APPENDIX 1. POTENTIAL THEMES FOR QUALITATIVE ASSESSMENTS

Does your assessment apply to any of these areas? Below, common themes and sub-themes related to low coverage of failed impact assessments have been listed. Use these as you review your program in *Step 1* and consider what the issue might be. Note where you have evidence already to support that your program DOES or DOES NOT have any of these issues. These are just illustrative examples, so it is also possible that your problem is not found within these questions.

What program questions/gaps in knowledge are you left with? Below are a few examples based on the themes listed:

- We know migrant populations pass through the areas with low coverage. We do not know whether the program is reaching them. If it is not, we will also want to learn more about how to effectively reach them.
- We know from our coverage survey results that many people are receiving treatment but not swallowing it and that the main reason given is fear of drugs. We want to better understand why people are afraid of drugs and how to help them overcome that fear.
- We can see that drug coverage seems to vary a lot by drug distributor. We want to know why. Why are some drug distributors able to effectively reach the community while others are not?

Make a list of these programmatic questions and decide whether qualitative assessment will help you answer them.

MDA uptake-related issues:

1. High population migration in the area means that many individuals miss MDA each round. *Examples:* known significant population migration, daily economic migration, seasonal migration for work or pastoral work, change in geopolitical context since the previous MDA, or economic migration among men
2. Community is afraid of participating in the MDA. *Examples:* reported serious adverse events in the community, rumors persist in the community, personal bad experience with delivery or adverse events, or challenges related to community resistance
3. Lower coverage in urban areas. *Examples:* urban population refuses the drugs, community drug distributors (CDDs) are less motivated in urban areas
4. Some populations are missing treatment. *Examples:* out-of-school children, men refuse to participate and take drugs because they think it causes sterility, women miss several years of MDA because they are pregnant during scheduled MDA and drugs are not available after MDA
5. Poor CDD motivation and performance lead to high CDD attrition rates. *Examples:* MDA implementation incentives or changes in general health system policy and structure
6. Community is tired of MDA. *Examples:* fatigue after many rounds of MDA, social mobilization has waned over time and/or messages have become stale, lack of relevance to current health problems (why take medicine when you are not sick?), or security reasons
7. High reported coverage but failed disease-specific assessment. *Examples:* directly observed treatment not implemented, unknown or changing population denominator, or known movements of population

Programmatic issues:

8. Timing of MDA with conflicting events. *Examples:* conflicting geopolitical activities (elections), rainy season, or farming season

9. Not enough CDDs. *Examples:* inadequate ratio of CDDs to community members or inappropriate placement and number of fixed posts/booths

10. Inadequate supervision of MDA. *Examples:* poor capacity/commitment of supervisor, hard-to-reach areas do not receive the same level of supervision, or lack of budget for supervision during MDA

11. Inadequate training for CDDs. *Examples:* quality of training declines because of cascade training effect, lack of budget meant no training conducted this year, lack of hands-on practice during training

12. Disruptions have been reported in the supply chain. *Examples:* drug stockouts reported by CDDs, health care providers, community members, lack of/insufficient numbers of IEC materials, or lack of/insufficient payment of per diems

13. Social mobilization is insufficient. *Examples:* community members do not know about MDA (when it is happening, why, or how), CDDs do not feel supported by community members (because they are unaware), materials and messages have not been updated since the first year of MDA, or materials and/or messages are not appropriate/tailored for the population

14. Challenges to MDA data reporting, feedback, data access, and sharing to facilitate MDA coverage related evidence-based decisions. *Examples:* MDA data quality-related issues, standalone MDA reporting system not integrated into the health management system (District Health Information System-2), involvement of leaders with interest and influence in MDA during feedback meetings, or lack of access to MDA reports in a summarized and appealing format

15. Partnership and coordination issue at regional and district levels. *Examples:* challenges with district-level officials involved in the MDA process, coordination challenges between national and district levels, inconsistent communication between the levels, or change in leadership over the course of the MDA