be*strengthen stock supply management system*, need to provide additional ambulances and vehicles, health worker training focusing on nutritional focal persons and even needs to employee nutritional staffs and should improve their monitoring and evaluation system.There should be different strategies designed formonthlynutrition screening at a selected screening village and child growth monitoring and promotion. Updated guidelines for malnutrition management and mainstreaming of nutritional sensitive issues with different sectors to have shared vision in under-five child acute malnutrition early treatment had to be

disseminated early.Health promotion and nutritional health education and promotion, meal preparation demonstration, training of health workers had to be strengthened.Health workers had to update themselves and had better to be committed to serve and rely on scientific judgement by measuring anthropometric measurements rather than using visible absence of wasting. Active community participation had to be promoted.Finally, further researches had to be done to investigate on the coverage and effectiveness of health education and promotion in the area regarding to social behaviour change communications including the strength of monitoring and evaluation systems of projects and programs for acute malnutrition treatment and prevention of the problem. It would be good to install nutritional health education and promotion projects in the area.

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8. Annexes

8.1. Information sheet

Title of the research: Barriers that delay for Acute Malnutrition Treatment among Parents/caregivers having under-five children in government health facilities in Lay Gaynet, South Gondar Zone, Amhara Regional State, Northwest Ethiopia: 2020.

Research Title Code: _____; **The Principal Investigator**: Habtemariam Abate Meshesha; **Address**: Addis Ababa University Health education and promotion department School of Public health. Addis Ababa, Ethiopia.**Dear Participant;** my name is _____. I am representing Habtemariam Abate Meshesha the Principal Investigator. He is a master of public health education and promotion of graduating student. Currently, he is conducting research on Barriers for Acute Malnutrition Treatment Services among Parents/caregivers having under-five children in government Health facilities and you areselected for the study.**Purpose of the study**: the study is going toexplore Barriers for Acute Malnutrition Treatment Services among Parents/caregivers having under-five children in government Health facilities for the partial fulfillment of Master of Public health in health education and promotion.**Voluntarism and Freedom to withdraw**: Before your decision in participating in the study, you have to be sure that you understand the purpose of the study with full voluntarism and you have a full right to ask me any questions that you want to ask. **Harms/Risks**: the question may take up to 1½-2 hours. The participation is In-depth interview, and key informant interview, including structured interview and there is an audio-recording and photo capturing only for the research purpose. Additionally, repeated contact might be required for detail information and to incorporate forgotten ideas. Otherwise, there is no any harm participating in this study.**Benefits**: The

participation does not have any short-term individual incentives, compensations, financial and other direct benefits.**Confidentiality**:Your response will never be transferred to a third body other than the researcher and interviewer and your questionnaire will be documented in a secreted manner.**Contact address for More Information:**Addis Ababa University, College of health science, school of public health, department of health education and promotion, 2019 postgraduate student, Addis Ababa Ethiopia, Office phone: (+251) 115-524-967 and the Ethical Review Board at Addis Ababa University. Principal Investigator: *Habtemariam Abate;phone: 0939859169; e-mail: Kalhab2006@gmail.com. Advisers: Dr. Adugnaw Birhane, phone: 0911391111, e-mail:adugnawbm@gmail.com. Mr. Mulugeta Tamir, phone: 0911809770, e-mail: awonmuller@yahoo.com*

8.2. Consent Agreement Form

Dear Participant:

Title of the thesis project: Barriers for Acute Malnutrition Treatment Services among Parents/caregivers having under-five children in government health facilities in Gaynt, South Gondar Zone, Amhara Regional State, Ethiopia: 2020.

I, the undersigned, confirm that, it is with a clear understanding of the objectives and conditions of the study that I give my consent to be part of the study. I have been given the necessary information about the research. I have understood that it is my right to withdraw from the study at any time; the proposal has been explained to me in the language I understand.

Participant

*Name*_____*Signature*_____*Date*_____

Interviewer

Name_____ Signature_____

Interview code_____

Signature of data collector: _____ Date of Interview _____

Signature of Interviewee _____

Thank you for your response!

8.3. English Version Questionnaire and Interview guide

English Version Questions for the study on barriers to access for acute malnutrition services among caregivers having under-five children in Gaynet, South Gondar, Amhara regional State;Northwest Ethiopia. 2020.

Part I: Socio-demographic and economic questions

No.	Statements	Response	Skip
1.	Sex of the infant/young child	1. Male2. Female	
2.	Date of Birth of the infant/young child (full month/s)	_____	
3.	Age of the infant/young child (full month/s)	_____	
4.	Place of delivery	1. Home 2. Health facility 3. On travel	
5.	Mode of delivery	1. Vaginal 2. Caesarean section	
6.	Sex of the participant	1. male 2. female	
7.	Age of the participant (full years)	_____	
8.	Marital status of the participant	1. single 2. Married 3. Separated 4. Divorced 5. widowed	
9.	Religion	1. orthodox 2. Muslim 3. Catholic 4. Protestant 5. Others (specify…….)	

10.	Ethnicity	1. Amhara 2. Tigrie 3. Oromo 4. Others (Specify……)	
11.	Family size	1. Less than four 2. 4-7 greater than or equal to 7	
12.	Caregiver relation with the infant/young child	1. Grandmother 2. Stepmother 3. Other (Specify….)	
13.	Educational status of the participant	1. No formal education 2. primary school completed 3. The secondary school completed 4. College/University Diploma/degree and above	
14.	Occupational status of the participant	1. Government employee 2. Merchant 3. Day labour 4. Housewife 5. Jobseeker 6. Farmer	
15.	Household head	1. Father 2. Mother 3. Children 4. Relative	

Interview Guide

Part II: Service Specific accessibility questions for Accessing Acute Malnutrition Treatments.

Part II-A. In-depth Interview guide for parents/caregivers'

- ❒ Have you ever heard about under-five child acute malnutrition? (further description about under-five child acute malnutrition information)
- ❒ Do you know about under-five child acute malnutrition? Please describe it what it is in your existing knowledge.
- ❒ Do you have source of information about under-five child acute malnutrition? Please tell me where you get information about under-five child acute malnutrition.

a. Reasons for delay in seeking for acute malnutrition care (AMC)?

b. Reasons for delay in reaching Acute malnutrition care (AMC)?

c. Reasons for delay in receiving adequate Acute malnutrition care (AMC)?

1. What do you know about acute malnutrition treatment services? Did you ever asked/heard about it?What it means? Please explain what you know?
2. When do you go to for your under-five child acute malnutrition treatment in usual way? Why?
3. Where do you prefer when you seek health care for your under-five child? (Traditional healer, religious belief, holly water, allopathic health institution/facility) and which care do you prefer in first line? Why? What other solutions you will do after that preference if the problem not solved?

4. Please tell me what services you got for your under-five child acute malnutrition care visit in health facility? (counselling about child growth monitoring (anthropometric measurement: height/length, weight, BMI, MUAC, head circumference, growth pattern on growth chart), well and sick child visit, immunization, postnatal care, micronutrient (vit-A, Iodine, Iron) supplementation, feeding as per age category); what else?
5. What barrier might delay you from seeking early utilization/visit of health facility for under-five child AM care?
   5.1. Knowledge of the services
   5.2. Opportunistic costs (work load, care for other family member, time for social-networking…)
   5.3. Traditional beliefs, cultural norms, perceived benefits and risks, and how do you think that these factors affect your health seeking for your child care? What else reasons?
6. What challenges had you faced when you seek AM care for your under-five child?
   6.1. Distance/accessibilityand availability of health facility, geographical situations: mountainous terrain, rivers, poor roads and infrastructures… what else
   6.2. Lack of transportation systems (ambulances, public transport, cost of transportation…)
7. What challenges faced you when you receive AM care in health facilities?
   7.1. Lack of intimate relationship: compassionate, respectful and quality and equity AM care provider health professional
   7.2. Poor facilities in health service supplies for AM care
   7.3. Inadequate referral system (clear consultation what to do and where to go next, lack of sense of humbleness during referring and accepting the referral)
   7.4. Long recovery/rehabilitation time due to poor care provision
8. In your opinion, what have to be done to improve the delay for under-five child care for AM from your perspectives: traditional belief, cultural norms, perceived benefit and risks, on understanding of AM treatment/care service, GMP utilization (parents/caregivers Vs health professionals)?
9. Finally, do you know any parent/caregiver whose under-five child is acutely malnourished or very thin and wasted but did not visit health facility for AM treatment in

your neighbour who might be stay at home or other healing site (traditional healer, wholly water/spy, home remedy) or other else? If so, how could I meet them? Could you contact me with them please?

Part II-B. Key Informant Interview guide for Health Workers

1. How many years did you have worked in AM treatment services for under-five children?
2. What trainings (off-job, on-job) do you have on AMTS provision (CRC, AMM, IYCF…) what else?
3. What understanding of the treatment protocol of AM management (AMM) for 0-59 months of children do you have: OTP, TSFP, SC?
4. What AMTS did you provide for under-five children (GMP: Height/Length, weight, head circumference, and MUAC measurement; Plotting of measurement values on growth chart, Counselling based on the growth chart about growth pattern for the parent/caregiveras per principles of greeting, asking, listening, identifying, discussing, recommending, accepting and appointing (GALIDRAA approach)).
5. How did you accept and treat parents/caregivers while their under-five child is acutely malnourished and come to you for care? (humility, respect, speed, appropriate and adequate diagnosis, case management, clear referral, provision of therapeutic food and/or medical supplies); what else?
6. How do you believe in providing quality of AM care based on AMM guideline? Involving parents/caregivers in the management of AM treatment, hygiene and sanitationhealth education….)

7. What is your intention of resigning from your job? Why? What else and what you recommend?
8. In your opinion, what barriers delay the provision of quality of care for under-five child AM treatment? (Parents/caregivers poor understanding of complications and risk factors in under-five child AM and when to seek medical help, health workers poor experience, Poor understanding of complications and risk factors in pregnancy and when to seek medical help, lack of CRC health workers, poor medical supplies, what else……)

Part II-C. KII guide for Community/Religious Leader/s

1. Reasons for delay in seeking for acute malnutrition care (AMC)

1.1. Describe factors that you know and hinder parents/caregiver's health seeking for their under-5 children?

1.2. What is the belief of the community about health care for their under-5 children, which institution is their first preference/traditional, modern/? Why they prefer it?

1.3. In your opinion, please explain and list the community perceptions, beliefs and understandings towards under-5 child malnutrition, under-5 child-care…

2. Reasons for delay in reaching acute malnutrition care (AMC)?
3. Reasons for delay in receiving adequate Acute malnutrition care (AMC)

Part III. Check-List for Opinion Description of Health professionals about the barriers that delay parents/caregivers for acute malnutrition treatment.

1. Opinion about parents/caregivers understanding and health seeking behaviour.
   1.1. Health seeking behaviour:_____
   _____
   _____
   1.2. Beliefs and perceptions of under-5 acute malnutrition:
   _____
   _____
   _____
   1.3. Related to opportunities costs:
   _____
   _____
   _____
   1.4. Other barriers you perceived:
   _____
   _____
   _____
2. Opinion about health service provision readiness and medical supplies.
   2.1. Existence of under-5 child acute malnutrition treatment service_____
   _____
   _____

2.2. Presence of conducive room for treatment
_____
_____
_____
_

2.3. Availability of medical supplies and food rations_____
_____
_____
__perceived as a barrier for treatment delay: conducive working environment, motivation award of employer, skill of management,
…….____
_____
_____
_____

3. Opinion about health professionals experience, willingness to serve, relationship with patients, CRC service, …
   3.1. Responsibility and accountability to serve in CRC manner_____
   _____
   _____

   3.2. Experience in under-5 child acute malnutrition treatment_____
   _____
   _____

   3.3. Understanding of acute malnutrition treatment guideline_____
   _____
   _____

   3.4. Knowledge of growth monitoring and promotion (measuring, recording, interpreting, plotting on growth chart, counselling technique(GALIDRAA approach) on Infant and Young Child Feeding (IYCF), and understanding of essential nutrition actions and contact points_____
   _____
   _____

Part IV. Memo-Note

1. What was spoken?
   1.1. _____
      1.1.1. How they spoke? Facial expression, tone of speaking, way of speaking/sense of reliance on the service/professionals/facility/ …
      _____
      _____.
   1.2. _____
      1.2.1. How they spoke? Facial expression, tone of speaking, way of speaking/sense of reliance on the service/professionals/facility/…
      _____
      _____.
   1.3. _____
      1.3.1. How they spoke? Facial expression, tone of speaking, way of speaking/sense of reliance on the service/professionals/facility/ …
      _____
      _____
   1.4. _____
      1.4.1. How they spoke? Facial expression, tone of speaking, way of speaking/sense of reliance on the service/professionals/facility/ …

_____
_____
_____.

2. What was observed while acute malnutrition care is provided?
   2.1. _____; how the treatment was delivered/the humility and sense of responsibility and professional ethics/relationship between care provider and client……
   _____
   _____
   2.2. _____; how the treatment was delivered/the humility and sense of responsibility and professional ethics/relationship between care provider and client……
   _____
   _____
   2.3. _____; how the treatment was delivered/the humility and sense of responsibility and professional ethics/relationship between care provider and client……
   _____
   _____

Observation Check list to assess the skills of health workers providing acute malnutrition treatment for under-five children:

Screening for level of care			Filling the card			Counselling		
	Yes	No		Yes	No		Yes	No
Scale correctly lying from a strong point			Date(month) clearly indicated			Greeting,		
Scale at zero (Calibration of scale) before placing the child			Name recorded			Asking and Listening		
Child undressed carefully Vs parents feeling			Date of birth recorded			Identify the problem and discuss		
Child held by the body when put on the scale			Birth weight recorded			Recommend and agree letting the mother express her idea		
Waited for needle to stop wobbling			Place of birth recorded			Counsel on the basis of the growth curve and child feeding based on the child age		
Scale read at eye level			Correct plotting of weight			Reach on consensus and agree; and thank parent/caregiver		

Person reading the weight is records the data			Correct joining of weight on growth chart			Acknowledge the client and appoint		

Any acute malnutrition treatment care performed:
observation 1:
_____
_____
_____
observation 2:
_____
_____
_____
observation 3:
_____
_____
_____
observation 4:
_____
_____
_____

8.4. ዕዝል (አራት)፡- የአማርኛቅጅለጥናትተሳታፊዎችስለጥናቱየሚሰጥማብራሪያቅጽ

<u>የጥናቱርዕስ፣</u>

ከአምስትዓመትዕድሜበታችባሉህጻናትላይለሚከሰትከሚገባውብታችየሆነየዝግብምግብ/የተመጣጠነምግብእጥረትክብካቤናህክምናወላጆች/አሳዳጊዎችንእንዲዘገዩየሚያደርጉቸውመሰናክሎች፣ ላይ,ጋይንትወረዳበሰሜንምዕራብኢትዮጵያ2012.

<u>የጥናቱመለያ ቁጥር፣</u> _____***<u>የጥናቱዋናተመራማሪ፣</u>*** *ሀብተማርያምአባተመሸሻ**<u>አድራሻ፡</u>*** አዲስአበባዩኒቨርሲቲ፣አዲስአበባኢትዮጵያ**<u>ስልክ ቁጥር፤</u>**

(+251) 939859169/ 960438012

እንደምንአደሩ/ዋሉ፣ _____ አባላለሁ :: የመጣሁትከአዲስአበባዩኒቨርሲቲየህብረተሰብጤናትምህርትቤትየጤናናተግባቦትትምህርትክፍል የ2ኛዲግሪተመራቂተማሪየሆኑትንህብተማርያምአባተንወክዬነው፡፡

በአሁኑሰዓት *ከአምስትዓመትዕድሜበታችባሉህጻናትላይለሚከሰትከሚገባውብታችየሆነየዝግብምግብ/የተመጣጠነምግብእጥረትክብካቤናህክምናወላጆች/አሳዳጊዎችንእንዲዘገዩየሚያደርጉቸውመሰናክሎች፣ በ2012* በሚልርዕስላይየምርምርጥናትበማጥናትላይይገኛሉ፡፡

<u>ውድየጥናቱተሳታፊ፣</u>በዚህጥናትእንዲሳተፉተጋብዘዋል፡፡ ጥቂትጊዜወስደው ስለጥናቱ መረጃለማግኘትይህንንጽሑፍያንብቡ/ይነበብለዎታል፡፡ ማንኛውንምከጥናቱጋርየተያያዘናግልጽያልሆነልዎትጉዳይካሎትበነጻነትይጠይቁ፡፡ በጥናቱለመሳተፍከመወሰንዎትበፊትበትክክልእንደተረዱያረጋግጡ፡፡

በጥናቱየመሳተፍፍቃደኝነትናከጥናቱተሳትፎራስንየማግለልነጻነት፡-በጥናቱለመሳተፍየእርስዎንሙሉፈቃደኝነትይጠይቃል፤ ላለመሳተፍምመወሰንይችላሉ፡፡ ለመሳተፍፍቃደኛባይሆኑየሚደርስብዎትምንምችግርየለም፡፡ ለመሳተፍወስነውድንገትህሳብቢቀይሩከጥናቱመውጣትይችላሉ፡፡

የጥናቱዓላማ፡

*ከአምስትዓመትዕድሜበታችባሉህጻናትላይለሚከሰትከሚገባውብታችየሆነየዝግብምግብ/የተመጣጠነምግብእጥረትክብካቤናህክምናወላጆች/አሳዳጊዎችንእንዲዘገዩየሚያደርጉቸውመሰናክሎች*ንመለየትየመፍትሄህሳብማስቀመጥነው፡፡ ስለሆነምየተወሰኑጥያቄዎችንልጠይቀዎትእወዳለሁ፡፡

የንጽሸጉዳት፡-በዚህጥናትበመሳተፍየሚደርስቦትየተለዩችግርባይኖርምቃለመጠይቁከ1-1 2 ሰዓትየስራሰዓትሊዎስድይችላል፡፡ የማይመችዎትጥያቄችምሊኖሩይችላሉ፡፡ ድካምሊሰማዎትስለሚችልበመሀልማረፍይችላሉ፡፡ የማይመችዎጥያቄዎችካሉሳይመልሱማለፍይችላሉ፡፡ ከዚህወጪግንበዚህጥናትመሳተፍምንምዓይነትየንጽሸጉዳትየሌለውመሆኑንላረጋግጥለዎትእወዳለሁ፡፡

ጥቅም፡-በዚህጥናትበመሳተፍበቀጥታየሚያገኙትጥቅምየለም፡፡

ነገርግንሰዎችመረጃየሚሰጡትናበጥናታዊምርምርየሚሳተፉትተመራማሪዎችስለሰውልጅጤናጉድለትመንስኤየሚሆኑየጤናችግሮችንበመለየትየተሻለመረዳትናመፍትሄለ ማስቀመጥነው፡፡

በዚህጥናትመሳተፍከአምስትዓመትዕድሜበታችባሉህጻናትላይለሚከሰትከሚገባውበታችየሆነየዝግብምግብ/የተመጣጠነምግብእጥረትከብካቤናህከምናላይወላጆች/አሳዳ
ጊዎችንእንዲዘገዩየሚያደርጓቸውመሰናክሎችንለማወቅየሚያስችልሲሆንችግሩንለመፍታትየተለያዩየመንግስትምይሁንመንግስታዊያልሆኑድርጅቶችየተለያዩየመከላከልስራ
እንዲሰሩየሚያስችልየመፍትሄሀሳብበማቅረብከፍተኛአስተዋጽኦይኖረዋል፡፡
የእረስዎበእውነትናበሐቀኝነትላይየተመሰረተምላሽናተሳትፎለዚህጥናትመሳካትከፍተኛአስተዋጽኦአለው፡፡
ሚስጢራዊነቱ፡-የምሰበስበው ማንኛውም መረጃምስጢራዊነቱየተጠበቀነው፡፡ ዓላማውምለሳይንሳዊጥናትናምርምርተግባርብቻየሚውልነው፡፡
እርስዎየሚሰጡትመረጃከጥናቱተመራማሪዎችውጪለማንኛውምአካልተላልፎየማይሰጥናሊያየውምአይችልም፡፡
መጠይቅዎምስነምግባራዊናሚስጥርንበጠበቀመልኩየሚቀመጥይሆናል፡፡
መረጃስለማግኘት፡- ጥናቱየሚካሄደውበአዲስአበባዩኒቨርሲቲ፣
የህብረተሰብጤናተምህርትቤትየጤናናተግባቦትትምህርትክፍልእንዲሁምበጥናትናምርምርስነምግባርቦርድታርሞናተገመግሞነው፡፡
ጥናቱንበተመለከተምንምዓይነትጥያቄካለዎትቃለመጠይቅለሚያደርጉባለሙያዎችማቅረብይችላሉ፡፡
ተጨማሪካሎትየጥናቱተመራማሪህብተማርያምአባተመሸኘንወይምየጥናቱዋናአማካሪየሆኑትዶ/ር
አዱኛውብርሃኔናየፒ.ኤችዲተማሪናተጨማሪአማካሪየሆኑትንሙሉጌታታምሬንበሚከተለውአድራሻማግኘትይችላሉ፡፡
የጥናቱዋናተመራማሪ፡ ስ.ቁ፡-0939859169 በኢ-ሜይል፡- kalhab2006@gmail.com
ዋናአማካሪውን፡ ስ.ቁ፡- 0911-391-111 በኢ-ሜይል፡- adugnawbm@gmail.comወይምተጨማሪ
አማካሪመምህሩን ስ. ቁ፡-0911-805-081 በኢ.. ሜይል:-awonmuller@yahoo.com

ዕዝልአራት፡- የስምምነትመግለጫፎርምየአማርኛ ቅጽ

የተከበሩ ተሳታፊዎች
የፅንሰ-ከአምስትዓመትበታችበሚገኙህጻናትላይበአማራክልልበደቡብጎንደርዞንላይ,ጋይነትወረዳበሚገኙየመንግስትጤናተቋማትውስጥለወላጅ / አሳዳጊዎችለአሰቃቂ/ከሚገባውበታችለሆነየተመጣጠነምግብእጥረትሕከምናናከብካቤመዘግየትእንቅፋቶች2012 ::
እኔ ፣ በፊርማየየማረጋግጠውየጥናቱአካልለመሆንፈቃድየምሰጥበትንየጥናቱንዓላማዎች እና ሁኔታዎችግልፅበሆነመረዳትበማግኘቴነው።
ስለምርምሩአስፈላጊውንመረጃተሰጥቶኛል :: በማንኛውምጊዜከጥናቱየመተውመብቴእንደተጠበቀመሆኑንተረድቻለሁ ፣ ሀሳቡበተረዳሁትቋንቋተብራርቶልኛል።
ተሳታፊ ቃለ-መጠይቅአድራጊ
ስም_____ ፊርማ_____ ቀን_____ስም_____ ፊርማ_____
ቃለመጠይቅኮድ _____
የመረጃሰብሳቢውፊርማ-_____ ቃለመጠይቅየተደረገበትቀን _____
የ ‹ቃለመጠይቅ› አድራጊውፊርማ _____ለምላሽህአመሰግናለሁ!የአጥኚውስምናፊርማ: -_____ ቀን: - _____

ስለሰጡንምላሽእናመሰግናለን!

የአማርኛትርጉምመጠይቅ እና ቃለመጠይቅ መመሪያ

በላይ,ጋይንትወረዳ፣ ደቡብጎንደርዞን፣
በአማራክልልሰሜንምዕራብኢትዮጵያውስጥከአምስትዓመትበታችበሆኑህጻናትላይለሚገጥማቸውከሚጠበቀውበታችየሆነየተ መጣጠነምግብእጥረትእንክብካቤናህከምናለማግኘትየሚያዘገዩመሰናክሎችላይጥናትለማድረግየተዘጋጀየአማርኛመጠይቆች፤ 2012 ዓ.ም.

ክፍል 1፡ የስነ-ሕዝባዊ እና ኢኮኖሚያዊመጠይቆች

የመጠይቅመለያ ቁጥር: _____ ቃለመጠይቁየተደረገበትቀን _____ መጠይቁየተጀመረበትሰዓት ____ ቃለመጠይቁንያደረገውስም: _____ መጠይቅየተደረገበትቀበሌ: _____ መጠይቅየተደረገበትጤናተቋም/ቀበሌ:_____ ጎጥ/መንደር: _____			
ተ.ቁ	የጥያቄዝርዝርመግለጫዎች	መልስ	ይለፍ
1.	የህጻኑጾታ	1. ወንድ 2. ሴት	
2.	የሕፃኑ / ትንሹልጅየተወለደበትቀን (ሙሉወር / ቶች)	_____	
3.	የሕፃኑ / ታናሽልጅዕድሜ (ሙሉወር / ቶች)	_____	
4.	የተወለዱበትሁኔታ/ቦታ	1. ቤትውስጥ 2. በጤና ተቋም 3. በጉዞ ላይ	
5.	የአወላለድሁኔታ	1. በተፈጥሮሁኔታ 2. በቀዶህክምና	

6.	የወላጅ/አሳዳጊጾታ	1. ወንድ 2. ሴት	
7.	የወላጅ/አሳዳጊዕድሜ (ሙሉዓመታት)	_____	
8.	የወላጅ/አሳዳጊየጋብቻሁኔታ	1. ያላገባ/ች 2. ያገባ/ች 3. የተፋታ/ች 4. ተለያይተውየሚኖሩ 5. የሞተችበት/ባት	
9.	ሃይማኖት	1. ኦርቶዶክስተዋህዶ 2. ሙስሊም 3. ፕሮቴስታንት 4. ካቶሊክ 5. ሌላካለይጠቀስ ----------	
10.	ብሔር	1. ትግሬ 2. አማራ 3. ኦሮሞ 4. ጉራጌ 5. ሶማሊ. 6. ሌላካለይጠቀስ _____	
11.	የቤተሰብመጠን	1. ከአራትበታች 2. 4 3.4-7 4. 7 ወይም ከዛ በላይ	
12.	የሕፃኑ/ኗ / ተንከባካቢከሕፃን / ህፃንልጅጋርያለግንኙነት	1. አያት 2. የእንጀራእናት 3. ሌላ (ይግለጹ....)	
13.	ያጠናቀቁትከፍተኛየትምህርትደረጃስንትነው?	1. መደበኛትምህርትየለም 2. የመጀመሪያደረጃ ት / ቤትተጠናቀቀ 3. የሁለተኛደረጃ ት / ቤቱተጠናቀቀ 4. ኮሌጅ / የዩኒቨርሲቲዲፕሎማ / እና ከዛበላይ	
14.	የወላጅ/አሳዳጊየስራሁኔታ	1. የመንግስትሰራተኛ 2. ነጋዴ 3. የቀንሰራተኛ 4. የቤትእመቤት 5. ስራፈላጊ 6. ገበሬ	
15.	የቤትመሪ	1. አባት 2. እናት 3. ልጆች 4. ዘመድ	

የቃለመጠይቅ መመሪያ

ክፍል2-ከሚገባው

በታችየሆነየተመጣጠነምግብእጥረት/ዝግበምግብሕክምናናክብካቤአገልግሎትለማግኘትየሚዘገይበትምክንያ

ትየሆኑመሰናክሎችንለመለየትየተዘጋጀመጠይቅ

ክፍል2-ሀ. ለወላጆች/ አሳዳጊዎችየ ጥልቅ ዝርዝር ቃለመጠይቅመመሪያ

- ❒ ከ5-ዓመት በታችለሆኑህጻናትከሚገባውበታችስለሆነየተመጣጠነምግብዕጥረትሰምተውያውቃሉ?
- ❒ ከ5-ዓመት በታችበሆኑህጻናትከሚገባውበታችስለሆነየተመጣጠነምግብእጥረትያውቃሉ?(ከሚገባውበታችስለሆነየተመጣጠነምግብዕጥረት 5-ዓመት በታችበሆኑህጻናትላይያለዎትንእውቀትእባክዎንያብራሩልኝ
- ❒ ከ5-ዓመት

  በታችለሆኑትልጅዎትከተገቢውበታችስለሆነየተመጣጠነምግብእጥረትመረጃየሚያገኙበትመንገድምንድንነው?እባክዎትንመረጃየሚያገኙበትንዘዴዎችይግለጹልኝ.

  ሀ. ከሚገባውበታችየሆነየተመጣጠነምግብእጥረትእንክብካቤ/ህክምናፍላጎትእንዳይኖር/ለማግኘትየሚዘገዩበትምክንያቶችምንድንነው?

  ለ. ከሚገባውበታችየሆነየተመጣጠነምግብእጦትእንክብካቤ/ህክምናለመድረስ/ለማግኘትእንቅፋትየሚሆኑምክንያቶችምንድንናቸው?

  ሐ. ከሚገባውበታችየሆነየተመጣጠነምግብእጥረትእንክብካቤ/ህክምናለመቀበልየመዘግየትምክንያቶችምንድንናቸው?

  1. ከሚገባውበታችስለሆነየተመጣጠነምግብእጥረትአያያዝአገልግሎቶችምንያውቃሉ?ምንማለትነው? ስለዚህ

2. ከአምስትዓመትበታችለሆኑህጻናትየጤናእንክብካቤሲፈልጉየትይመርጣሉ? (ባህጉዳይጠይቀው / ሰምተውያውቃሉ (ከሬድዮ፣ ቴሌቪዥን፣ ማህበራዊ መገናኛ፣.....?እባክዎንየሚያውቁትንያብራሩልኝ/ይንገሩኝ?
3. ዕድሜያቸውከአምስትዓመትበታችለሆኑህጻናትከባድ/ከሚገባውበታችየሆነየተመጣጠነምግብእጥረትሕክምናበመደበኛሁኔታ/መንገድመቼነ ውየሚሄዱት? ለምን?
4. ላዊፈዋሽ ፣ የሃይማኖታዊእምነት ፣ የውሃ፣ የአልፐላስታልየጤናተቋም / ተቋም) እና በመጀመሪያመስመርየትኛውንየእንክብካቤማዕከልይመርጣሉ? ለምን? ችግሩካልተፈታከዚህምርጫበኋላምንሊሎችመፍትሄዎችይኖሩታል?
5. እባክዎንከአምስትአመትበታችለሆኑህጻናት / የተመጣጠነየተመጣጠነምግብእጥረቱእንክብካቤበጤናተቋምውስጥምንአገልግሎትእንዳገኙይንገሩኝ? (የልጆችእድገትክትትልምክር (ስነ-አተሮሜትሪመለካት-ቁመት / ርዝመት ፣ ክብደት ፣ ቢኤኤም ፣ MUAC ፣ የጭንቅላትዙሪያ ፣ በእድገትገበታላይየእድገትሁኔታ) ፣ ደህና እና የታመመልጅጉብኝት ፣ ክትባት ፣ ከወሊድበኋላየሚደረግእንክብካቤ ፣ ጥቃቅን (ቫይታ-ኤ ፣ አይዮዲን ፣ ብረት)) ማሟያ ፣ እንደየዕድሜምድብመመገብ); ሌላስ?
6. ከአምስትአመትበታችለሆኑህጻናትከሚገባውበታችለሆነየተመጣጠነምግብእጥረትእንክብካቤንበተመለከተየጤናመገልገያቅድመአጠቃቀምን / ጉብኝትንከመፈለግዎምንእንቅፋትሊያግድዎት/እንዲዘገዩሊያደርግዎትይችላል?
   6.1. ስለአገልግሎቶቹያለዎትአውቀት
   6.2. ተያያዥናተደራቢኃላፊነቶች (የሥራጫና ፣ ለሌላየቤተሰብአባልእንክብካቤ ፣ ለማህበራዊአውታረመረብጊዜ ፣....)
   6.3. ባህላዊእምነቶች ፣ ባህላዊልምዶች ፣ ስለእንክብካቤውናህምናውያለየተገናዘቡጥቅሞች እና ጉዳቶች፣ እና እነዚህምክንያቶችለልጅዎእንክብካቤፍለጋዎጤናላይተጽዕኖየሚያደርጉትእንዴትነውብለውያስባሉ? ሌሎችምክንያቶችስ?
7. ዕድሜያቸውከአምስትዓመትበታችለሆኑህጻናትከሚገባውበታችየሆነየተመጣጠነምግብእጥረት/መቀንጨርናዝቅተኛክብደትየጤናችግርሲገጥ መዎት/እንክብካቤሲፈልጉምንችግሮችነበሩት?
7.1. የጤናተቋምርቀት / ተደራሽነት እና ተገኝነት ፣ ጂዮግራፊያዊሁኔታ-ተራራማመሬት ፣ ወንዞች ፣ ደሃመንገዶች እና መሰረተልማትዎች... ምንሌላነገርይኖራል
8. የትራንስፖርትስርዓቶችእጥረት (አምቡላንሶች ፣ የህዝብትራንስፖርት ፣ የትራንስፖርትዋጋ...)
9. በጤናተቋማትውስጥእንክብካቤ/ህክምናሲሰጥዎምንተፈታታኝ/ፈታኝሁኔታዎችኢጋጥመውዎታል?
   9.1. የቅርብግንኙነትአለመኖር: ርህራሄ ፣ አክብሮት እና ጥራት እና ፍትሃዊየእንክብካቤ/ህክምናአቅራቢየጤናባለሙያ
   9.2. ከሚገባውበታችለሆነየህጻናትየተመጣጠነምግብእጥረት/ዝብተምግብአገልግሎት፣እንክብካቤ እና ህክምናየጤናአገልግሎትአቅርቦቶችደካማተቋማትመኖር
10. በቂያልሆነአላላክናየማጣቀሻስርዓት (ቀጥሎምንመደረግእንዳለበት፣ የትእንደሚደረግ፣ ግልፅምክክር ፣ በአለላክወቅትበማጣቀሻ እና በመቀበልወቅትየትሕትናስሜትማጣት)
10.1. በደካማእንክብካቤናህክምናአቅርቦትምክንያትረጅምየመልሶማገገም / የመልሶማቋቋምጊዜ
11. በእርስዎአስተያየትከአምስትዓመትበታችለሚሆኑየህፃናትእንክብካቤመዘግየትንለማሻሻልምንመደረግአለበትብለውያስባሉ፤ ባህላዊእምነት ፣ ባህላዊልምዶች ፣ የተገናዘቡጥቅሞች እና ጉዳቶች ፣ የዝብተምግብችግርስለሆነየሕክምና / እንክብካቤአገልግሎት ፣ የህጻናትዕድገት፣ ክትትልናማስተዋወቅ/ምክክርአጠቃቀም (ከወላጆች / ተንከባካቢዎች እናየጤናባለሙያዎች)?
12. በመጨረሻም ፣ ከአምስትአመትበታችየሆነህጻንበዝብተምግብየተዳከመወይምበጣምቀጭን እና የቀነጨረነገርግንለህክምና/እንክብከቤወደጤናተቋምያልሄደወይምበቤታቸውየሚገኙወይምበሌላየፈውስጣቢያ (ባህላዊፈዋሽ ፣ ጠበል ፣ የቤትውስጥመድኃኒት) ወይምሌላ? የሄደህጻንያላቸውወላጆች/አሳዳገዎችያውቃሉ? እንዴትሊያገናኙኝይችላ? ከእነሱጋርእኔንማነጋገርይችላሉ?

ክፍል-ለ. ለጤና ሠራተኞች ቁልፍ መጀመሪያ ጥያቄ መጠይቅ መሞያ

1. ከአምስትአመትበታችለሆኑህጻናትየዝቡተምግብሕክምናእና ክብካቤአገልግሎትስንትዓመትሰርተዋል?
2. በዝቡተምግብህክምናናእንክብካቤአገልግሎትአሰጣጥላይ(CRC, AMM, IYCF...) ምንምንስልጠናዎች (ከስራውጭ ፣ በስራላይ) አለዎት/ወስደዋል?
3. ከ0-59 ወራትለሆኑሕፃናትየዝቡተምግብአያያዝናክብካቤ(acute malnutrition managemnt) የሕክምናመመርያዎችምንዓይነትግንዛቤአለዎት?
4. ከአምስትአመትበታችለሆኑህጻናትምንዕይነትየዝቡተምግብክብካቤናህክምናአገልግሎትይሰጣሉ (ቁመት / ርዝመት ፣ ክብደት ፣ የጭንቅላትዙሪያ እና MUAC መለካት ፤ የእድገትሂደትማሳያሰንጠረዥላይየመለኪያእሴቶችማሸግ ፣ ለወላጅ/ተንከባካቢየእድገትንድፍላይየተመሠረተየምክርአገልግሎት። (GALIDRAA አቀራረብ) ፣ እንደሰላምታ ፣ መጠየቅ ፣ ማዳመጥ ፣ ችገሩንመለያየት ፣ መወያየት ፣ መምከር ፣ መቀበል እና መቅጠርመርሆዎችመሠረትማድረግ
5. ዕድሜያቸውከአምስትዓመትበታችየሆነውልጃቸውበከባድበሽታየተጠቃሲሆንወላጆችን / ተንከባካቢዎቻቸውንእንዴትተቀብለውክብካቤናህክምናበመስጠትአነጋገረዋቸዋል? (ትህትና ፣ አክብሮት ፣ ፍጥነት ፣ ተገቢ እና በቂምርመራ ፣ የጉዳይአያያዝ ፣ ግልጽሪፈራል/አላላክ ፣ የህክምናምግብአቅርቦት እና / ወይምየህክምናአቅርቦቶች); ሌላስ?
6. ከሚገባውበታችየሆነየተመጣጠነምግብእጥረትአያያዝ መመሪያ መሠረትየዝቡተምግብችግርክብካቤንጥራትበማቅረብእንዴትያምናሉ? የAMህክምና ፣ ንፅህና እና ጽዳትናየጤናትምህርትአስተዳደርውስጥወላጆችን / ተንከባካቢዎችንበማሳተፍላይ...
7. **ከስራዎ**ለመልቀቅ/መቆየትያለዎትህሳብ/ዓላማምንድነው? ለምን? ሌላምን እና ምንይመክራሉ?

8. በእረስዎአመለካከት፣ ከአምስትዓመትበታችለሆኑህጻናትየእንክብካቤጥራትአቅርቦትመዘግየትምን**እንቅፋቶችአሉት**? *(መጎጅ / ተንከባካቢከአምስትዓመትበታችላሉህፃ ንልጅላይለሚሰቱችግሮችእናለአደጋተጋላጭመሆኑንያዶች፣ደካማንዛቤእናየጠፍአርዳታመቹመሪለግ፣ የጠፍሰራተኞችደካማዝግጁነር፣ በእርግዝናወቅጥያለችግሮችእናየአደገ ኛዎኑንያዶች፣ደካማንዛቤእናየሕክምናዕርዳታመቹበትሪዜ፣ CRC የጠፍሰራተኞችእጥረት፣ ደካማየህክምናአቅርቦቶች፣ ለለማ ……)*

ክፍል-ሐ የ KII መመሪያለማህበረሰብ/ የሃይማኖትመሪዎችእናቁልፍመረጃዎች

1. ከሚገባውበታችየሆነየተመጣጠነምግብእጥረትንለመፈለግየመዘግየትምክንያቶች
1.1. ዕድሜያቸውከአምስትአመትበታችለሆኑህጻናትወላጆች/ተንከባካቢዎችየጤናአገልግሎትንመፈለግበተመለከተየሚያውቁትን እና የሚያደናቅፏቸውንሁኔታዎችይግለጹልኝ?ምንምንእንቅፋቶችአሉባቸው;
1.2. ከ 5 አመትበታችለሆኑሕፃናትጤናአጠባበቅ (የህክምና) ፣ የመጀመሪያ / ምርጫ / ባህላዊ ፣ ዘመናዊ / / የህብረተሰቡእምነትምንድነው? ለምንያንይመርጣሉ?
1.3. በእርስዎአስተያየትእባክዎን ከ5 አመትበታችለሆኑህጻናትየተመጣጠነምግብእጥረትእንክብካቤ ፣ ..... የህብረተሰቡዕይታ ፣ እምነት እና ግንዛቤበዝርዝርያብራሩልኝ፡፡
2. ከሚገባውበታችየሆነየተመጣጠነምግብእጦትህክምናናክብካቤአገልግሎትየሚሰጥበትቦታ/ተቋምለመድረስየሚዘገዩበትምክንያቶችምንምንሊ ሆኑይችላሉ?በዝርዝርያብራሩልኝ
3. በቂየሆነየተመጣጠነምግብእጥረትህክምናናክብካቤአገልግሎትበጤናተቋምደርሰውለመቀበል/ለማግኘትየሚዘገዩበትምክንያቶችምንምንሊሆ ኑይችላሉ? በዝርዝርያብራሩልኝ

ክፍል3. ወላጆችን /

ተንከባካቢዎቻቸውንበአደገኛየተመጣጠነምግብእጥረትምክንያትየሚዘገዩመሰናከሎችንበተመለከተየጤናባለሙያዎችአስተያየትዝርዝርንይመልከቱ፡፡

1. ስለወላጆች / አሳዳጊዎችከሚገባውበታችየሆነየተመጣጠነምግብእጥረትግንዛቤእናአገልግለሎትፍላጎትባህሪዎችያሉአስተያየቶች።
   1.1. የጤናፍላጎትባህሪ:_____
   _____
   1.2. ዕድሜያቸውከ-5 ዓመትበታችለሆነየተመጣጠነምግብእጥረትያለውእምነት:
   _____
   _____
   1.3. ከተያያዥኃላፊነቶች፣አጋጣሚዎች/እድሎችናወጪዎችጋርተያይዞ:
   _____
   _____
   1.4. ሌሎችየሚገመቱናየሚመለከቱ/ታዩእንቅፋቶች:
   _____
   _____
2. ስለጤናአገልግሎትአቅርቦትዝግጁነትእናየሕክምናአቅርቦቶችአስተያየት.
   2.1. ዕድሜያቸውከ 5
   ዓመትበታችለሆኑህጻናትከባድየተመጣጠነምግብእጥረትሕክምናአገልግሎትመኖር_____
   _____
   _____
   2.2. ለህክምናናከብካቤምቹየሆነከፍልመኖሩ_____
   _____ _
   2.3. የህክምናአቅርቦቶችእናለታካሚህጻናትየኃይልሰጭየምግብአቅርቦትመኖር_____
   _____

2.4. ለህክምናመዘግየትእንደእንቅፋትሆኖታየ-ምቹየስራአካባቢ፣የአሠሪየማበረታቻሽልማት፣የአመራርችሎታ፣
....._____
_____

3. ስለጤናባለሙያዎችተሞክሮ፣ለማገልገልፈቃደኛነት፣ከህመምተኞችጋርግንኙነት፣ CRC አገልግሎት፣...
   3.1. በ CRC
   አቀራረብለማገልገልኃላፊነትእናተጠያቂነት_____
   _____
   3.2. ዕድሜያቸውከ 5
   ዓመትበታችለሆኑህፃናትተገቢያልሆነየምግብእጥረትያለውየከብካቤ/ህክምናየስራልምድናክህሎት_____
   _____
   _____
   3.3. ከሚገባውበታችስለሆነየተመጣጠነምግብእጥረትመመሪያያለውየግንዛቤሁኔታ_____
   _____
   3.4. የእድገትክትትልእናእድገትንማወቅናማሳወቅ (መለካት፣መመዝገብ፣መተርጎም፣በእድገቱገበታላይእቅድማውጣት፣የምክርቴክኒክ
   (GALIDRAA አቀራረብ) በሕፃናትአመጋገብእንዲሁምአስፈላጊየአመጋገብእርምጃዎችእናየግንኙነትነጥቦችንመገንዘብ፡፡
   _____
   _____

<u>ክፍል 4 ማስታወሻ</u>

1. ምንተነገረ?
   1.1. _____
   1.1.1. እንዴትተናገሩ? የፊትሁኔታመግለጫ፣የንግግርድምጽ፣የንግግርመንገድ / በአገልግሎቱ /
   ባለሙያዎችላይየመተማመንስሜት_____
   _____
   1.2. _____
   1.2.1. 3.1.1.1. እንዴትተናገሩ? የፊትሁኔታመግለጫ፣የንግግርድምጽ፣የንግግርመንገድ / በአገልግሎቱ /
   ባለሙያዎችላይየመተማመንስሜት/...
   _____ _____
   1.3. _____
   1.3.1. እንዴትተናገሩ? የፊትሁኔታመግለጫ፣የንግግርድምጽ፣የንግግርመንገድ / በአገልግሎቱ / ባለሙያዎችላይየመተማመንስሜት/...
   _____ _____
   1.4. _____
   1.4.1. እንዴትተናገሩ? የፊትሁኔታመግለጫ፣የንግግርድምጽ፣የንግግርመንገድ / በአገልግሎቱ / ባለሙያዎችላይየመተማመንስሜት/...
   _____
   _____
2. ከሚገባውበታችየሆነየተመጣጠነምግብእጦትበሚሰጥበትጊዜምንታየ?
   2.1. _____; ህክምናውእንዴትእንደተሰጠ / የትህትናእናየኃላፊነትስሜትእናየባለሙያስነምግባር /
   ግንኙነትበእንክብካቤሰጪውእናበደንበኞችመካከልያለግንኙነት
   ....._____
   _____

2.2. _____; ህክምናውእንዴትእንደተሰጠ / የትህትናእናየኃላፊነትስሜትእናየባለሙያስነምግባር / ግንኙነትበእንክብካቤሰጪውእናበደንበኞችመካከልያለግንኙነት.....
_____

2.3. _____; ህክምናውእንዴትእንደተሰጠ / የትህትናእናየኃላፊነትስሜትእናየባለሙያስነምግባር / ግንኙነትበእንክብካቤሰጪውእናበደንበኞችመካከልያለግንኙነት.....
_____
_____

ክፍል 5 የምልከታቅጽ

ከአምስትአመትበታችለሆኑህጻናትከሚገባውበታችየሆነየተመጣጠነምግብእጥረትክብካቤናህክምናየሚሰጡየህክምናባለሙያዎችንየክብካቤናህክምናችሎ

ታለመገምገምየተዘጋጀቅጽ

ለእንክብካቤደረጃምርመራ			**ካርዱንመሙላት**			**ምክርናምክክር**
	አዎ	አይ		አዎ	አይ	
የክብደትመለኪያሚዛንንበትክክልናየተደላደለቦታላይማስቀመጥ			ቀን (ወር) በግልጽአመላካች			ሰላምታ
ልጅንከማስገባት/ከመለካትበፊትበዜሮላይ(ሚዛንልኬትክክለኛነት)			ስምተመዝግቧል			መጠየቅእናማዳመጥ
የህፃኑ/ኗአልባሳትበጥንቃቄይወልቀልእናየወላጆችስሜት			የተወለደበትቀንመመዝገቡ			ችግሩንለይተውተወያየ
ልኬቱላይሲቀመጥበሰውነትዕቅፍተይዟል			የልደትክብደትተመዝግቧል			እናትሀሳቧንእንድትገል
መወዛወዙንለማቆምእስኪቆምመጠበቅ			የትውልድቦታተመዝግቧል			በልጁዕድሜላይበመመ

ልኬታበአይንደረጃያነባል			ክብደትንበትክክልግራፍላይማስቀመጥ			ስምምነትላይመድረስእ ተንከባካቢንአመስግናለ
ክብደቱንየሚያነበውሰውውሂቡን/መረጃውንየሚመዘግብይመዘግባል			በእድገትገበታላይየክብደትልኬትንማገናኘትናትክክለኛነት			ለወላጅ/አሳዳጊእውቅና

ማንኛውምከሚባወቅታችየሆነየተመጣጠነምግብእጥረትየሚደረግሕክምናናክብካቤ፡ -

ምልከታ1:

ምልከታ2:

ምልከታ3:

ምልከታ4: