IMPLEMENTATION OF NATIONAL HEALTH POLICY IN MANAGING MALNUTRITION AMONG UNDER FIVE CHILDREN BY USING INTEGRATED MANAGEMENT OF ACUTE MALNUTRITION AT KISHAPU DISTRICT

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A Dissertation submitted for partial fulfillment of the requirements for the degree of Masters of Science in Health Economics and Policy of Muhimbili University of Health and Allied Sciences

October, 2024

CERTIFICATION

The undersigned certify that have read and hereby recommend for acceptance by the Muhimbili University of Health and Allied Sciences a dissertation entitled ***"Implementation of National Health Policy in Managing Malnutrition among under five children by using Integrated Management of Acute Malnutrition at Kishapu District"*** in partial fulfilment of the requirement for the degree of Masters of Science in Health Economics and Policy of Muhimbili University and Allied Sciences.

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DECLARATION AND COPYRIGHT

I, Charles Mnada Mayala, declare that this dissertation is my original work and that it has not been presented and will not be presented to any other university for similar or any other degree award.

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DEDICATION

With heartfelt gratitude, I dedicate this work to my loving wife Litty H. Jomo, and Yombo's family for their unwavering moral support.

ACKNOWLEDGEMENT

I would like to express my gratitude to God Almighty for His unwavering love and blessings throughout my academic journey. The completion of this dissertation fulfils the requirements for my Master's Degree in Health Economics and Policy at Muhimbili University of Health and Allied Sciences.

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Additionally, I would like to thank the DMO on behalf of DED for his support and readiness to allow me to conduct this study at District Hospital

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ABSTRACT

Background: Acute malnutrition among children under five is still a serious public health concern worldwide. Estimates suggest that if there were zero acute malnutrition, the global burden of disease (GBD) could be lowered by 32%. Tanzania is still one of ten developing countries in Sub-Saharan Africa with a persistently high prevalence of acute malnutrition among under five children, despite the promotion of integrated management of acute malnutrition.

Objective: To assess the implementation of the National Health Policy in managing malnutrition among children under five by using Integrated Management of Acute Malnutrition at Kishapu District Hospital.

Methodology: Qualitative exploratory case study conducted at Kishapu District Hospital. A purposive sampling strategy was used to select the study participant which included five clinicians, three nurses, one nutrition officer and one social worker in Key informant Interview also here was one FGD of seven participant together with document review, all used in information gathering process. Data were analyzed using qualitative content analysis approach

Results: The study found that , at Kishapu District Hospital, the implementation of National Health Policy by using IMAM guideline in managing malnutrition to under fives is being conducted daily. Three categories emerged from study analysis as follows; One, Procedure in identification of acute malnutrition. Two, Productiveness of IMAM in managing acute malnutrition, thirdly, the barriers for IMAM implementation

Conclusion: This study offers a proof of the implementation of National Health policy to the primary healthcare institution in a rural Tanzanian environment when it comes to controlling malnutrition utilizing the IMAM guidelines. It supports research on the importance of efficient early detection techniques and IMAM guideline application. As per the IMAM national guideline, the Kishapu district hospital's implementation of the guideline generally has low upholding the fundamental criteria of maximum coverage and access, as well as timeliness.

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ABBREVIATION AND ACRONYMS

DC	District Council
DED	District Executive Director
DMO	District Medical Officer
FGD	Focus Group Discussions
GBD	Global Burden of Disease
HMT	Hospital Management Team
IMAM	Integrated Management of Acute Malnutrition
IMCI	Integrated Management of Childhood Illness
ITC	Inpatient Therapeutic Care
KII	Key Informant Interview
MAM	Moderate Acute Malnutrition
MOH	Ministry Of Health
MOHCDGEC	Ministry of Health Community Development Gender, Elderly and Children
MUAC	Mid Upper Arm Circumference
OTC	Out-patient Therapeutic Care
RUTF	Ready to Use Therapeutic Food
RHMT	Regional Health Management Team
SAM	Severe Acute Malnutrition
TB	Tuberculosis
TDHS-MIS	Tanzania Demographic Health Survey and Malaria Indicator Survey
UNICEF	United Nations International Children's Emergency Fund
USAID	United State Agency for International Development
WHO	World Health Organization

DEFINITIONS OF TERMS

National Health policy: is a collection of decisions, plans, and actions intended to give guidance for enhancing and maintaining everyone's health by lowering mortality, morbidity, and disability while also increasing life expectancy and nutritional status(1).

Malnutrition: is a medical and pathological condition in children aged 0-59 months that is explained by the presence of stunting, undernutrition, obesity, or overweight.(2).

Acute malnutrition: This syndrome is simply defined as quick weight loss resulting from reduced food consumption and/or illness, together with rapid onset of bilateral pitting edema of the lower limbs.(3).

Moderate acute malnutrition (MAM):It is a medical disease characterized by typical mild wasting. The diagnosis is MUAC 11.0-12.5 cm or W/H 70-80%.(4).

Severe acute malnutrition (SAM): is a kind of malnutrition characterized by extreme wasting or bilateral pitting edema. A diagnosis of W/H < 70% or MUAC < 110 mm has been made.(4).

Global acute malnutrition: In a nutshell, it's the global sum of severe acute malnutrition and intermediate forms of malnutrition.(3)

Management of acute malnutrition: This is the procedure that starts with diagnosing malnutrition and ends with the administration of both medicinal and complementary therapies. Giving supplemental nutrients and receiving medical attention either as an outpatient or as an inpatient in a hospital are recommended standard practices for treating acute malnutrition.(5).

Integrated management of acute malnutrition: This is a strategy to reduce acute malnutrition that combines inpatient treatment for children under five who have severe acute malnutrition with complications, outpatient treatment for severe acute malnutrition without complications, and management of acute moderate malnutrition through supplemental feeding programmes.(4)

Early detection of acute malnutrition: A standard based process for active case finding or early diagnosis of malnutrition(6)

Effective use of IMAM guideline: It describes putting all three of IMAM's essential elements into practice early detection, community mobilization, and standard practices recommended by IMAM guidelines.(5)

Recovery from SAM: Two factors are used to characterize SAM recovery: the number of days it takes for a kid to recover from SAM after receiving effective therapy, and the percentage of children with SAM who are cured through hospital care. (7)

1.0 INTRODUCTION

1.1 Background

Acute malnutrition in children under five is still a major global public health concern, and it has a substantial impact on the high rate of increase in Non Communicable Diseases (NCDs) in many nations and area (8). Malnutrition within the first 1000 days of life is said to have a detrimental effect on a person's health, future academic success, and socioeconomic standing(9). In addition, poverty and unsanitary surroundings contribute to the severity of malnutrition during the first 1000 days of life by encouraging the spread of illnesses. This is due to the possibility that a person consumes poor-quality food or experiences malabsorption issues as a result of an (10). According to estimates, the global GBD could be lowered by 32% if there was no acute malnutrition(8).

In developing nations, acute malnutrition has disproportionately afflicted people, especially in Sub-Saharan Africa, where over 90% of cases of acute malnutrition worldwide occur (10). An estimated 50.6 million children under five are undernourished in developing nations, and the case fatality rate for those who are hospitalised due to severe malnourishment ranges from 30 to 50 percent. (11). East Africa ranks in the top five regions in Sub-Saharan Africa for both the prevalence and case fatality rate of acute malnutrition.

Tanzania is ranked among the top ten nations in the world with the highest rate of malnutrition and the worst experiences (12)(4). 34% of Tanzanian children under five suffer from stunting. (1)(4), roughly 5% of children under the age of five are wasted, while 14% are underweight(13). A little over 53% of children under the age of five die from malnutrition. Children who survive malnutrition often experience a variety of negative consequences, such as stunting, which is a sign of growth failure . (11).

Along with its high occurrence are factors that affect the severity of the malnutrition, how quickly it recovers, and its long-term effects(13). These elements include the existence of subpar health services, inadequate food security, and bad governance. Inadequate medical care for illnesses including measles, respiratory disorders, malaria, diarrhea, and HIV/AIDS is also included in the poor quality of health

services, which begins with prenatal care, delivery, and newborn care. Poor governance, particularly in countries where there are political disputes, the occurrence of natural disasters like hunger and droughts, as well as inadequate or nonexistent food security at home, are further contributing causes. (14).

Acute malnutrition is given international attention and included in the Sustainable Development Goals in an effort to lessen its burden. In particular, it falls under SDG #2, which is all about eradicating waste (2). Depending on the kind of malnutrition and the resources available, several strategies have been used in different regions and nations to address the issue of malnutrition. There is no one preventive strategy that works for everyone, and while there is no dispute about how to treat malnutrition, the various treatments are not always applied in an efficient manner. (11).

Various nations have begun to develop and/or adopt policies from other nations that support the management of malnutrition and its eradication, as well as the conservation of food. It is imperative for policymakers to promptly execute evidence-based and cost-effective measures aimed at ending hunger, addressing malnutrition in all its forms, and addressing obesity. (15)

By developing a more straightforward medical protocol to support people at all health levels and in the community, the treatment of acute malnutrition can be made easier through integration and collaboration with other health services. (16). The goal of Integrated Management of Acute Malnutrition is to prevent malnutrition by increasing community awareness, identifying cases, and providing good follow-up in management. It also aims to provide management guidelines and a link in managing various medical conditions such as HIV and TB, which exacerbate malnutrition in children under five. (4).

Along with the aforementioned, the government also implements several initiatives to promote food security nationwide and ensure that everyone, including children under five, has a healthy nutritional status. According to the USAID-conducted Tanzania Nutrition Profile from 2021, Tanzania is generally regarded as having a secure food supply, primarily due to its staple food crops. The agriculture sector has the potential to increase productivity and serve as the catalyst for the country's overall economic

growth(17). Tanzania established the Nutritional Services Section through the Office of the Chief Medical Officer in the Ministry of Health. This section oversees the coordination of nutritional services within the health sector and guarantees the efficient decentralization of all nutrition-related actions and resources at the local government authorities. Key line ministries have designated nutrition focal points to make sure that nutrition is addressed throughout all sectors. This comprises the Ministry of Agriculture, Livestock, and Fisheries; the Ministry of Water and Irrigation; the Ministry of Education, Science, Technology, and Vocational Training; and MOHCDGEC.(17). Tanzania is prioritizing decentralization in order to guarantee that individuals working in the closest proximity to the impacted communities prioritize nutrition. (17)

Despite all of the government's efforts, as stated by the national health policy, poverty alleviation and other health development gains that are necessary for all Tanzanians are dependent on good health as a critical component of national development. Since gaining independence, the government has placed a strong emphasis on providing equitable and high-quality preventative, promotive, curative, and rehabilitative health care at all levels. Despite this, malnutrition remains a problem in Tanzania, where the prevalence is still close to 54% (4). In Tanzania, the majority of acute cases of malnutrition are evident and arise from either inadequate nutrition or untreated chronic infections (18). To address this scenario, multidisciplinary strategies have been put in place to guarantee that malnutrition is reduced. IMAM was presented as one of the key strategies to support the early detection and management of acute malnutrition, among other things (12)(15). Therefore, the purpose of this study was to assess the application of the National Health Policy in Kishapu District for the management of malnutrition in children under five years old through the use of IMAM.

1.2 Statement of problem

The National Health Policy comprise of many things one of them it mandates investments in eradication of Malnutrition. Its goals are to enhance standard treatment of acute malnutrition, reduce disability, morbidity, and death, and provide direction towards the development and sustainability of everyone's health status.

Pilot studies and trials have demonstrated that implementing the IMAM guidelines effectively is a crucial tool in reducing the mortality rate from malnutrition and the prevalence of wasting in children under five. (9). Tanzania changed its 2010 IMAM guideline in 2018 after taking into account recommendations from the WHO, having been impressed by the high potential of IMAM guideline implementations in piloted nations. Studies on the actual application of the IMAM guideline, however, reveal that the prevalence of SAM is still significant (over 20%) in the wake of inconsistent application of the guidance.

Studies conducted in Tanzania have mostly documented the causes and consequences of the high prevalence of malnutrition, but the application of the IMAM guidelines is still a taboo subject. As a result, even though the government and important implementing partners continue to prioritize the fight against malnutrition, crucial policy issues related to its implementation—such as the methods local authorities have used to operationalize IMAM, the efficient application of IMAM guidelines, and the causes of the low rate of recovery from SAM—are inadequately investigated and underreported. Based on this, the study evaluated the implementation of IMAM at Kishapu district Hospital to align with Tanzania's National Health Policy's goal of enhancing the health and well-being of all Tanzanians. (1).

1.3 Conceptual framework

The purpose of this study was to evaluate the application of the IMAM Guidelines as an intervention in the treatment of acute malnutrition in children under five in Kishapu District, in order to mirror the application of national health policy in the treatment of malnutrition in children under five. There were multiple constructs in this investigation. The immediate outcome while implementing IMAM are reduction in mortality and morbidity hazards of malnutrition, and the strategic components of

IMAM. To put it briefly, IMAM is made up of three main parts, as the conceptual framework suggests.

ITC for patients with severe acute malnutrition and those with co morbidities is the first component. The second part of IMAM treats patients with severe acute malnutrition without consequences through OTC.(5) In order to increase awareness and adherence to medicinal and therapeutic food, the third component is health providers' involvement in the community.

According to the conceptual framework, more new instances will be identified, more patients will recover, and fewer hospital days will be required as the intended consequence. The WHO recommends level of waste as a fundamental indicator of IMAM adoption at all levels Tanzanian (1). The established effects of stunting are rarely reversible, resulting in both physical and mental impairment such as cognitive function and sluggish learning capacity in school. Several elements combine to accomplish this outcome in the actual world when IMAM is implemented. (19)(4).

When health professionals treat malnourished children, the IMAM guidelines provide a framework of actions to take in order to achieve the desired result. The goal of the IMAM guideline is to reduce case fatality by improving high recovery from severe acute malnutrition by providing guidelines and interactive methods on various medical interventions and medical disciplines. (19) When the right medication is taken, Ready to Use Therapeutic Food (RUTF) is available, and the Ministry and other Partners provide on-the-job training, IMAM can be administered as intended

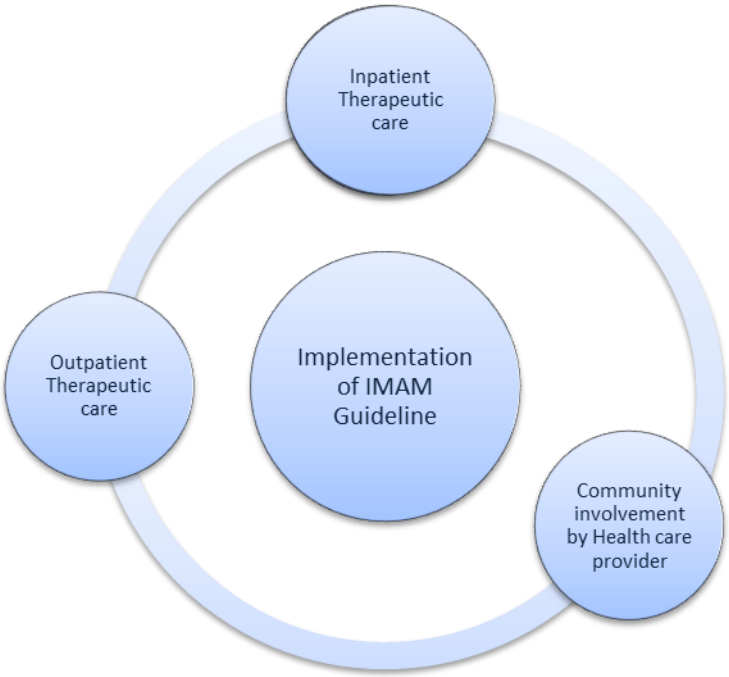


Figure 1.1. Conceptual framework on IMAM approach

1.4 Rationale of the study

The world's projection by 2030 is dedicated to the objective of eliminating hunger, food insecurity, and all types of malnutrition. (2),as a result, most non-communicable diseases, including heart conditions, would be able to be reduced over time. This means that reducing the risks of death and morbidity from acute malnutrition in children under five years old is dependent on the effective application of the IMAM guidelines, which are a reflection of national health policy.

Health management teams RHM, CHMTs and HMTs would be supplied with evidences on strategic implementation of IMAM guideline in Shinyanga specifically Kishapu District Hospital. Researchers are a significant stakeholder who might gain from this study as well and the study's findings will be made public so that other researchers working on related or related topics can use them as a reference.

1.5 Research questions

1.5.1 General research question

How is National Health Policy in managing malnutrition to under five using IMAM guideline implemented by Kishapu District Hospital**?**

1.5.2 Specific research questions

1. What strategies are used in early identification of acute malnutrition at OPD in under five years children by using IMAM?
2. How does IMAM guideline in IPD being effectively implemented in managing acute malnutrition?
3. What are obstacles which, in the Kishapu community, affect SAM recovery through IMAM guidelines?

1.6 Objectives of the study

1.6.1 General objective

To assess the implementation of National Health Policy in managing malnutrition to under 5 by using IMAM guideline at Kishapu District Hospital**.**

1.6.2 Specific objectives

1. To assess strategies used in early identification of acute malnutrition at OPD in under five years children by using IMAM.
2. To assess IMAM guideline in IPD being effective implemented in managing acute malnutrition.
3. To identify obstacles which, at Kishapu community, affect SAM recovery through IMAM guideline.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 The concept of malnutrition

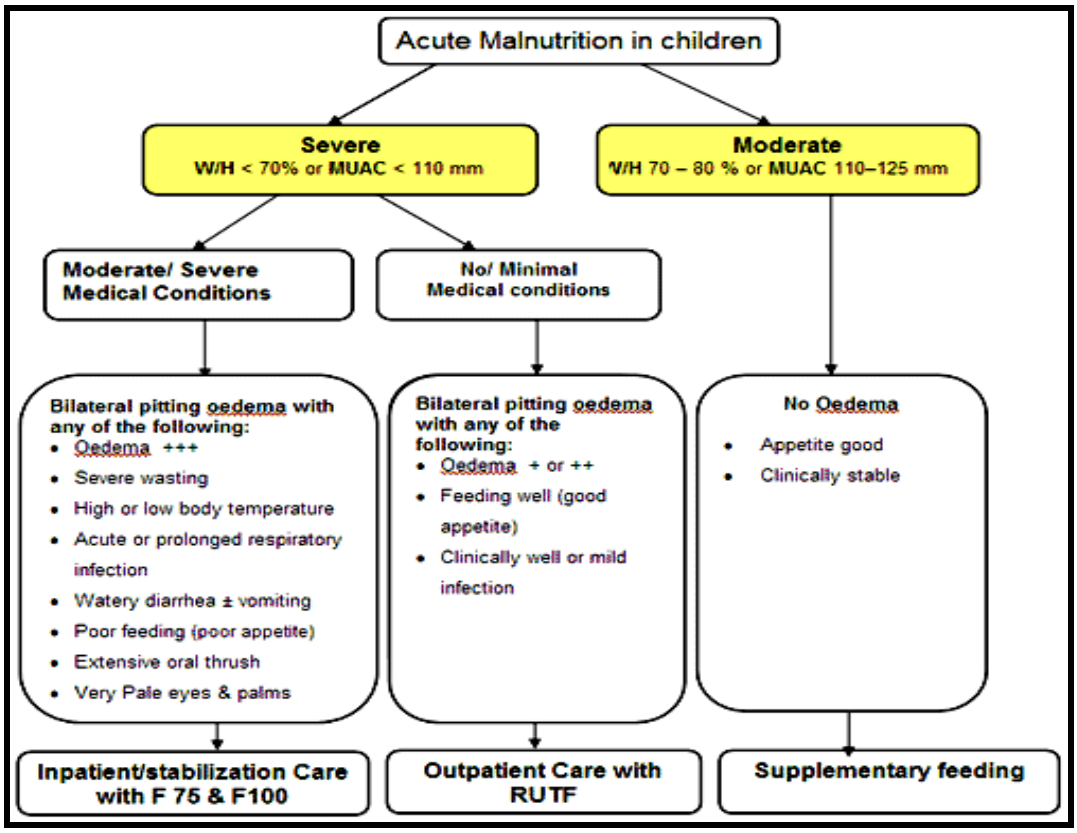
The term malnutrition in low nutrient intake is categorized into three groups of conditions. One, of the most severe kind of acute malnutrition is under nutrition, which is indicated by low weight for height. This requires medical treatment(12). Marasmus and Kwashiorkor fall into this group (10). Stunting ranks second and is characterized by low height for age, while underweight ranks third and is explained by low weight for age(20).The conditions of overweight and obesity are caused by high nutrient consumption, which is referred to as malnutrition, while this type of malnutrition is frequent in industrialized nations, it is less common in developing and middle-income nations like Tanzania.

Numerous negative repercussions of malnutrition are seen in those who experience it, as well as in families, society, and the medical community at large(9). A person suffering from malnutrition always experiences recurring infections, and the majority of those who survive end up temporarily or permanently disabled. Second, they spend the majority of their time as a family seeking medical care. Thirdly, the government and the health sector spend a lot of money addressing malnutrition because hospital stays might last months, more resources are needed, and ultimately, the country produces less for economic development. Due to an imbalance between the body's utilization of nutrients and the amount of nutrients consumed, malnutrition can take on various forms once it first manifests.
(19).

2.2 The concept of Acute Malnutrition

Acute malnutrition is a prevalent medical disease and type of malnutrition that is prevalent in underdeveloped countries and is characterized by severe nutritional deficiencies.(19). Acute malnutrition in children under five years old is a rapidly developing disorder marked by abrupt weight loss brought on by illness or a decrease in food intake, as well as bilateral pitting edoema being its clinical feature(3). There are two categories for acute malnutrition: primary and secondary. The lack of needed

rich food supplements is a major contributing factor to primary acute malnutrition, which is caused by sociocultural, economic, and environmental factors. Conversely, secondary acute malnutrition develops from atypical nutritional losses or a decrease in food intake brought on by underlying illnesses(9).



Source: WHO (2006)

Figure 2.1.The concept of acute malnutrition

Acute malnutrition is also frequently categorised as SAM or MAM based on the degree of wasting severity and edema. The WHO provides an illustration of how to categorise acute malnutrition using these criteria in Figure 2.1. The first step towards implementing the IMAM guidelines effectively is creating a prototype for this kind of classification. It is essential for efficiently identifying SAM through efficient SAM and MAM management (7).SAM, which is distinguished by bilateral pitting edoema or severe wasting. Additionally, patients with SAM are extremely exposed to the risk of dying(5) .Additionally, SAM is divided into two groups: Kwashiorkor and Marasmus(5). Moderate wasting is a hallmark of MAM (4).

2.3 Early detection of acute malnutrition

The ideal approach to early detection of acute malnutrition is to screen for malnutrition as soon as possible using nutritional screening tools. This involves determining and assessing a person's nutritional state in order to rule out malnourishment, low body mass index, or wasting(12). Nutritional assessment refers to the technical and operational context of early detection of acute malnutrition. It mainly involves screening, which looks at four things: weight loss, deteriorating food intake rates, the body mass index (BMI), and signs of serious infections (21). Additionally, it involves fundamental age-related score calculations, nutrition inadequacies, and illness severity assessment.

The risk of malnutrition (low BMI, weight loss) is evaluated using either etiological or phenotypic criteria. Preventing undernourished children from worsening their nutritional status is the philosophy behind early identification. It is crucial to note that promptly detecting acute malnourishment serves as a foundational method for proactive case detection, or alternatively, early malnutrition diagnosis. To achieve a high cure rate and a corresponding decrease in the prevalence of severe wasting in children under five, the latter is a crucial element of an effective IMAM.

2.4 Integrated management of acute malnutrition (IMAM)

In the medical field, the phrase "management" is frequently used to describe the treatment strategy for a particular medical problem. Identification, the degree of the sickness or condition, its etiology, and the type of illness or condition all influence how it is managed. Supplementary meals and medical care, either through outpatient or hospitalized inpatient care, are part of management.
IMAM is a key strategic concept for addressing acute malnutrition in children ages 0-59 months. Its primary objective is to integrate all services for treating acute malnutrition and continuing routine healthcare to every level of the healthcare facility infrastructure. The IMAM guidelines are meant to be used by dietitians and medical practitioners who work at health facilities and community (5). The majority of patients with acute malnutrition who do not have problems can be treated with

outpatient care services in the community and OPD clinics, according to a 2007 WHO-UNICEF recommendation(5).

The Tanzanian IMAM guideline aims to lower the risks of acute malnutrition-related mortality and morbidity in children under five by rehabilitating these children to a state of health where they can continue their recovery upon discharge; to stop the condition of these children from worsening and necessitating more intensive treatment; to help prevent acute malnutrition in young children during the crucial 1000-day window; and to prevent micronutrient deficiency disorders in children under five that are linked to acute malnutrition(4).

2.5 Theoretical perspectives on IMAM implementation approach

IMAM is a worldwide approach to reduce malnutrition, according to the theoretical viewpoint. When properly executed, IMAM represents a long-term approach to addressing malnourishment (9). Early malnutrition detection and service linkage are associated with effective IMAM implementation. A number of principles serve as the theoretical foundation for the efficient application of IMAM at all levels(16). Timeliness is ingrained in the early detection of acute malnutrition; maximum coverage and access focus on the acceptability and accessibility of services to the majority of potential target population; appropriate care and recovery length (days) and rate (percentage of cure rate) are some of these principles. These guidelines acknowledge that in order to make IMAM as successful as anticipated and to have a significant impact on outcomes, local context-focused initiatives and service optimization measures are required (12).

The first temporal principle in the application of IMAM stresses exhausting and utilising all chances in a particular local environment in order to maximise early identification and connection of under-five acute malnutrition individuals. According to this theoretical perspective, identification operations must be successfully integrated and carried out on a regular basis in all healthcare facilities and at the community level(12)From a local standpoint, national IMAM guidelines in developing nations recommend using teachers and community health workers (CHWs) to maximise early identification and linkage as well as community

mobilisation. This is a desirable implementation strategy. The recommendations also call for and legalise their employment.

Reducing the incidence and effects of wasting is the ultimate goal of conventional integration, which is the fundamental IMAM viewpoint (10). The two dimensions that comprise the core perspective of integration are the integration of early identification and the integration of effective treatment for acute malnutrition. Increasing the duties of important stakeholders, cutting costs and improving efficiency, improving financial sustainability, and expanding coverage while upholding equity in the application of IMAM guidelines are the fundamentals of both vertical and horizontal integration (22)(15).

2.6 Empirical evidences

2.6.1 Strategies for early detection of acute malnutrition

In 46 sub-Saharan African countries, a scoping qualitative study used a Mixed Method Appraisal Toot (MMAT) to try and produce evidence on early identification of acute malnutrition in children under five (21). Among other important findings, it was shown that, despite the availability of efficient assessment instruments, inadequate methods existed for the early diagnosis of acute malnutrition. Body mass index and no weight for heights, or MUAC, were often employed metrics to evaluate malnutrition. A qualitative case study conducted in Mali looks at methods for spotting acute malnutrition early on (6).The results of the study demonstrated that a combination of community health workers, volunteers, and mass nutrition screenings was a successful tactical method for the early identification of acute malnutrition. According to Saunders et al. (2018), a further qualitative investigation encompassing four countries in sub-Saharan Africa shown that incorporating early detection activities was a crucial approach for efficiently diagnosing severe malnourishment in children under five years of age..

Through a qualitative case study, the effects and value of teaching families in the Kasai Province of the Democratic Republic of the Congo on the early detection of acute malnutrition were investigated. Implementing partners, such as Alice for International Medical Action, shared their experiences (20). The findings demonstrated that educating families about the signs of malnutrition and how to

recognise them was one effective method for identifying and treating acute malnutrition early on (16).

A common and effective strategy for early detection of acute malnutrition has been reported in several qualitative studies, including a recent study conducted in five sub-Saharan African countries. This strategy involves screening children at any point of contact in health using MUAC tape screening for acute malnutrition as well as interdisciplinary and collaborative intervention.(23)(24).A study conducted in seven developing nations revealed through narrative review that normal clinical practices were less likely to identify cases of acute malnutrition. The study focused on the early diagnosis and management of acute malnutrition(25).

The collective conclusion of the studies included in this part is that different countries have different approaches to early malnutrition identification, and most of the time, those approaches are less successful. Another prevalent approach that has been documented in several countries is the routine and periodic screening for acute malnutrition coupled with awareness-raising. The efficacy of this tactic isn't as well researched or documented, though.

2.6.2 Implementation of IMAM in managing acute malnutrition

According to a case study on the application of IMAM guidelines in Ghana, the theoretical framework for implementation proved ineffective. Two factors contributed to this observation: irregular application of the strategy for early identification of acute malnutrition and early treatment beginning. The study investigated and came to the conclusion that using the guidelines is a crucial part of implementation.

The successful implementation of the IMAM guidelines requires the timely identification of acute malnourishment and the commencement of therapy for under-five malnourished children(21). Coherent implementation of all four essential integration components is a crucial aspect of effectively utilising the IMAM guidelines (9). Nonetheless, there is a wealth of empirical data demonstrating both the inadequate integration of IMAM into the current healthcare system and the ineffective adherence to the guidelines. It is recognised that raising awareness of IMAM is a crucial component in ensuring its efficacy and affordability (16).

2.6.3 Factors affecting recovery from SAM through IMAM guideline

The high opportunity cost, distance, low community awareness of SAM indicators, and the need to appropriately refer malnourished children were all identified in a qualitative study conducted from Ethiopia as hurdles to successful SAM recovery (12). A systematic review on the recovery from SAM among children under five in Bangladesh also showed complementary evidence (21). Furthermore, the comprehensive evaluation identified care default as a significant impediment to SAM recovery.

Positive and negative variables can have an impact, and obstacles to rehabilitation might take the form of multifaceted, regional, and sociocultural care-related hurdles as well as delays in seeking care(12). Numerous studies have repeatedly noted that one of the main causes of the low SAM recovery rate in malnourished children under five years old is obstacles to receiving SAM care and refusal of care. In sub-Saharan Africa, a low recovery rate from SAM was observed in a comprehensive review combining meta-analysis. (21)

Among the main concerns expressed regarding the low recovery rate were the availability of funds, medications and dietary supplements, and the logistics of procurement. The latter has frequently been mentioned in conjunction with service delivery delays and medical facility adherence to WHO SAM treatment and service delivery guidelines. It was noted in the Kabale district of southwest Uganda that neglectful behaviour and delayed referral of children with SAM could be obstacles to attaining a high treatment rate (5).

Similarly, actual data regarding IMCI(19), list the four main obstacles to the cogent and successful application of IMAM, which also greatly affect the poor rate of recovery from SAM treatment. The following are the barriers: 1) tertiary health facilities provide little or no supportive supervision and training; 2) insufficient funding to support programme activities; 3) time is wasted on ineffective but meaningful IMCI consultations, which causes more complications; and 4) there is a communication gap between implementers and policy makers, which causes confusion in the interpretation and application of the guidelines(25).

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Study context

The study was conducted at Shinyanga region in Kishapu district Hospital found in Kishapu district. Shinyanga region is one among the 31 regions found in Tanzania mainland, its estimated land coverage is 18,555 km^2, and it is among the top five region with highest persistent prevalence of acute malnutrition despite the historical massive interventions available. Over the recent two years Kishapu district council has reported increasing prevalence of acute malnutrition and a lowest cure rate among malnourished under five children. For this reason, the council qualified to be a case study area. Kishapu DC has a total of 57 Health facilities, 2 being hospitals, 7 Health Centers and 48 Dispensaries. Kishapu District Hospital is the only health Facility in Kishapu DC which have a specialized malnutrition ward for intensive management of Malnutrition to under five years children.

3.2 Study design

An exploratory case study using qualitative approach was used. Real-world experiences from implementers was better captured and understood in a qualitative case study, which achieved the goal of better understanding the implementation of IMAM. It made possible for researchers to combine real-world experiences and practical lessons learned about IMAM deployment in the study area. Previous scholars have regularly referenced a similar point elsewhere(25).

3.3 Study population

All qualified medical personnel who work directly with the Kishapu District Hospital to identify and treat acute malnutrition made up the study's target group. The skilled medical staff from Kishapu DH who were purposefully selected involves in managing acute malnutrition made up the study population. Key personnel in the delivery of services to children who have been recognised as malnourished include nutritionists, licenced nurses, and clinicians. According to the guidelines, SAM without difficulties

should be managed through OTC, while SAM with complications should be managed through ITC. ITC and OTC should ideally be administered by licenced nurses and clinicians. Given this description, the study population included nutritional officers, clinicians, and trained nurses who worked in paediatric or malnutrition units or coordinated nutritional interventional actions.

3.4 Sample size and sampling procedure

Selection of Shinyanga region, Kishapu district council and consequently Kishapu district hospital was attained through a purposive sampling procedure. Investigator was one of the health care staff from Kishapu district council. Therefore, conveniently prefer to carry this study in this district keeping into mind that it is amid administrative areas with elevated prevalence of malnutrition and its case fatality rate. However, decision to use district hospital was enclosed to the fact that it is the only health facility in Kishapu District which provide treatment for SAM through well-furnished malnutrition unit. Selecting informants for the study involved using the length of stay in the paediatric ward, specifically in the malnutrition section, as a criterion at the hospital level(24).This criterion was used, in line with previous research (Wong 2008), to choose OPD clinicians, trained nurses in the pediatric/malnutrition unit, and nutritionists.

The study included 17 participants in all. Whereas seven participants engaged in a single focused group discussion and the remaining ten participated in a key informative interview.

A key concept in determining the appropriate sample size for this investigation was data saturation. The researcher concluded the interview when he realised that speaking with any more informants would not yield any new information. This was consistent with the findings of several earlier researchers (23). Notwithstanding, literature on saturation of qualitative data suggest a minimum qualitative sample of at least five to 30, emphasizing that minimum and actual sample size depends on nature of objectives(24).After 10 participants, it was determined that a minimum sample size was required to achieve saturation.

3.5 Data collection strategy

3.5.1 Data collection techniques

Primary data was collected from the study population. Data collection was achieved through main two methods. These methods were key informant interview, focus group discussions, and supported by document review. Each method and its relevance is explained below;

(i).Key informant interview

Key informant interview was the most appealing data collection method. This was face to face interview with health care providers from pediatric/ malnutrition unit and OPD at Kishapu district hospital. The interview comprised question on strategies implemented in Kishapu district council for early detection of acute malnutrition, effective use of IMAM guideline in managing acute malnutrition, and factors influencing recovery from SAM through IMAM.

Interview involved probing technics to explore key information. In the process of interviewing researcher was taking notes along recording all conversions. The key informant lasted for 30 to 45 minutes with one interviewee. The Key informant Interview composed of 5 Clinicians, 3 Nurses, 1 Nutrition Officer and 1 Social work Officer.

(ii). Focus group discussion (FGD)

One expert focus group discussion (FGD) was held with 7 health care providers to solicit experience, knowledge, challenges and practices as well as their differences in all these aspects on IMAM guideline implementation. Researcher accurately moderated the FGD to ensure that every participant present his/her views adequately and equally to other participants. The FGD was semi structured, but mainly with unplanned questions wisely premeditated and performed. It utilized the same interview checklist questions. Use of FGDs in this study would align with a number of researchers(24).

(iii). Document review

A review of documents and implementation reports was necessary to supplement provider views on IMAM's implementation in the study area. The review included key implementation aspects, including implementation strategies specifically for early identification of acute malnutrition, admission, treatment, discharge, and follow-up reports.

3.5.2 Trustworthiness of data collection tools

The following issues, as suggested by Guba and Linkcon (1989), was strictly observed by the researcher to ensure high trustworthiness of data collection tools:

Transferability: Overall descriptions of the results of the study benefited from the study's context. The use of a purposive sampling procedure would enable the researcher to capture a wide reach of experiences from all appropriate categories of key informants. Subsequently, this helped to increase generalization of the results from the study.

Credibility: Regular quality data checks was made to maintain high credibility of data collected. Additionally, data triangulation was used, which involved for the use of multiple data collection tools (in this case key informant interview and documentary review)

Dependability: Data was captured using voice notes alongside with taking notes during interview. Two independent people's transcriptions was considered, manual processing, and excel sheets was compared to establish common and missing information.

Conformity: Results, conclusions, implications and recommendations are only based on information gathered during data collection.

3.6 Data management and data analysis

3.6.1 Data management

Data collected was kept with high and strict confidential. To maintain this researcher was create excel sheet with password to protect all data extracted for analysis.

3.6.2 Data analysis

It was a step by step process of gathering information where by the right order of events was determined by collecting, classifying, and analyzing data before it was evaluated. A computer was used to transfer and encrypt the audio files that the participants had recorded. After that, it was played back numerous times to ensure that all of the participant's information was captured. The data was translated from Kiswahili to English and then transcribed with accuracy from the notes and recordings.

Conversations were verbatim transcribed using audio recordings of the conversations. The transcription was completed there before being verbatim translated into English for analysis because some of the interviews were conducted in Kiswahili. Data was extracted from the interview and audio recording transcripts to assess the effectiveness of what was said. Later on thematic analysis was conducted as follows

A content analysis was used to examine data per each specific research objective. The following steps were involved in data analysis:

(i). **Reading for content**: Reading and re-reading the text allowed to examine it, uncover concepts and connect them with what other individuals had to say. The concepts or ideas noted were given the key themes.

(ii) Coding: The data were organized and coded in this step to divide enormous amounts of data into manageable portions**.**

(iii) Displaying: After transcripts being coded, an inventory of the material connected to the assigned code was made.

(iv) Reduction: To make it simpler for the reader to comprehend the dimensions of the categories and to hasten data interpretation, data were presented in matrices with categories**.**

(v) Interpretation: The analysis was identified and interpreted after the text had been read, coded, and its themes extracted**.**

3.7 Ethical considerations

Ethics was maintained with high discipline, then ethical approval was thought and obtained from the IRB of MUHAS for ethical clearance. Permission to conduct the study was requested to DED Kishapu via DMO Kishapu. A written consent was obtained from the participants before interview. Participants could decline to be interviewed and those interviewed were free to end the interview at any point. Participants were given any incentives for taking part in the study. Confidentiality was strictly observed throughout the study. Participants were informed about the objectives of the study and their participation was voluntary. There was no any risk involved on participating in this study.

CHAPTER FOUR

4.0 FINDINGS

4.1 Qualitative findings

Results documented by this study were generated from ten key informants and one Focused Group Discussion comprising of seven participants at Kishapu District Hospital. The study involved equal number of male and female in Key informants, the dominant working experiences among informants was 1 to 4 years with half of the respondents belonging to this category.

A total of 17 participant were involved in the study where by 10 of them were the Key informant Interview and the remaining 7 were participant in one Focused Group Discussion.

Table 1: Summary of the findings

GENERATED CODES	SUB-CATEGORIES	CATEGORIES
Presence of Triage Team,	Involvement of multi-stakeholder team	Procedures in identification of Malnutrition
Involvement of nutritionist		
IMAM is used in all department that involve pediatric services		
traditional healers refer children with Malnutrition to the facilities		

Education is facilitated by Nutritionist to the Community through RCH and OPD,	community sensitization strategies	
Use of recovered cases to educate community about malnutrition		
Training to HCW on IMAM	Presence of strategies for HCW capacity building	
Job AID are placed on the pedriatic ward walls		
Specialized ward for management of SAM	Supportive environment for implementation of IMAM	Productiveness of MAM in managing acute malnutrition
assessment equipments/tools are available to the OPD, IPD, RCH, CTC		
Guiding assessment of growth parameters	IMAM guides malnutrition service provision	
IMAM guides laboratory investigations		
IMAM guide treatment modalities		
IMAM guides preparation of Therapeutic foods		
IMAM guide tracing of SAM patients		
IMAM guides Prevention of Malnutrition is initiated from pregnancy to postpartum and EBF practices		

Lack of Triage Unit and equipment's for assessment,	Facility related barriers	Barriers for IMAM implementation
lack printed guidelines,		
lack of specialized ward for SAM with child friendly stimulants		
Healthcare workers not trained on IMAM guidelines,		
Lack of Cooking facility/kitchen		
Low Adherence of the Community on the nutritional advices	Community related barriers	
Poor cooperation from the Community in treating and preventing SAM		
Not all women are capable of doing EBF		
Relying on Tradition means to cure for Malnutrition		
long hospital stay discourages adherence to follow up clinics		
Myth and Believes existing in the community (Food taboos)		
Root causes of malnutrition not taken in to considerations (socio Economic factors of Malnutrition)	Socio-economic barriers	

Poor involvement of key actors	Actor related barriers	
Poor adherence to IMAM guidelines among HCW,		

4.2 Procedures in identification of Malnutrition

The analysis of data revealed several Procedures in identification of Malnutrition among children at Kishapu district hospital; these included involvement of multidisciplinary team, presence of strategies for Health care workers capacity building and community sensitization.

4.2.1 Involvement of multi-stakeholder team

Study informants reported at the district hospital, there were involvement of many stakeholders as this enabled to have good communication and enable malnourished children were not missed in any how, In this Involvement of multi-stakeholder team study participant reported presence of a Triage Team which composed of a nurse at the OPD whois specialized to identify children with malnutrition. Study participant reported also involvement of nutritionist for nutritional and therapeutic food advice during the course of treatment. Furthermore from the study there were traditional healers involved to refer children with Malnutrition to the facilities following different training. To ensure the involvement of mult-stakeholders team work in cooperative way , from the study participant reported that IMAM was used in all department that involve pediatric services in order to ensure all children are being assessed and managed accordingly.

This was being highlighted by one of study participant by saying

> "…..*In general there is good cooperation to all department dealing with pediatric services as , the identification of Malnutrition can occur at RCH or OPD, the child will be admitted in pediatric ward ..*"**(KINo 5)**

4.2.2 Community sensitization strategies

From the study, it was said in order to implement well the IMAM guideline different strategies must be available and for this study strategies reported were Education

being facilitated by Nutritionist to the Community through RCH and OPD, this aimed at ensuring the community is much aware of early signs and symptoms with their treatment modalities, and another strategy was the Use of recovered cases to educate community about malnutrition. With this strategy it was said by participant that it makes the community to believe more on recovered cases that can be managed at the hospital. This was elaborated by one of the study participant by saying

> *"…we commit to provide good services to all SAM cases so that day by day they become ambassadors in the community and in that it has been helping the community to be aware…..now we appreciate the increase number of SAM cases…"***(FGD No2)**

4.2.3 Presence of strategies for Health Care Workers capacity building

Study participant at Kishapu District Hospital reported that in order for the IMAM guideline to be implemented there were things observed to capacitate health care providers so as to be aware and understand the IMAM guideline. One of the strategy reported was presence of Job AID being placed on the pediatric ward walls, this helped the health worker to use the Job aid as their treatment road map while attending Malnutrition children. Another strategy reported by study participant was provision of Training to Healthcare workers on IMAM guideline, this strategy aimed at creation of knowledge and skills to all health care provider in order to manage well malnourished children, this was highlighted by one of the participant by saying

> "……*the Kishapu District Hospital is working close with Health partners under the Ministry of Health regulation to promote different intervention in prevention, diagnostic, treatment and care and by doing so we will communicate with different health partners in order to provide a training to all HCW in order to be knowledgeable and aware of IMAM guideline****...."(KI*****No 8)**

4.3 Productiveness of IMAM in managing acute malnutrition

The interviewed participants reported that, in order for the IMAM guideline to bring intended outcome as stipulated by the National Health Policy, the consistence use of IMAM in managing acute malnutrition at Kishapu District Hospital three things

reported. One being supportive environment for IMAM implementation and second was through IMAM it guides malnutrition service provision thus making it being usefully.

4.3.1 Supportive environment for IMAM implementation

From the study participant, the supportive environment elicited was the presence of different assessment equipment's or tools being available at the OPD, IPD, RCH, CTC since by having these tools helped Health provider in identification and classification of malnutrition, furthermore it was reported by participant also there is presence of Specialized ward for management of SAM, this was seen to create a motive environment for special care to all malnourished children since SAM children needs special care, this was said by one of the participant as he reported.

> *"……The Kishapu District Hospital is expanding its services as we can see all of us and no its good we have a specialized ward for malnutrition as these children have special care compared to other medical condition…"*(**KI No 8**)

4.3.2 IMAM guides malnutrition services provision

During the study, participant reported that IMAM guideline as an intervention helped in prevention and management of all forms of malnutrition and played role in guiding services to be offered to malnourished child, by guiding assessment of growth parameters, IMAM guides laboratory investigations this was seen from the guideline so as to take only relevant investigations. IMAM guide treatment modalities, this was reported by one of the participant as IMAM guide treatment according to severity of malnutrition and presence of other medical condition. IMAM guides Prevention of Malnutrition is initiated from pregnancy to postpartum and EBF practices, IMAM guides preparation of Therapeutic foods, IMAM guide tracing of SAM patients this was reported by participant and emphases on how to track and make good follow up to ensure good recovery. One of the study participants reported that

> *"…….this guide is more than the treatment of malnutrition because through the IMAM guide I can say that it interacts with other children's guides as it contains charts that give you a compass for*

*monitoring growth and development and if you see the child diverted then it is a sign that there is a problem in nutrition or other medical condition..”***(KI No 4)**

4.4 Barriers for IMAM implementation against recovery from SAM

In Kishapu district there are four major factors emerged from the study which hinders the implementation of Integrated Management of Acute Malnutrition guideline, these are facility related, community related, social economic barriers and involving of stake holders factors.

4.4.1 Facility related barriers

From the study, participants reported different things are not supportive for the IMAM implementation, starting with awareness of IMAM to health worker, there are few who have training and knowledge on it, another thing is; there is no or lack of specialized ward for sensory stimulation as part of management for recovering SAM children, and there is a big shortage IMAM guideline and no hospital kitchen for therapeutic locally made food. One of the study participant said.

“…..*If you say the hardcopy guideline, I saw the book once when we received training about 4 years ago on malnutrition, after that I have never seen it, I don't have it even in the malnutrition ward….”****(*****FGD No 7)**

Another study participant on facility related barriers reported as follows.

“*..We don’t have the hospital kitchen instead we have a trained nurse who helps us to prepare therapeutic foods at her home place…”* ***(KI No7)***

4.4.2 Community related barriers

From the study in Kishapu district hospital, community related barriers being reported by study participants are low nutritional advice and the importance of using variety of food groups, from this the community had low adherence of nutritional services. On top of that, from the study poor cooperation from the community in adhering to treatment and preventive services from SAM and MAM being reported but also most of people at Kishapu reported by one of study participant started to seek medical

attention from tradition healers other than health facilities. One of study participant explained the community related barriers by saying.

> *"……Still in this community, some people do not believe on medical condition as they believe on superstition and being be witched, having selection of foods .....and when they encounter malnutrition condition the first thing is to visit traditional healers…*","*…….With experience in working , I can say that there is still a big challenge in community adherence concerning nutritional things, more effort should be placed…"* **(KI No 10,)**

4.4.3 Social-economic barriers

From the study one of the root cause of malnutrition and not taken into consideration is social economic factors where by the society is much concerned with daily social – economic activities and not considering about the child's health , hence it makes the viscous circle of malnutrition and poverty not to end.

> *"…The main point is the level of society, the type of social economic activities, the income of each person, the importance of the ANC and other factors are not much taken into consideration, people are much busy with daily activities and forgetting their children and once they are sick, they use the accumulated wealth in treating the child…. This makes the viscous circle of poverty and malnutrition not to cut off…"* **(KI No. 8)**

4.4.4 Actors or stake holders related barrier

As it has been found from the study, there is poor involvement of the key actors and other even don't know who are the actors and stake holders on IMAM guideline implementation. This makes it being difficult to implement as they don't even know who to involve and what to do if they are the one to act.

> "…….*I have become a malaria coordinator for a while, I can say that we do not know the meaning of key actors and stakeholders and that is why we do not know how to use them, there are stakeholders within the*

hospital, community, governmental and non-governmental institutions, The issue of malnutrition is very challenging we need to have cooperation with all hospital staff, involve the community and all health partners…"(KI No10,)

CHAPTER FIVE

5.0 DISCUSSION

The study aimed to assess implementation of National Health policy in managing malnutrition among under fives by using Integrated Management of Acute Malnutrition at Kishapu district Hospital. Three categories emerged from the analysis of 10 interviews and 1 FGD are as follows; One, Procedure in identification of acute malnutrition which included involvement of mult-stake holders. Two, Productiveness of IMAM in managing acute malnutrition, it included facility supportive environment and IMAM guidance in malnutrition services. Thirdly, the barriers for IMAM implementation which were facility and community related.

The observed practices are in accordance to the national strategic roadmap plan on nutritional which is integral part of IMAM guideline implementation. However, the discussions with health care providers reported low community involvement , one of the study gave Evidence of the limited reach of community mobilization and sensitization has been reported in sub-Saharan Africa(21). This makes community less aware of Malnutrition. Hence having many un noticed malnourished children in the community.

Another crucial component of the IMAM guideline to promote early detection of malnutrition and efficient linkage to care and treatment , the study found that health facility implement this component through final screening. The same lists of strategies for early identification of acute malnutrition are found in various earlier studies(16)(20). Kishapu does not, however, employ cutting edge techniques, such as the integrated methods family MUAC, which have been effectively adopted in Mali and the Democratic Republic of the Congo(26).This makes a delay in early identification of malnutrition.

The readiness of the hospital in implementation of the National health policy in managing malnutrition to under five by using IMAM evidenced by constructing the malnutrition ward, having medical personnel who manage malnutrition cases. The study also gave a paving way toward cutting circle of malnutrition by sporting the

barriers of IMAM implementation and by knowing this, it gives a way on eradicating the sported barriers and obstacles (12)

The trustworthiness of the key findings is addressed by using the four criteria for assessing the trustworthiness of qualitative findings; credibility, dependability, transferability and conformity by Guba and Lincoln (strategies for ensuring trustworthiness in qualitative research projects). The credibility of the findings of this study was enhanced through triangulation of participants with experiences and study questions. Before data collection, informed consent to participate in the study was thought from the study participant. Data were collected using Interview guide and FGD guide in order to ensure that the findings reflected on participants' perspectives and experience other than the researcher understanding of questions under the study. categories were deductively generated and presented with the support of subcategories and quotes.

It is important to recognize the limitations of this study. First off, fear of the unknown and familiarity with the health provider may have an impact on the outcomes. Some dishonest employees who engage in unethical behavior may see this study as a threat to their interests. As a result, it could be harder for them to cooperate and give truthful responses. To address this challenge, Clear information including fully confidentiality and the importance of the study was made clear to participant. Finally, time was a constraint because some staff members, especially the OPD doctors, were busy and it took a long time to interview them. However, even with these drawbacks, the information gathered from this study can reflect the reality on how the IMAM guideline is implemented.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

From this study, Kishapu District Hospital had revealed evidence on inconsistency and inappropriate use of the guideline which might be attributed to lack of exposure and awareness on the guideline among health care providers in the service contact area.

Generally the current implementation status of IMAM guideline at Kishapu district hospital does not promote core principles of maximum coverage and access, and timelines as stipulated under IMAM national guideline. It validates evidences on the role of effective strategies for early detection and treatment of malnutrition through effective use of IMAM guideline and barriers against recovery from SAM.

Internal coordination of care in public health care facilities is a constraint to effective use of IMAM guideline and this might be the case for many other interventions. Lack of local initiatives on effective linkage to care might be a sign of poor governance. All barriers identified by this study provide signal on the negative impact of operational, technical and community related factors on recovery of under five children from SAM. Thus, these factors should be taken care at all levels of health care service delivery to under five children.

6.2 Recommendations

Based on results presented and its discussion, the followings are key recommendations from this study.

(i) The Kishapu district hospital through CHMT should establish nutritional committees at ward and village levels and supervise them to enhance them being active and functional by requiring them to report on quarterly bases the number of malnutrition identified and linked to health facilities.

(ii) The Shinyanga RHMT and other regional with highest number of registered traditional healers and high malnutrition prevalence like Simiyu and Geita should adopt and scale up a strategy of early referral of children to care through traditional healers

(iii) Kishapu CHMT should extend the scope of community mobilization to household level through influential people and champion families

(iv) Health care providers and all other key stakeholders involved in implementation of IMAM guideline should be exposed to guideline through trainings or orientations

(v) CHMT should incorporate routine use of IMAM guideline specifically the scope and consistency use of IMAM guideline as indicator under their supportive supervision checklist at facility level

(vi) CHMT through District Executive Director should mobilize domestic resources and solicit external fund to establish dedicated malnutrition units in all health centers.

(vii) The Kishapu district hospital management Team and CHMT should plan for completion of the existing malnutrition unit at the district hospital

(viii) Health care facilities should focus more on counseling and use of behavioral change communication messages which promote health behavior

(ix) The council in collaboration with implementing partners should possibly train all health care providers in service contact areas with under five children

(x) Sustained follow up and engagement of community in managing SAM should be a priority and compulsory component of local plan on nutritional intervention

6.3 Issues for further studies

From the study, few things very important being observed due to their importance and this study did not explore is potential mechanisms to overcome barriers to recovery from SAM. Thus, exploring feasible approaches to curb the barriers identified by this study is a resilient area of study for further researchers. Moreover, further researchers should estimate the cost implication of IMAM guideline implementation.

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APPENDICES

APPENDIX I: INFORMED CONSENT (ENGLISH)

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES (MUHAS)

DIRECTORATE OF RESEARCH AND PUBLICATIONS

MUHAS: INFORMED CONSERT

STUDY NUMBER: _____

CONSENT FORM FOR PARTICIPATING IN A RESEARCH STUDY

INTRODUCTION

You are being asked to participate in this study because you are an employee/administrator of Kishapu District in Health sector who has extensive experience with management of Malnutrition. This research is carried out by Charles M Mayala from the Muhimbili University of Health and Allied Sciences (MUHAS) as a fulfillment of his postgraduate study (Master of Science in Health Economics and Policy); the supervisors of this study are Dr. Nathanael Sirili and Ms. AlphoncinaKagaigai from MUHAS, Dar es Salaam Tanzania.

Research subjects are voluntary and only include people who choose to participate. Please read this consent form carefully and take your time to make your decision. If you agree to participate in this study, you will be asked to sign and date this consent form. You will get a backup copy. Please feel free to ask any words or information that you do not understand well.

RESEARCH TITLE:

"I***mplementation of Integrated management of acute malnutrition among under-fives at Kishapu district****."*

The aim, risks, inconveniences, discomforts, and other important information about the study are listed below. You are free to ask questions about this study at any time.

THE AIM OF THE STUDY

This study aims to assess the implementation of integrated management of acute malnutrition among under-fives at Kishapu district.

PARTICIPATION

Dear Participant; I would like you to participate in this study. You have been selected because you met the criteria for the topic of this study. Interviewer guidelines will be used and privacy will be maintained as much as possible. I hope that you will be willing to share your information with the researcher. If you have questions about this study, please don't hesitate to ask at any time.

CONFIDENTIALITY

All information and matters related to your participation in the study will be treated as confidential; no unauthorized person will have access to your information. Once the interview process is completed, the information will be disposed of in a secure (encrypted) manner to enhance the confidentiality of the study. Additionally, to protect confidentiality, your names will not be used in the written copy of the study results.

RIGHT TO REFUSE OR WITHDRAW

It is your choice to participate in this study. Also, you don't have to talk about anything you don't want to and you can end the interview at any time. However, your opinion is very important in this study.

BENEFITS

There is no direct benefit to you from being in the study; however, your participation in this study will provide valuable information for future steps to improve management of malnutrition.

RISKS

There will be no harm to you as a result of participating in this study although some of the questions will be personal which may raise your feelings and sensitivities.

WHOM TO CONTACT

If you ever have questions about this research, you can call the Chairman of the Research and Publications Committee, MUHAS. P.O. Box 65001, Dar es Salaam-Tanzania 255 0222151596.

DECLARATION

I have read the contents of this form and understand it. My questions have been answered. I kindly agree to participate in this study. Signing this form indicates that you agree to participate in this study; however you may decide at any time even between the interviews that your participation will be withdrawn.

Interviewee's Signature _____Date_____ Time _____

Interviewer signature _____Date _____ Time _____

THANK YOU FOR YOUR CONSENT

KIAMBATANISHO II: RIDHAA YA KUFAHAMISHWA (KISWAHILI)

FOMU YA RIDHAA YA MSHIRIKI WA UTAFITI

KUGUGENZI YA UTAFITI NA MACHAPISHO

MUHAS: FOMU YA RIDHAA YA KUSHIRIKI UTAFITI

NAMBARI YA FOMU: _____

FOMU YA RIDHAA YA KUSHIRIKI KATIKA UTAFITI

UTANGULIZI

Unaombwakushirikikatikautafitihuukwasababuwewenimfanyakazi/msimamiziwahudumazaafyakatikawilayayaKishapuambayeunauzoefukatikautoajiwahudumazamatibabuyautapiamlo. Utafitihuuunafanywana Charles M Mayalakutoka Chuo Kikuu cha AfyanaSayansiShirikishi Muhimbili (MUHAS) ikiwaniutimilifuwamasomoyakeyaShahadayaUzamili (Sera naUchumiwaAfya); wasimamiziwautafitihuuni Dk. Nathanael Sirilina Bi. AlphonsinaKagaigaikutoka MUHAS, Dar es Salaam Tanzania.

Ushiriki wako katika utafiti huu ni wa hiari. Tafadhali soma maelezo katika fomu hii ya ridhaa kwa uangalifu na uchukue wakati wako kufanya uamuzi wako. Ukikubali kushiriki katika utafiti huu, utaombwa kutia sahihi na tarehe katika fomu hii ya ridhaa. Utapata nakala ya kuhifadhi. Tafadhali jisikie huru kuuliza maswali au taarifa yoyote ambayo huelewi vizuri.

KICHWA CHA UTAFITI:

“Utekelezazi wa miongozo ya matibabu ya utapiamlo kwa watoto wenye umri wa miaka chini ya mitano katika Wilaya ya Kishapu”.

Lengo, hatari, usumbufu, na taarifa nyingine muhimu kuhusu utafiti zimeorodheshwa hapa chini. Uko huru kuuliza maswali kuhusu utafiti huu wakati wowote.

LENGO LA UTAFITI

Utafiti huu unalenga kuelewa Utekelezazi wa miongozo ya matibabu ya utapiamlo kwa watoto wenye umri wa miaka chini ya mitano katika Wilaya ya Kishapu

USHIRIKI

Ndugu Mshiriki; Ningependa ushiriki katika utafiti huu. Umechaguliwa kwa sababu ulitimiza vigezo vya mada ya utafiti huu. Miongozo ya wahojaji itatumika na faragha itadumishwa iwezekanavyo. Natumai kuwa utakuwa tayari kushiriki maelezo yako na mtafiti. Ikiwa una maswali kuhusu utafiti huu, tafadhali usisite kuuliza wakati wowote.

USIRI

Taarifa na masuala yote yanayohusiana na ushiriki wako katika utafiti yatachukuliwa kuwa siri, hakuna mtu ambaye hajaidhinishwa na mamlaka ya chuo na mkurugenzi Kishapu atapata taarifa zako. Punde tu mchakato wa usaili utakapokamilika, taarifa hiyo itatupwa kwa njia salama (iliyosimbwa kwa njia fiche) ili kuimarisha usiri wa utafiti. Zaidi ya hayo, ili kulinda usiri, majina yako hayatatumika katika nakala iliyoandikwa ya matokeo ya utafiti.

HAKI YA KUSHIRIKI AU KUTOSHIRIKI

Ni chaguo lako kushiriki katika utafiti huu. Pia, sio lazima kuzungumza juu ya kitu chochote ambacho hutaki na unaweza kumaliza mahojiano wakati wowote. Hata hivyo, maoni yako ni muhimu sana katika utafiti huu.

FAIDA

Hakuna manufaa ya moja kwa moja kwako kutokana na kuwa katika utafiti, hata hivyo, ushiriki wako katika utafiti huu utatoa taarifa muhimu kwa ajili ya hatua za baadaye za kuboresha ubora wa huduma za matibabu ya utapiamlo kwa watoto walio naumri ya miaka chini ya mitano.

HATARI

Hakutakuwa na madhara yeyote katika ushiriki wako kwenye huu utafiti ingawa baadhi ya maswali yanaweza kuwa na mtizamo ya kibinafsi ambayo yanaweza kuibua hisia binafsi na usikivu wako.

NANI WA KUWASILIANA NAYE

Ukiwa na maswali kuhusu utafiti huu unaweza kuwasiliana na Mwenyekiti wa Kamati ya Utafiti na Machapisho chuo kikuu cha Muhimbili, S.L.P 65001, Dar es Salaam-Tanzania; au kwa simu nambari ya simu: 255 0222151596.

TAMKO

Nimesoma maelezo yaliyomo kwenye fomu hii na kuelewa. Maswali yangu yamejibiwa. Ninakubali kushiriki katika utafiti huu kwa hiari. Kutia saini kwenye fomu hii kunaonyesha kuwa umekubali kushiriki katika utafiti huu, hata hivyo unaweza kuamua wakati wowote hata kati ya mahojiano na ushiriki wako utaondolewa.

Sahihi ya Mhojiwa _____Tarehe_____ Muda _____

Sahihi ya mhojaji _____Tarehe _____ Muda _____

ASANTE KWA RIDHAA YAKO

APPENDIX III: KEY INFORMANT INTERVIEW GUIDE

QN 1. IMAM start with early detection of acute malnutrition among under 5 year's children. How is detection of acute malnutrition program implemented in this council?

Probes about

What are the local initiatives / strategies implemented by this council to promote early detection of all malnourished children? How is the hospital implementing early detection of acute malnutrition? Who are the key actors involved in detection. Why detection through available strategies give low yield. How is community mobilization organized?

So what

QN 2. The primary focus and important aspect of acute malnutrition is to achieve integration of activities on management. How are acute malnutrition cases managed in this hospital?

Probes about

How is linkage of malnourished under five years children to this hospital implemented? Who are key actors involved in linkage to care among diagnosed acute malnourished under five years children. What is the hospital doing to ensure effective use of IMAM guideline used in managing acute malnutrition among under 5 years children? So what have been the success stories in use of IMAM guideline in this hospital? How about the challenges the hospital face in implementation of IMAM guideline.

QN 3. The aim of IMAM strategy is to reduce wasting up to below 5 % through reduction of case fatality and morbidity of severe acute malnutrition (SAM). What are the potential barriers against recovery from SAM through IMAM guideline in Kishapu District?

Probe about

How is the current situation on recovery from SAM and level of wasting in Kishapu district council? Why SAM recovery rate continue to be a challenging issue in this

council, who are key actor involved in promoting high recovery rate from SAM in this district hospital. So what are the outcome of their involvement?

KIAMBATANISHO IV: MWONGOZO WA MAHOJIANO

1. IMAM inaanza kwa kugundua mapema utapiamlo wa hali ya juu miongoni mwa watoto walio chini ya miaka 5. Je, ugunduzi kwa kufuata mwongozo wa utapiamlo unatekelezwa vipi katika halmashauri hii?

Inachunguza kuhusu
-Je, ni mipango/mikakati gani ya ndani inayotekelezwa na idara ya afya ili kukuza utambuzi wa mapema wa watoto wote wenye utapiamlo?
-Je, hospitali inatekelezaje utambuzi wa mapema wa utapiamlo uliokithiri?
- Ni nani wahusika wakuu wanaohusika katika ugunduzi. Kwa nini ugunduzi kwa kutumia IMAM upo chini.
- Je, uhamasishaji wa jamii unapangwaje?

2. Lengo kuu na kipengele muhimu cha utapiamlo mkali ni kufikia ujumuishaji wa shughuli za usimamizi. Je, kesi za utapiamlo hudhibitiwa vipi katika hospitali hii?
Inachunguza kuhusu
Je, uhusiano wa watoto wenye utapiamlo chini ya miaka mitano kwenye hospitali hii unatekelezwa vipi? Ambao ni wahusika wakuu wanaohusika katika uhusiano na utunzaji kati ya watoto walio na utapiamlo wa chini ya miaka mitano. Je, hospitali inafanya nini ili kuhakikisha utumiaji mzuri wa mwongozo wa IMAM unaotumika kudhibiti utapiamlo uliokithiri miongoni mwa watoto walio chini ya miaka 5? Kwa hivyo ni hadithi gani za mafanikio katika matumizi ya mwongozo wa IMAM katika hospitali hii? Vipi kuhusu changamoto zinazokabili hospitali katika utekelezaji wa mwongozo wa IMAM.

3. Lengo la mkakati wa IMAM ni kupunguza upotevu hadi chini ya 5% kwa kupunguza vifo na magonjwa ya utapiamlo mkali (SAM). Je, ni vikwazo gani vinavyowezekana dhidi ya kupona SAM kupitia mwongozo wa IMAM katika Wilaya ya Kishapu?
Chunguza kuhusu

Je, hali ikoje kwa sasa ya kuhusiana na utambuzi wa SAM katika halmashauri ya wilaya ya Kishapu?

- Kwa nini kiwango cha kupona kwa SAM kinaendelea kuwa suala gumu katika halmashauri hii?

-Nani ndio ambao ni wahusika wakuu wanaohusika katika kukuza kiwango cha juu cha kupona kutoka kwa SAM katika hospitali hii ya wilaya. Kwa hivyo ni nini matokeo ya kuhusika kwao?

APPENDIX VETHICAL CLEARANCE PERMIT

UNITED REPUBLIC OF TANZANIA

MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

OFFICE OF THE DIRECTOR – RESEARCH, PUBLICATIONS AND INNOVATION

Ref. No.DA.282/298/01.C/1748 Date: 15/05/2023

MUHAS-REC-06-2023-1748
Charles Mnada Mayala
School of Public Health and Social Sciences
MUHAS

RE: APPROVAL FOR ETHICAL CLEARANCE FOR A STUDY TITLED: IMPLEMENTATION OF INTEGRATED MANAGEMENT OF ACUTE MALNUTRITION AMONG UNDER 5 CHILDREN AT KISHAPU DISTRICT

Reference is made to the above heading.

I am pleased to inform you that the Chairman has on behalf of the University Senate, approved ethical clearance of the above mentioned study, on recommendations of the Senate Research and Publications Committee meeting accordance with MUHAS research policy and Tanzania regulations governing human and animal subjects research.

APPROVAL DATE: 15/06/2023
EXPIRATION DATE OF APPROVAL: 15/06/2024

STUDY DESCRIPTION:
Purpose:
The purpose of this case study is to assess the IMAM guideline implementation by health facilities in Kishapu district council.

The approved protocol and procedures for this study is attached and stamped with this letter, and can be found in the link provided:
https://irb.muhas.ac.tz/storage/Certificates/Certificate%20-%2014812.pdf and in the MUHAS archives.

Appendix VI: Introductory letter to Kishapu DC

In reply quote;
Ref. No. HD/MUH/T.646/2021

19th June, 2023

District Medical Officer,
Kishapu District,
P.O. Box 1288,
SHINYANGA

Re: INTRODUCTION LETTER

The bearer of this letter is Charles Mnada Mayala (HD/MUH/T.646/2021), a student at Muhimbili University of Health and Allied Sciences (MUHAS) " pursuing MSc. Health Economy and Policy

As part of his studies he intends to do a study titled: "***Implementation of Integrated Management of Acute Malnutrition of Among Under 5 Children at Kishapu District.***"

The research has been approved by the Chairman of University Senate.

Kindly provide him the necessary assistance to facilitate the conduct of his research.

We thank you for your cooperation.

Ms. Victoria Mwanilwa
For: DIRECTOR, POSTGRADUATE STUDIES

c.c. Charles Mnada Mayala

9 United Nations Road, Upanga West; P.O. Box 65001, Dar Es Salaam. Tel. G/Line: +255-22-2150302/6. Ext. 1015; Direct Line: +255-22-2151378;Telefax:+255-22-2150465;E-mail:dpgs@muhas.ac.tz;Web:https://www.muhas.ac.tz

Appendix VII: Permission letter from Kishapu council

THE UNITED REPABLIC OF TANZANIA
PRESIDENT'S OFFICE
REGION ADMINISTRATION AND LOCAL GOVERNMENT
KISHAPU DISTRICT COUNCIL

Phone No: 0282770020,
Fax No: 0282770019,
Email: info@kishapudc.go.tz
Web site: www.kishapudc.go.tz

District Executive Director Office,
P. O. Box. 1288,
22 DHD-DC ROAD
37592 KISHAPU.

Ref. No. KDC/D.20/34/VOL.II/22 20/06/2023

Director – Postgraduate Studies
Muhimbili University of Health and Allied Science
9 United Road; Upanga West
P. O. Box 65001
DAR ES SALAAM

RE: PERMISSION TO DO RESEARCH

Please refers to the heading above. Also refers to your letter dated on 19th June 2023 with Ref. No. HD/MUHAT.646/2021.

For this letter your request for your student Charles Mnada Mayala to do his research with the title "IMPLEMENTATION OF INTEGRATED MANAGEMENT OF ACUTE MALNUTRITION OF AMONG UNDER 5 YEARS CHILDREN IN KISHAPU DISTRICT" has been accepted.

We thank you for your cooperation.

Dr. Joseph Bahati
For; District Executive Director
KISHAPU

0 JUN 2023

C. c. Charles Mnada Mayala