# Rapid Expansion of Treatment and Rehabilitation of Severely Malnourished Malawian Children

## Final Report

**31 May 2007**

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MSH MANAGEMENT SCIENCES for HEALTH

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## Acronym List

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|---|---|
| CAS | CTC Advisory Services (CAS) |
| CHAM | Christian Health Association of Malawi |
| CSB | Corn-Soy Blend |
| CTC | Community Therapeutic Care |
| CWW | Concern World Wide |
| DHMT | District Health Management Teams |
| DIP | District Health Implementation Plans |
| GAM | Global Acute Malnutrition |
| HBC | Home Based Care |
| HSA | Health Surveillance Assistant |
| MoH | Ministry of Health |
| MSH | Management Sciences for Health |
| MUAC | Mid Upper Arm Circumference |
| NGO | Non Governmental Organization |
| NRU | Nutrition Rehabilitation Units |
| OFDA | US Office of Foreign Disaster Assistance |
| OTP | Outpatient Therapeutic Program |
| RETR | Rapid Expansion of Treatment and Rehabilitation of Severely Malnourished Malawian Children |
| RUTF | Ready-to-Use Therapeutic Food |
| SAM | Severe, Acute Malnutrition |
| TA | Traditional Authorities |
| TNP | Targeted Nutrition Program |
| WFP | World Food Program |

# Executive Summary

Management Sciences for Health commenced the scale up of Community Therapeutic Care (CTC) services as part of the US Office of Foreign Disaster Assistance (OFDA) famine response at the end of January 2006. Services were scaled up to 59 sites from an original 6 sites in five districts. Services were and are currently being implemented through Ministry of Health (MoH) and other non-governmental organization sites by personnel employed at these institutions. District Health Management Teams (DHMT) in the 5 districts were involved in planning for and supervising services. During the period from January 2006-January 2007, 5,557 severe and acutely malnourished children were enrolled into the program. Of these 85.5% were cured, 10.1% defaulted and 2.4% died. This performance met standard SPHERE criteria for exit indicators.

Other inputs include the training of 3,787 personnel and volunteers and provision of essential equipment and supplies such as *Chiponde*, weighing scales, MUAC tapes, height boards and cupboards for the secure storage of *Chiponde*. DHMTs were assisted to plan for the ongoing integration of CTC into routine district operations especially through the use of the annual District Implementation Planning process. A substantial network of community volunteers (1,546) was built up around the service provision sites. At district level local nutrition coordination committees called District Targeted Nutrition Forums were re-vitalized. The implementation of the program saw collaboration between the Nutrition Unit of the MoH, DHMTs, and organizations such as Valid International, Concern Worldwide and UNICEF.

The one year program demonstrated that CTC can be effectively implemented through peripheral health facilities. MoH and NGO staff, together with volunteers, grasp the concept very well and are able to effectively implement this program. A further success of the program has been to widely increased access to nutrition services for children with severe, acute malnutrition (SAM). Depending on individual district characteristics (number of NRUs and number of OTP sites), stand alone outpatient therapeutic program (OTP) sites (those which are not operating immediately adjacent to existing NRUs) have managed between 72% and 80% of all OTP admissions. This represents a huge contribution to keeping mothers at home and children within their family groupings. Data suggests that newly created OTPs have contributed towards meeting a huge unmet need for nutritional support with increased numbers of children entering the CTC program despite agricultural conditions being much improved. In Mulanje, immediately prior to the 2005 famine, 362 children were admitted with SAM at 2 service provision sites (NRUs) whilst in the post-famine period 1,473 children were admitted at 10 OTP sites – a good example of more cases being detected despite much improved agricultural conditions.

Future challenges to sustaining CTC include a need to expand the current number of OTP sites bringing them closer to where the people live, a mechanism to ensure a secure supply of *Chiponde*, ensuring an effective supervision and support system by DHMTs and harmonizing disparate nutrition interventions such as institutional nutrition management, supplementary feeding programs and general food support programs at district level.

## Introduction

In February 2006, Management Sciences for Health (MSH) received funding from the Office of Foreign Disaster Assistance (OFDA) for a project titled the Rapid Expansion of Treatment and Rehabilitation of Severely Malnourished Malawian Children (hereafter referred to as the RETR project). The purpose was to rapidly scale up treatment and rehabilitation of children with severe malnutrition. The program was designed as a response to the food crisis that affected Malawi from mid-2005 to mid-2006. This food insecurity situation had threatened the lives of thousands of children as confirmed by a nationwide nutrition survey conducted in December 2005. Results of the survey revealed very high global acute malnutrition (GAM) of more than 10% in one of the eight MSH-supported districts (Salima). Three other districts (Balaka, Mulanje, and Chikwawa) had GAM levels of 5-10%.[1] A GAM rate of 10% signifies a critical negative nutrition status and a rate of 5-10% GAM is a serious warning signal.

The fund was administered in two phases of six months each. During Phase 1 (February – July 2006) MSH and district health management teams (DHMT) introduced and strengthened a system that would reach and provide early treatment for children with severe malnutrition at a facility close to home. Scale up was built on an earlier pilot initiative implemented by MSH from March 2005 to January 2006, which introduced and assessed the impact of community-based therapeutic care (CTC) at five health facilities in Balaka, Salima and Mzimba. Program rollout extended CTC in these three districts and introduced CTC to two additional districts of Mulanje and Chikwawa. A no-cost extension (Phase 2) ran from August 2006 – January 2007 and focused on institutionalizing CTC systems and mainstreaming some aspects of the service into the programs of these five districts.

Program implementation was facilitated through the utilization of MSH infrastructure (technical, administrative and logistical) built up to support a bilateral program in Malawi (Malawi Program for Reducing Childhood Morbidity and Strengthening Health Systems). The bilateral program will support CTC implementation until the end of the project period in September 2007.

## Program Overview and Results

The four objectives of the RETR project are:

1. To ensure that 60 newly established outpatient therapeutic program (OTP) points are able to implement CTC **(Phase I)**
2. To ensure that the intervention enrolls 65% (5000) of estimated moderate and severely malnourished children under 5 into the CTC program **(Phase I)**
3. To ensure the development of an effective referral system for malnourished children between various feeding program components **(Phase I)**
4. To ensure the sustainability of CTC as a routine district level intervention **(Phase II)**

**Assessment and surveillance data used**

- Prior to the OFDA-funded MSH intervention, 6 OTP service points existed (Two points each in Balaka, Mzimba, and Salima Districts)

[1] Malawi Nutrition Survey, December 2005

- Status of severe acute malnutrition (SAM) in Malawi as determined through the Malawi Nutrition survey December 2005 (see Table 1)

Table I: Status of severe malnutrition by district

| | Balaka | Chikwawa | Mulanje | Mzimba | Salima |
|---|---|---|---|---|---|
| Estimated # of children based on 2% estimated prevalence (as used in proposal)[2] | 1,036 | 1,408 | 1,671 | 2,403 | 1,257 |
| Estimated # of children based on UNICEF survey Dec 2005 (% SAM in parentheses) | 1,502 (2.9%) | 1,830 (2.6%) | 3,509 (4.2%) | 2,884 (2.4%) | 3,079 (4.9%) |
| Actual # admitted to OTP by end of January 2007[3] | 997 | 1,007 | 1,605 | 1,067 | 881 |

## *Objective 1: To ensure that 60 newly established OTP points are able to implement CTC*

Table II: OTP Coverage February 2006 – January 2007

| District | No. Facilities | OTP Centers | % Coverage |
|---|---|---|---|
| Balaka | 13 | 11 | 85% |
| Chikwawa | 17 | 12 | 71% |
| Mulanje | 22 | 10 | 45% |
| Mzimba | 49 | 13 | 27% |
| Salima | 17 | 13 | 76% |
| **Total** | **118** | **59** | **50%** |

All five targeted districts actively responded to the CTC initiative with establishment of 59 OTP sites at the end of OFDA support in January 2007. Two smaller districts (Balaka and Salima) have installed CTC in all their main government and Mission facilities which means access to the service has been further widened in these districts (Table II includes private facilities). Mzimba DHMT used government resources to establish four additional CTC centres. See Annex A for full output project statistics.

## *Objective 2: To ensure that the intervention enrolls 65% (5,000) of estimated moderate and severely malnourished children under 5 into the CTC program*

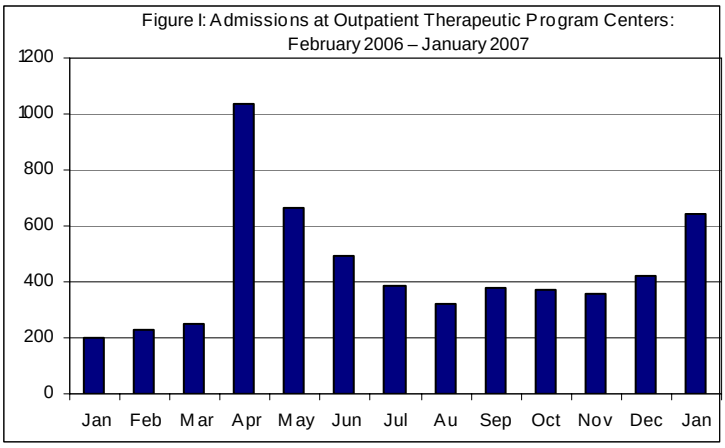
**Overall Enrollment**

The rollout process was finalized by May 2006, upon completion of all training, initial community mobilization and program installation. High admission numbers were recorded in these two months. Admission rates significantly dropped during June to August following the bumper harvest when children had an adequate food intake at home. The bumper harvest followed a successful targeted fertilizer subsidy program allowing many poor subsistence farmers had a good yield after almost a decade of negative food production (see Figure I).

- During this period, all facilities in Balaka, Chikwawa and Salima received corn-soy blend (CSB) from World Food Program (WFP) to treat moderate malnutrition. This intervention helped to prevent much of malnutrition from becoming severe.

[2] Based on district data calculations by Ministry of Health
[3] Monthly CTC reports from 59 facilities in 5 districts

- However, admissions started to rise again in September 2006 and peaked in January-March when malnutrition rates sharply increase each year. This results from a combination of food insecurity and demanding farming activities which in turn lead to reduced attention to child feeding obligations and general child care responsibilities.



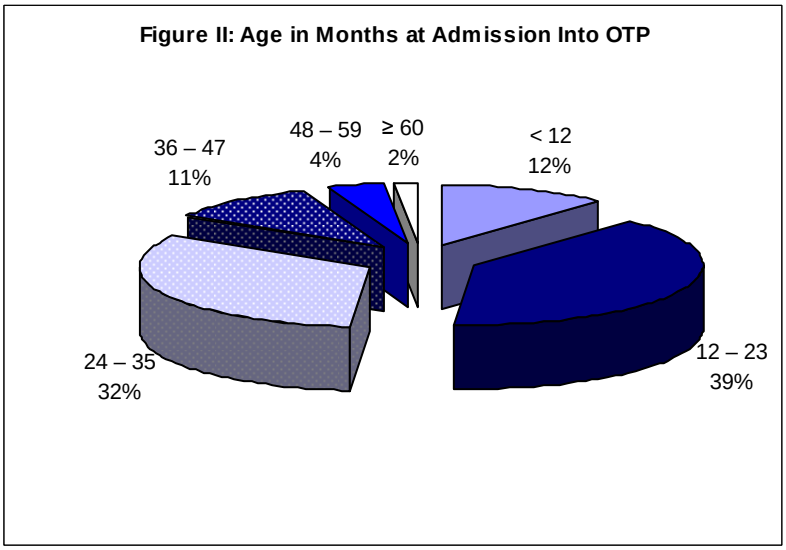

- By January 2007, admissions from all five districts had reached 5,557 and grown to 7,112 at end of March 2007.

**Gender at admission**

Gender differences on admissions followed the national demographic pattern with women accounting for 52% of the total population. The March 2007 impact assessment, undertaken by MSH, showed a ratio of 53% females to 47% males among 1,284 total admissions to OTPs. This may imply equal caring of male and female children, especially as gender mainstreaming is presently emphasized in development planning and implementation and the gender message is reaching parents.

**Age at admission**

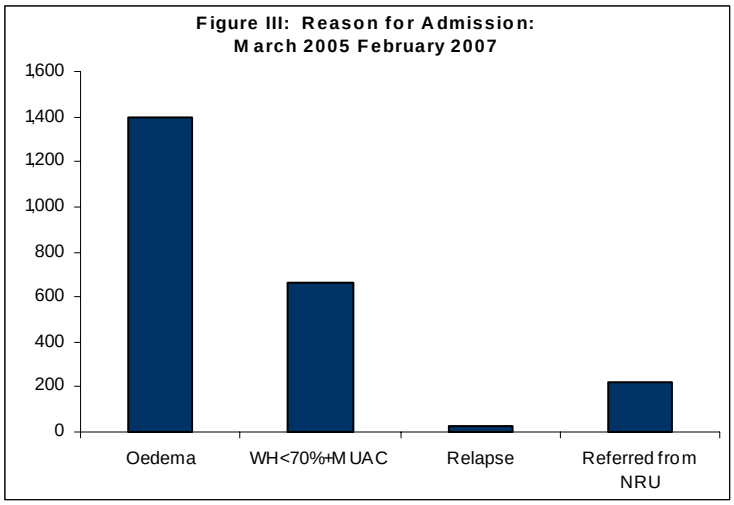
Nearly three-quarters (71%) of admissions fell in the weaning age bracket of 12 -35 months. Observations at OTP centres show that a significant number of care givers are pregnant at the time they bring a malnourished child for nutritional care. In such situation, local customs dictate immediate cessation of breastfeeding which in many cases leads to the child's rejection of any other food offered. All training activities included a strong family planning element. Only 15% of children admitted were between 36 and 60 months, implying the need to reach parents with preventive nutrition education for this age group. Throughout project implementation, on-the-job training emphasized nutrition education which was continuously delivered during nutrition and health talks as and at one-on one counselling of care givers.




**Reason for admission**

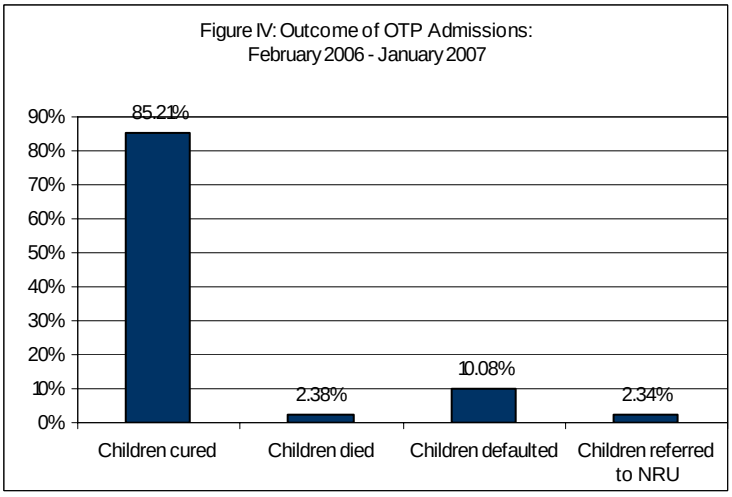
The post project impact assessment conducted in March 2007 showed that oedema was the most common reason for admission (60%) and over two thirds of these children were aged between 12 and 35 months. A further 29% of the children were admitted because of a weight for height

measurement of less than 70%. This group also had a general low measurement of the mid upper arm circumference (MUAC) of less than 11 centimetres. Children who had been referred from nutrition rehabilitation units (NRU) accounted for 10% of admissions, a high figure that further demonstrated growing NRU-OTP linkages.



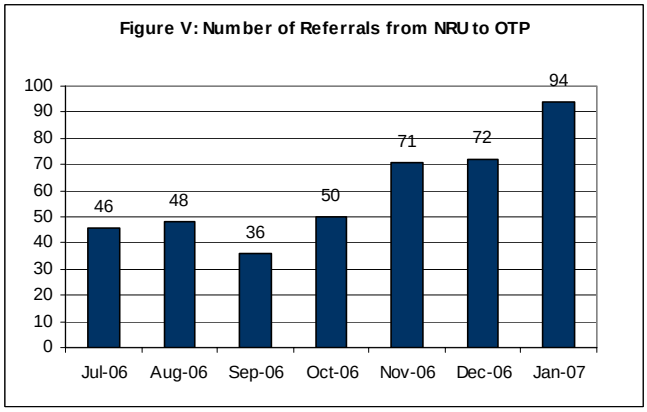

**Outcome**

Cure rates at OTP centres are high. A cure rate of over 80% was sustained by participating districts. A death rate of less than 3% was recorded in the 12 months of project implementation. While default rates were contained at 13%, this remained a challenge for children brought long distances from their communities. In Mzimba and Mulanje districts where facility coverage is still low, there is an urgent need to introduce more OTP centres to reduce walking distances to the service.




*Objective 3: To ensure the development of an effective referral system for malnourished children between various program components*

**Functional referral system between NRUs and OTPs developed**




CTC statistics indicate that 417 children were referred from NRUs to OTPs (reliable data collection having started in July 2006 following a concerted effort to strengthen data collection on referrals). This is an indication of the development of an effective referral mechanism between NRUs and OTPs. The increase in referrals from NRUs to OTPs is also linked to increased utilization of skills and experience in interpreting and using CTC protocols and indicators. Increasingly, children are being transferred to OTP as soon as their appetite returns and when any accompanying infections have been successfully treated. A review of discharge rates from NRUs indicates a doubling of

discharges during the first 10 days of admission - from 19.1 % to 42%. Average length of stay decreased from 18.7 days to 14 days – a decrease of 4.7 days. The national level forum on the targeted nutrition program (TNP) has also played a key role in ensuring consolidation of OTP and NRU guidelines, thereby removing any fears and uncertainties among old NRU service providers (doubt about the effectiveness of ready-to-use therapeutic food [RUTF] and home-based management of malnutrition).

In three districts, CTC is coordinated by clinical staff who have taken a special interest in following up on children who fail to respond to nutritional treatment. Continuous on-the-job training on correct assessment of children in the OTP is also given to other health providers. Results have been seen through improved documentation of non-responding children being referred to district hospitals for further medical care. Some children admitted to NRUs from OTPs were tested for HIV with some children testing positive. However, accurate recording and reporting systems need to be developed which will provide a better impression of HIV prevalence amongst children admitted to NRUs.

## *Objective 4: Ensure the sustainability of CTC as a routine district level intervention*

### Inclusion of CTC in district health plans

- The MSH/Malawi bilateral project, with a strong systems strengthening focus has placed MSH in a unique position to help both the central MoH and DHMTs to explore and find ways to make CTC sustainable. This systems strengthening focus has included an emphasis on strengthening the annual district planning process. District planning guidelines for CTC were developed for use at district level and were finalized at a November 2006 workshop. This included participation by district, NGO and MoH representatives. The Nutrition Unit of the MoH developed a final set of nutrition priorities for districts which was incorporated in the 2007/2008 DIP guidelines which contains a significant section on CTC.
- MSH has played a crucial advocacy and advisory role in policy/program enhancement at the MoH, through the national CTC Advisory Services (CAS) under Concern World Wide (CWW). CWW has taken the MSH planning initiative further by assisting the MoH to replicate the CTC planning guidelines to all other CTC implementing districts and their partner NGOs.
- Most important is the increasing responsibilities that DHMTs are taking in the management of CTC. All CTC coordinators at district and facility level are government or Christian Health Association of Malawi (CHAM) employees. Districts have also taken full charge of RUTF deliveries to implementing facilities.
- Through this emergency activity, substantial capacity has been built in the 5 MSH-supported districts; DHMT members, community leaders, and especially parents of beneficiary children better understand the concepts and implementation approaches to CTC.

**Continued support to strengthening supervision and monitoring activities by DHMTs**

- Supervision is one of the most critical elements of CTC. MSH's bilateral program has supported development of alternative approaches to supervision, aimed at ensuring at least one regular supervisory visit to a health facility and its catchment area. Along these lines, MSH developed a supervisory tool that can be used by any trained health or extension worker. To increase supervision skills, MSH advocated inclusion of other non-health extension staff in CTC training at district and facility levels.
- MSH also initiated the design of assessment and monitoring tools to be used by community volunteers in acquiring basic nutrition and food security information for children referred and or enrolled at OTP. The volunteers are also able to use a "follow up" tool to monitor progress of a child on RUTF.
- District program review meetings were instituted. These meetings, which included participation by facility staff and DHMT supervisors aimed to enhance an effective review of indicators which contribute to improved facility management of CTC.

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**Strengthening community networks for active case-finding and effective referral and follow up**

- The MSH CTC emphasized community involvement and worked towards enabling communities to identify children in need, refer the children for therapeutic care and manage treatment within the community.
- This approach requires continued renewal of skills and information on nutrition and how to combat malnutrition. MSH and partner DHMTs define the community as all immediate surrounding bodies that influence the wellbeing and growth of a child. These begin with the nucleus family, household, extended family, village and area. MSH has therefore supported mobilization of these community structures providing targeted information on child nutrition and CTC, specifically.

Traditional Authorities in a CTC planning session in Balaka District

- While special CTC skills were imparted to volunteers, other community/civic leaders received formal briefings on CTC and other nutrition issues. These forums included strategy planning sessions with highest traditional chiefs – Traditional Authorities (TA) who outlined community strategies for sustaining CTC. Among several recommendations, TAs emphasized the need to have CTC built in all community development programs in rural Malawi.
- In December, 1,456 volunteers attended a focused refresher course to learn additional mobilization and nutritional assessment skills. The volunteers also received sets of working tools developed with MSH technical support, which are used as reference materials.

- A 7-minute film strip targeting decision makers and potential donors was produced during the pilot phase of CTC implementation done with funding through the bilateral program.
- MSH and its partner DHMTs entered into partnerships with other programs to link CTC with public health prevention initiatives at the community level.

**A Partnership Example**

In Mzimba, a tobacco growing estate examined possibilities of improving child feeding practices by giving mothers, who are employed by the estate, time to prepare meals for their young children. This was in response to data from a nearby health centre that showed that 31% of admissions into OTP came from the estate. Mzimba DHMT and MSH jointly funded a big community mobilization event which aimed at transmitting CTC messages to tobacco estate workers and to nearby villages. Local drama and other educational entertainment (edutainment) groups participated in the lively open day which attracted an audience of over 6,000 men, women and children. The event led to more families coming forward with their severely malnourished children for treatment which encouraged the estate to open a satellite CTC centre with support from the Mzimba DHMT.

A Drama Scene on CTC at a Mzimba Open Day

## *Other Outcomes*

**Provision of Skills**

Skills were provided to a total of 3,787 persons. Beneficiaries range from national trainers to community volunteers and community leaders (see Table III). A major task was to structure capacity building to respond to key sustainability challenges including management of data to improve various areas of service delivery.

Table III: Number of CTC Implementers Trained: February 2006 – January 2007

| | Male | Female | Total |
|---|---|---|---|
| National Trainers | 10 | 9 | 19 |
| District Trainers | 40 | 36 | 76 |
| Facility Service Providers | 583 | 297 | 880 |
| Volunteers | 689 | 857 | 1,546 |
| Local Leaders | 795 | 472 | 1,267 |
| **Total** | **2,117** | **1,671** | **3,787** |

**Information Systems Upgraded**

Reporting on indicators was strengthened into two ways.

First, continuous on-the-job training was given to increase understanding of the purpose and use of indicators to improve CTC management. Secondly, monitoring tools were simplified to reduce the burden of recording and data management for the Health Surveillance Assistants (HSA) who coordinate CTC at health facilities. A register which contains all key indicators was designed. There is good evidence of health centre staff increasingly utilizing information generated from the registers to strengthen service delivery. For example, in Mzimba the identification of clusters

of default cases from certain areas have led the DHMT to extend CTC to those areas. Improved quality of data has provided much needed information for national CTC policy formulation. In the districts, information from CTC registers provided the basis for CTC inclusion into future District Health Implementation Plans (DIP).

### Defining innovative linkages between CTC and other health programmes

An example from Salima demonstrates how CTC may be linked with home-based care programs. During January 2007, 286 Home Based Care (HBC) volunteers surrounding 7 health centres were trained in case-finding and referral of children with severe malnutrition. The HBC system was introduced to the program as one way of linking the broader health issues, such as HIV/AIDS, TB and others, with severe malnutrition in young children. At the end of March 2007, two months after HBC training, 212 children referred to health centres for assessment of their nutritional status by HBC volunteers. Health centres appear to have registered an increased number of children into their CTC program – a careful assessment of the control group of health centres is required before any firm conclusions can be drawn. This will be possible towards the end of July 2007.

### Provision of Equipment and Supplies

Unprecedented teamwork between MSH management, administration and technical staff enabled effective procurement and distribution of essential equipment and supplies – in a manner expected of an emergency intervention. Equipment included weighing scales, height boards, cabinets to store *Chiponde* and MUAC tapes (UNICEF donation). A distribution channel for RUTF was established. Each district was provided with a motorcycle to enhance supervision and program monitoring. Other tools sourced and delivered were guidelines/protocols, stationery and tools for volunteers.

### Recruitment of Nutrition Coordinators for District MSH Offices

Five District Nutrition Coordinators were recruited to provide immediate technical support to the generally thin district health office staff. This team brought varied expertise in child and public health. They supervised the CTC program in close collaboration with DHMT program coordinators.

### Manuals, Job Aids and other materials

The following materials were produced and distributed through the use of OFDA resources:

<u>Planning guidelines and information systems</u>

- Nutrition Activities for District Implementation Plan – MoH
- OTP Register
- CTC monthly reporting form

<u>Supervision support materials</u>

- Nutrition check list for district supervisors: Outpatient Therapeutic Programme & Nutrition Rehabilitation
- Check list for Health Surveillance Assistant
- CTC Mapping: *a Chichewa tool for volunteers*

<u>Volunteer training and support materials</u>

- Community Therapeutic Care Guidelines for Training Volunteers in Community Mobilization – Versions in English; Chichewa and Tumbuka.
- How to Manage *Chiponde* (RUTF) at Home *for extension workers*

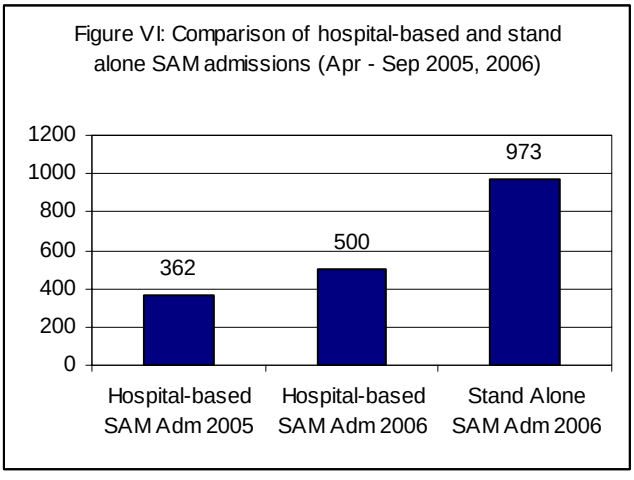
- How to Manage *Chiponde* (RUTF) at Home: *a tool for volunteers*- Versions in Chichewa and Tumbuka
- Skills Required for a Volunteer to Co-manage a CTC Programme in the Community: *a tool for volunteers.* Versions in Chichewa and Tumbuka.
- Notes on Training Volunteers in CTC: *a Chichewa tool for volunteers*
- Follow up: *a Chichewa tool for volunteers*
- Reporting CTC Activities: *a Chichewa tool for volunteers*
- Record Keeping: *a Chichewa tool for volunteers*
- Case finding check list for volunteers
- Referral form for volunteers

Other

- Messages on CTC on volunteers' T-shirts
- Messages on CTC on volunteers' book bags
- Success stories produced for the USAID Mission in Malawi: *Program Saves Malnourished Children* and *Malawi Program Alleviates Food Insecurity*
- Training materials for Protecting Vulnerable People in Relief Situations

## Lessons Learned

- *CTC can be rapidly and effectively scaled up through MoH structures.* Facility level staff have been able to implement the CTC approach with good results as is demonstrated by programme indicators which meet SPHERE standards. Volunteers appear to have grasped the concept and have been able to implement community level activities. It is clear that staff and volunteers have the capacity to implement CTC.
- *The implementation of CTC and OTP increases access to care.* This is best demonstrated as follows: Prior to the implementation of CTC, SAM children were managed at NRUs (numbering 10 in January 2006). During the following months four more NRUs became functional whilst 59 OTP sites were set up. 14 OTPs were set up at parallel with NRUs whilst 45 were set up as stand alone OTPs (no parallel NRU). Depending on the district involved, these stand alone OTPs contributed between 72% and 80% of all CTC admissions for the duration of the program.
- *There is in all likelihood, a huge unmet need with regards to children not being able to access care for SAM.* Mulanje data shows the following: during the early famine period in 2005 there were a total of 362 admissions to the two hospital-based NRUs (only sites providing services for SAM children). This number increased to 500 at the same two sites with OTPs added in the post-famine period despite better nutritional conditions in Mulanje. In the same period 973 children were admitted at stand alone sites. This indicates the contribution that peripherally-based stand alone OTPs make to meeting the large need which exists.



- *Referrals between various components of nutritional support are problematic.*
    - NRU staff have utilized the deployment of OTPs to discharge children earlier from NRUs. It is necessary to explore what proportion of referrals from NRUs eventually becomes enrolled into CTC programs.
    - Referrals between children enrolled in the CTC program to the supplementary feeding program appear to be problematic with little certainty whether referred children become enrolled into the program they are sent to. Approximately 41% of OTP discharges between July 2006 and January 2007 proceeded to supplementary feeding programs. Even more problematic is the management of children once they exit the CTC of SFP programs – especially in a context where general food support schemes are managed through district assemblies.
- *Targeted Nutrition Program (TNP) forums at district level may strengthen nutrition program management.* At the onset of the program, DHMTs and MSH recognized partnership opportunities which had not been sufficiently utilized to promote preventive and curative nutrition initiatives. This lead to the re-vamping of inactive TNPs to share nutrition and food security information and strategies. The forum is strategically chaired by the District Commissioner, who is the custodian of development programs. Although districts TNPs are not able to meet on a regular basis, informal contacts in the districts have been well established and impact of this partnership is seen through a broader understanding of nutrition issues among different players who include NGOs and the faith community. In future it may be a strategic option to strengthen district-level TNPs.
- *Implementation of this program has had shortfalls in coverage*. A limited number of health centres were included into the program (59 out of a total of 118). There is a need to expand CTC to a majority of health centres in each district. Only two of the five districts were able to provide OTP services to a majority of government and mission facilities. Many care givers continue to walk long distances to the nearest OTP centre. It may be feasible to provide services at health post level through the use of HSAs – this would enable easier access for communities located far from health centers. Unavailability of CTC in health facilities within a district created monitoring and supervisory problems when children from non-serviced catchment areas sought OTP care without the necessary follow up support. Such children were often statistically "lost" and caused gaps in the reporting system. The solution would be to standardize nutritional services in all facilities in a district.
- *Ongoing need to refresh staff in CTC.* There is a high level of staff turnover in MoH and CHAM facilities. The result is a continuous need to provide orientation to new staff as they join government and mission facilities. Only one district has shown interest in using government resources to provide CTC skills to new staff members.
- *Further steps are required to ensure program sustainability.* Whilst a foundation has been laid for CTC sustainability, there are gaps to be filled, mostly in terms of securing funding for RUTF. The Clinton/Hunter Foundation contribution is a short term solution. DHMTs have been assisted to budget for the procurement of RUTF. However, more follow up discussions and planning are required to ensure the districts will be ready for this major responsibility. DHMTs still need to show that they are committed to supervision of CTC and other nutrition activities from the district to household level. It is anticipated that MoH will be recruiting district nutritionists and NGOs will need to assist will CTC capacity building of the new staff, especially considering that the staff with minimal nutrition background might be recruited.

# Annex: Cumulative CTC Data

| CTC Summary Data Sheet February 2006 – January 2007 | | | | | | |
|---|---|---|---|---|---|---|
| | **Balaka** | **Chikwawa** | **Mulanje** | **Mzimba** | **Salima** | **Total** |
| **Objective 1: To ensure that 60 newly established OPT points are able to implement CTC** | | | | | | |
| Number of facilities implementing CTC | 11 | 12 | 10 | 13 | 13 | **59** |
| Total # Persons trained | 639 | 853 | 579 | 745 | 1,023 | **3,839** |
| # Central level (national TOTs) – additionally 4 central level staff trained. | 3 | 3 | 3 | 3 | 3 | **19** |
| # District trainers trained | 16 | 15 | 15 | 15 | 15 | **76** |
| # HC staff trained | 165 | 225 | 150 | 159 | 181 | **880** |
| # volunteers trained | 220 | 300 | 200 | 300 | 526 | **1,546** |
| # Local Leaders trained | 220 | 300 | 200 | 260 | 287 | **1,267** |
| # DHMT members oriented | 15 | 10 | 11 | 8 | 11 | **55** |
| Amount of RUFT provided by district (kg) | 8,193 | 9,035 | 10,348 | 7,154 | 8,584 | **43,314** |
| # Motorcycles provided | 1 | 1 | 1 | 1 | 1 | **5** |
| # Storage cabinets provided | 13 | 9 | 9 | 0 | 13 | **44** |
| # Heights boards provided | 13 | 19 | 16 | 15 | 17 | **80** |
| # MUAC tapes provided | 220 | 300 | 200 | 300 | 526 | **1,546** |
| # scale provided | 14 | 17 | 16 | 18 | 17 | **81** |
| # Facilities reporting stock outs of *Chiponde* during last quarter | 0 | 0 | 0 | 0 | 0 | 0 |
| **Objectives 2: To ensure that the intervention enrolls 65% percent of estimated severely malnourished children into the CTC program** | | | | | | |
| Estimated # malnourished children (2% of children under 5) | 1,036 | 1,408 | 1,671 | 2,403 | 1,257 | **7,775** |
| Estimated # SAM through UNICEF survey | 1,502 | 1,830 | 3,509 | 2,884 | 3,079 | **12,804** |
| # Children entering CTC program (February 2006 – January 2007) | 997 | 1,007 | 1,605 | 1,067 | 881 | **5,557** |
| # Children cured (aggregated all ages) | 593 | 688 | 1,113 | 841 | 486 | **3,721** |
| # Children who die (aggregated all ages) | 19 | 16 | 33 | 18 | 18 | **104** |
| # Children who default (aggregated all ages) | 105 | 72 | 102 | 66 | 95 | **440** |
| # Children followed up in the community (MoH staff or volunteers) | 388 | 65 | 756 | 133 | 266 | **1,608** |

| CTC Summary Data Sheet February 2006 – January 2007 | | | | | | |
|---|---|---|---|---|---|---|
| | **Balaka** | **Chikwawa** | **Mulanje** | **Mzimba** | **Salima** | **Total** |
| **Objectives 3: To facilitate the development of an effective referral system for malnourished children various feeding program** | | | | | | |
| # Monthly District Targeted Nutrition Meetings | 3 | 2 | 4 | 2 | 3 | **14** |
| # Malnourished children from OTP referred for supplementary feeding/ general food distribution scheme | 170 | 99 | 436 | 70 | 122 | **897** |
| # Moderately and severely * malnourished children who enter the general food distribution scheme. | | | | | | |
| # of children referred from OTP to NRU hospitals for admission | 15 | 7 | 39 | 4 | 20 | **102** |
| Number of children referred from NRU/Hospitals to OTP | 43 | 131 | 59 | 89 | 76 | **398** |

* Data on general food distribution not available. Relief activities were ad hoc, temporary, available at a very small scale and coordinated through a separate department.

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**Guidelines for Volunteers Implementing CTC in the Communities – Tumbuka Version**

Aim of volunteers training is to help volunteer identify, refer a malnourished child and follow up a child receiving RUTF

A description of a malnourished child and the meaning of CTC, and RUTF

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- Calling for a meeting with chiefs and the community members and explaining what CTC and RUTF is, the importance of RUTF to a malnourished child and, the role and responsibility of the mothers, chiefs and the community members in the implementation of CTC.
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- Referring a malnourished child to a facility
- Follow up the child to see the progress of treatment and give advice on feeding practices.

# Kapwelelero ka Chimphonde Kwali Chibwandira pa Kaya: Uthenga kuẅapapi

- Chibwandira ncha mwana yekha uyo wambako kutupa panji kughanda chomene chifukwa chakuperewera vyakurgha mu thupi (kunyentchera)
- Sungani chimphonde pa malo ghambula chithukuzi. Malo agho ghangawanga na tunyerere chara.
- Pambele wandakhwase chimphonde, mupapi wageze maoko makora na sopo. Wamugegese mwana mawoko na kumuso wuwo na maji ghaweme na sopo. Mwana uyo wakurgha yekha wakwenera naye kugeza makora mawoko na pamaso.
- Vundulani chibwandira makora na sipuni yitaliko kuti yifike pasi pa botolo. Chibwandira china mafuta ghanandi. Nchiweme kuti mafuta agha ghaskazike makora mupaka pasi kuti mwana waleke kurya vimafuta pera.
- Ẅana ẅalwari ẅakukananga kurya chakurgha. Ntheura, mupani chimphonde pa choko Pachoko kananadi pa zuwa muhanya na usiku wuwo.
- Lawisiskani kuti mwana wargha chimphonde chakukhumbikira pa zuwa liri lose nga umo dokotala Wachiziya wayoboyera.
- Lutizgani konkhesa mwana uyo wachali pa bele.
- Pakurgha chimphonde, mwana wamwengeso na maji pafupi pafupi. Maji agha ghawe ghakubwatuska na kupozga makora. Kweneso mumalo mwakubwatuska maji, mungamanya kuẅika munkhwala wa maji wula ukuchemeka chlorine panji water guard. Maji agho ghasungikenge pamalo ghaweme.

***Agogo awa bakugeza maghoko nyengo yonse pambele adaleske mwana chibwandira***

- Para mwana wangafumira, lutizyani kumuliska chimphonde na kumumwesa maji ghanandiko. Kwene para kupesa kwalutizga, rutani nayo mwana kuchipatala.
- Mwana mulwari wakusawa chara kupima. Ntheura muvwalikani malaya ghakuthukizga thupi nyengo zose.
- Para mukufumapo pa nyumba na mwana, yeghani chimphonde chake kulingana na umo mubukulengepo kwali nkhu visopo, kuzowola, kunyifwa manyi nkuchipatal, kakani ka chibwaila ka chimphonde cha mwana.
- Sungani chimphonde pamalo patali na mawoko gha wana wanyake panyumba
- Mwana wangarghanga vyakurgha vinyake chara mupaka apo wayowoyelenge dokotala kuchipatala.
- Para mwana wakurgha makora yayi, panji wakukana chimphonde, wererani nayo kuchipatala mwa luwiro.

## Kumbukani kuti chimphonde ni munkhwala wa mwana uyo ni mulwari. Chimphonde ichi ncha mzinda chara.

# Milimo gha Ẅakujipeleka ẅa Ntchito ya Kovwira Ẅana ẅakupelera vya kurgha

### Kasi Kunyentchera ni vichi?

Kunyentchera ni matenda agho ghakwiza para mwana waperewera chakurgha cha magulu sikisi (ghankhondi na limoza) muthupi lake. Magulu agha ni (1) vyakulya vykupeleka nkhongono nga sima, vikhawu/mayawo, mboholi, mpunga (2) vyakurgha vyakukuzga thupi vya nyama nga somba nyama, mkaka (3) vyakurgha vya kukuzga thupi vya kumunda nge ntchunga, zgama, skawa, ndozi zakomila, nkhunde (4) vyakurgha vya kupeleka mafuta nge ni mafuta ghakuphikila, majarini, nthendero (5) vyakurgha vyakuvikiliya matenda nga mphangwe chomene chomene mphangwe zakubiriwira (6) vyakurgha vyakuvikilira matenda vya vipaso vyakupambanapana

### Ẅakujipereka Wamanye Ivyi Kukhwasana na Chimphonde

Ẅakujipeleka wakwamba ntchito yawo pakuwamanyiska wanthu muchikaya pa ungano uwo ukuchemeka na ma vileji (mafumu). Pa ungano uwu, ẅakujipeleka ẅakuwamanyiska wanthu vya:

- Chakulata chakupereka chimphonde ku ẅana wakunyentchera
  - Chimponde cha kuchipatala ni Munkhwala agho ghana vyose ivyo vikusangika para mwana wargha chakurgha cha magulu sikisi
  - Chimphonde ichi chikuwezera muthupi ivyo vyaperera chifukwa chakutondeka kurgha makora vyakurgha vya magulu sikisi.
- Umu chimphonde cha munkhwala ichi chikupambanira na chimphonde cha kukaya. Chimphonde ichi chinankhongono chifukwa ẅalikuyikamo: skawa, mkaka, shuga, mafuta gha kuphira na ma vitamini na tumchere icho pachingelezi ni minerals

*Ẅakujipeleka ẅa ku Mbalachanda pa visambizgo vya chimphonde*

- Uweme wa chimphonde kulinganisya na soya (Likuni phala panji mukaka wa ku wodi lamagulu)
  - Chimphonde chichoko waka chikuwezera muthupi nkhongono kujumpha umo mwana wangasangira ku soya.
  - Kasipuni kamoza pera kachimphonde kakupeleka twakukhumbikira muthupi kwakulingana na kabakuli ka bala la soya. Chifukwa nchakuti mu chibwandira, walikuyikamo tuvyakurya tunandi twa kasintha-sintha nga umo tayowoyera pafundo iyo tawazga kale.
- Kuti nchito ya chibwandira cha munkhwala ilutize makora pa nthazi, ẅakujipeleka wose ẅakwenela kukolerana makora na ẅalongozi na ẅapapi wose muvikaya.
- Kuti chibwandira ni munkhwala uwo ukuwezera kukula makora kwa mwana wakunyentchera.

**Skills Required By a Volunteer in the Community**

Children who are well fed i.e. the six food groups, and have received all the necessary vaccinations in good time, grow healthy.

Apart from other reasons, children more the 6 months get malnourished because of low food intake.

A volunteer should know malnutrition and its causes for him/her to be able to give good advice to the community members.

Some of the reasons why a child does not eat the six food groups are inadequate food for the household, loss of appetite due to other diseases e.g. HIV/AIDS and other diseases.

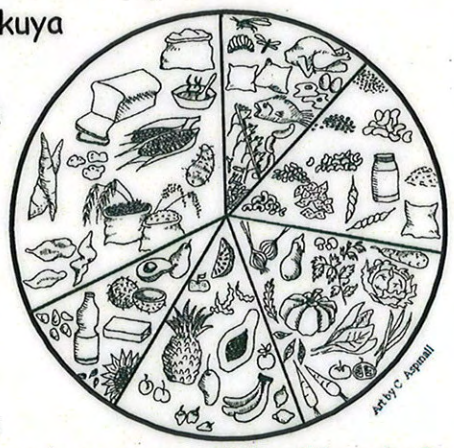
# Mfundo Zomuyenereza Volontiya Woyangánira Ana Onyentchera Kutumikira Dera Lake Bwino

## Volontiya adziwe izi za mwana wa Thanzi

- Mwana amene amadya chakudya chokwanira cha m'magulu asanu ndi limodzi nthawi zonse amakula bwino ndipo zizindikiro zowonetsa kuti akusuntha pa nthawi yake sizisowa; monga kusekerera, kukwawa, kuima, kuyenda, kuthamanga, kuitana maina amene amawamva panyumba, kusewela ndi zina zotele.
- Thupi la mwana amene amadya mokwanira limakhala la thanzi ndipo sikawiri kawiri kuti adwale maka ngati akulandira katemela wa ana pa nthawi yake.
- Magulu asanu ndi limdodzi a zakudya amene mwana amayeyenera kulandira tsiku liri lonse ndi awa:

## Magulu asanu ndi limodzi a zakudya

1. Gulu la zakudya zopatsa nyonga monga nsima, mpunga, chinangwa, mbatata, mkate
2. Gulu la zakudya zomanga thupi kapena kuthandiza kukuza thupi zochokera ku nyama monga nsomba (usipa, utaka, mlamba, nkhanu), kalulu, nyama (ya mbuzi, n'gombe, nkhumba, ya mtchire), nkhuku, baka, mazila, mkaka
3. Gulu la zakudya zomanga thupi zochokera ku kumunda monga nyemba, soya, mtedza, nandolo Wowuma, khobwe, nsawawa zowuma
4. Gulu la zakudya zothandiza kuteteza matenda komanso kusalalitsa khungu. Gulu ili limapezeka kwambiri mu ndiwo za masamba obiriwira monga nkhwani, khwanya, chisoso, kholowa. Komanso zakudya za kachaso wakuya monga karoti ndi maungu zili mugulu limeneli.
5. Gulu lina la zakudya zothandiza kuteteza matenda komanso kusalalitsa khungu. Gulu ili limakwanilisidwa ndi zipatso makamaka zipatso zobiriwira monga papaya, mango, malalanje. Zina ndi nthochi, mapichesi, mapulamu ndi zipatso zina za kutchile mu madela osiyanasiya
6. Gulu lopeleka mafuta monga mafuta ophikila, majarini (margarine), palm oil ndi coconut kumene amapezeka.




***Magulu asanu ndi limodzi a zakudya. Kodi Mungathe kuwatchula?***

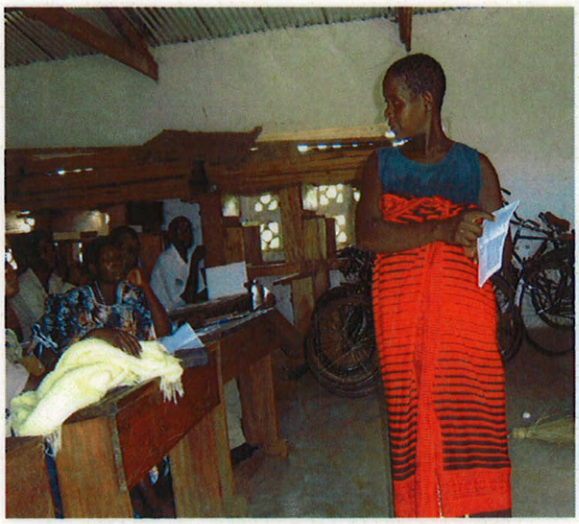
## Kodi Nanga ndi chifukwa chiani ana ena amanyentchera?

Mwa zina zimene volontiya angalongosolere m'mudzi za m'mene mwana amepezeka kuti wanyentchera kapena kutupikana:

- Mwana akanyentchera kapena kutupikana, ndiye kuti thupi lake likupelewera zakudya za magulu ena zimene zimafunikira kuti mwana amene wakwanitsa miyezi isanu ndi umodzi ndi kupitilira, adye mokwanira, malingana ndi muyezo, wake tsiku liri lonse.

- Pali zifukwa zosiyana siyana zimene zimachitisa kuti mwana alephere kupeza chakudya chomuyenereza kuti thupi lake likule moyenera.
- Volontiya amayenera kudziwapo za kunyentchera kapena kutupikana kuti akwanilitse kulangiza ndi kuthandiza abale a m'mudzi popewa kapena pochilitsa kunyentchera ndi kutupikana.

## Zina zimene zimalepheletsa mwana kudya mokwaniritsa magulu asanu ndi limodzi



*Volontiya uyu Ku Mchoka ku Salima akukumbutsa mavolontiya anzake za kasamalidwe ka wana*

- Kusowa chakudya chokwana kapena choyenera pa banja: volontiya ndi eni myumba kuti awunike chifukwa chake chimene chakudya chilichosakwanira pakhomopo.
- Kusasamala chakudya chikakololedwa monga kuthera kukonzela maphwando.
- Kulephera kukonza ndi kuphika bwino zakudya za pa nyumba monga ngati kusagwirisa ntchito soya pakhomo ngakhale kuti soya anakoleledwa mokwana.
- Kuleka kuyamwitsa mwana mosampatsa mwana uja mpata wokonzekera kusiya bele.
- Kubeleka pafupi pafupi kumene kumam'bera mayi nthawi yoti akalere ana ake.
- Matenda pafupi pafupi amasokoneza chilakolako cha chakudya mpaka mwana uja amofooka ndi kuyamba kukana kudya. Voluntiya apa ayenera kusindikiza za ubwino ndi kufunikira koti ana a angóno angóno azigona mu ukonde kapena neti yonyikidwa mu mankhwala usiku uli onse. Izi zimathandiza kupewa malungo. Komanso, volontiya amasindikiza kuti ngati mwana wadwala malungo, apatsidwe mankhwala oyenera, mwansanga nsanga ku chipatala.
- Ana ambiri amatupikana akakhala kuti atsegula pa kanthawi. Zifukwa zotsegulira m'mimba ndi zambiri kuphatikizapo kusowa ukhondo pa nyumba. Chifukwa cha ichi, volontiya ayenera kulumikiza malangizo a ukhondo ndi kaleredwe kabwino ka mwana.
- Chifuwa chachikulu ndi matenda amene mwana amatengela kwa mai wake monga HIV/AIDS nawonso amafooketsa thupi ndi kuchotsa chilakolako cha kudya. Volontiya ayenera kuthandizana ndi banja la mwana woteroyo pomutumiza mwana uja kuchipatala mwansanga komwe volontiya naye akalandira uphungu wodyetsela ndi kasamalidwe kamwana wodwalayo.

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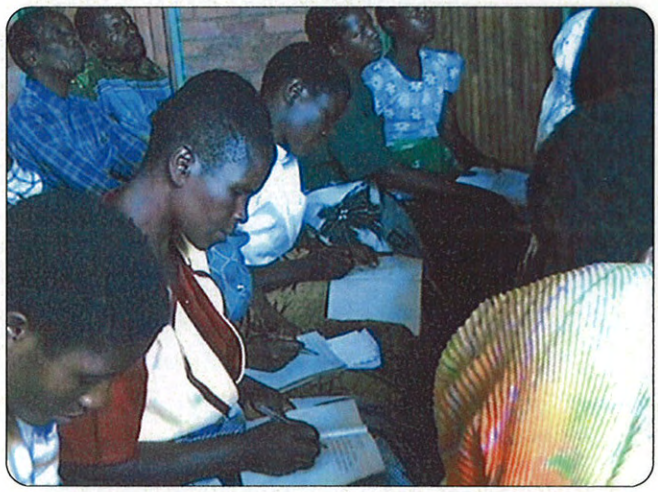
# Maphunziro A Mavoluntiya
# Pa Ntchito Zotukula Umoyo Wa Ana

## Cholinga cha Maphunziro

Kuthandiza ma voluntiya kuti athe;

- Kupeza mwana onyentchera
- Kumuyeza ndikuona ngati ali oyenera kulandira chiponde.
- Kulemba makadi
- Kutumiza mwana kukalandira chiponde kapena kukaonedwa ndi a Dotolo



*MaVoluntiya pa Maphunziro ku Chambe, Mulanje.*

## Zoyenera Kudziwa Volontiya

Kodi kunyentchera ndi chiani?
Awa ndi matenda amene amadza chifukwa choperewera chakudya choyenera komanso chamagulu onse asanu ndi a modzi (6) mthupi

Kodi nanga tanthauzo la Community Therapeutic Care (CTC) ndi chiyani?

- Community - Kumudzi
- Therapeutic - Kuchiza
- Care - Chisamaliro

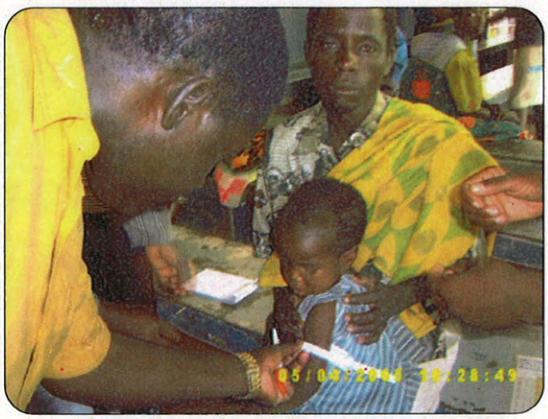
## Mutu Oyamba: Kuitanitsa Msonkhano

Tiyenera kuitanitsa misonkhano mwa atsogoleri monga mafumu. Pa nsonkhano anthu tiwadziwitse za chiponde:

- Kuti kodi chiponde ichi ndi chiyani ndipo chasiyana bwanji ndi chiponde cha kumudzi.
- Ubwino wa chiponde ku umoyo wa mwana wonyentchera
- Ubwino wa chiponde posiyanitsa ndi zina monga soya kapena kukagonekedwa ku chipatala.
- Udindo wa makolo pa kasamalidwe ka chiponde ku nyumba.

## Kupeza Mwana Onyentchera

Mwana onyentchera tingamupeze kuchipatala kapena kumudzi; amaoneka pa maso kuti ndi onyentchera:



*Chithunzi: Kuyeza mwana ngati ali wonyentchera ku Mchoka, Salima*

- Tikamuona tiyenera kumuyeza pa sikelo (weighing scale)
- Timuyeze mwamba la dzanja la kumanzere (Mid Upper Arm Circumference-MUAC) ngati ali opitirira miyezi khumi ndi iwiri (12 months)
- Timuyezenso utali wa thupi lake (height) pa Thabwa loyezerapo (height board)
- Ngati tilibe zipangizo maka maka MUAC tape, tionetsetse kuti makolo amutengere mwana ku chipatala cha dera lathu kuti akayezedwe komanso kupimidwa.

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MSH MANAGEMENT

### Kumuyeza Ndikuona Ngati Mwana Ali Oyenera Kulandira Chiponde

Mwana yemwe angalandire chiponde ndi yemwe

- Wayezedwa mkono (MUAC) ndipo yakwana 11cm kutsikira mmunsi. Chitsanzo 10.8cm, 10.5cm, 10.0cm
- Wayezedwa pa thambwa lopimila utali wa mwana (height board) ndipo yakwana 70% kapena kutsikirapo, chitsanzo 69%, 65%, 60%.
- Mwanayo ndi wotupikana (Oedema)

### Kulemba Makadi

Kuyambira pokweza sikelo, voluntiya ayenera kulemba bwino zomwe wapeza pa sikelo polemba mu buku kapena registala yomwe walandira, komanso polemba mu Khadi ya mwana. Akuyenera kutero kuti apewe

- Kupatsa chiponde mwana osayenera
- Kubweza mwana woyenera kulandira chiponde

### Pofuna kupewa zimenezi ayenera

- Kutenga MUAC bwino lomwe
- Kutenga utali (height) bwino lomwe

### Kutumiza Mwana Kukalandira Chiponde Kapena Kukaonedwa Ndi A Dotolo

- Tumizani mwana yekhayo amene mutamuyeza muli naye chikhulupiriro kuti alandira chiponde.
- Tumizani mwana yemwe ali ndi mavuto ena omwe angafunike a dotolo, monga mwana yemwe akuoneka ndi zironda mthupi.
- Potumuza mwanayo musauziretu kholo lake kuti akukalandira chiponde chifukwa mwina atha kukabwezedwa ngati simunayeze bwino MUAC, msinkhu, ngakhalenso sikelo imene.

### Kalondolondo

- Ma Voluntiya chitani kalondolondo kwa mwana aliyense yemwe munamutumiza ku chipatala.
- Kaoneni ngati akutsatira zomwe munamuuza
- Ngati sakutsatira mukumbutseni zonse
- Chitani izi kufikira mwanayo atachira.
- Muyenela kudziwa nambala:
  - Chiwelengelo cha ana osaposa zaka zisanu
  - Kuchuluka kwa ana onyentchera mdela lanu
  - Kuchuluka kwa ana amene ali pa pologilamu ya chiponde mdela lanu


*Mmudzi mwa Kalembo, Balaka. Kodi nanga ana osapitilira zaka zisanu ndi angati mmudzi wanu?*

## Tiyeni tilimbikire kuti tichepetse chiwerengero cha ana onyentchera kudera lathu

# Module 4
# Case Studies

Case Study No. 1 – The Gatekeeper

We were able to set up the supplementary feeding station at the village health clinic. It had the biggest yard in the village, surrounded by a live fence. We pitched the temporary tent just inside the gate to the compound. When we first arrived to set up the station, a crowd of women started collecting, curious to see what we were doing. Many of them had children that were seriously malnourished. As they saw the delivery truck pull up to the yard, they became more restless, surging forward, hoping to be first in line to have their children weighed and admitted to the program.

"Get away!" yelled Mr. Kiugu, the old gatekeeper, dressed in a faded military uniform. As he yelled at the women, he brandished a leather whip, and cracked it in the air. "Back, back!" he yelled. The crowd of women parted before him, as he grabbed one of them by the arm and threw her and her baby into the dust outside the fence. "Go away, you baby looks fine!" He stood in front of the gate, and continued to crack the whip. "You," he called out to one of the women cowering in front of him, "You and your baby can go in." She disappeared inside the compound.

Question: Identify the violations of rights.

Case Study No. 2 – The Missing Person

I was registering people for the feeding program. I sat at a bench and marked the names of mothers who came in with their children, one by one. During my break, I went for a walk around the village. I chanced to see a poor woman carrying her malnourished child. "Why aren't you at the feeding station?" I asked her. She looked at me and shook her head.

"The one at the clinic? No, that's for the Kikuyu people," she said. "I am a Luhya."

"Who told you it was for the Kikuyus?" I asked. "It's for everyone in the village."

A policeman was walking by at that moment. "You don't have to concern yourself about her," he called to me. "She's crazy! She has people to take care of her." He walked up to us. "You don't need food, do you?" he said to her, his eyes fixed on her eyes.

"No, sir," she said. "Sorry, sir." She walked carefully away.

Question: Identify the violations of rights.

Case Study No. 3 –

The long line of men and women had snaked through the yard of the feeding station all morning. As there were no trees in the yard, many of the mothers were seated on the ground with their children, fanning them with leaves.

Ngugi, our project Administrator, had been registering people underneath the terrace of the health center. He was drinking a Coke that he had on the table, as he slowly copied down each recipient's information in his methodical manner. He leaned back on the bench and stretched his arm up to look at his watch. "Time for lunch!" he sighed, and yawned. Without finishing with the person at the desk in the middle of registering, he got up and walked off, taking his Coke with him. The people in the yard watched him walk away.

Question: Identify the violations of rights.

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FROM THE AMERICAN PEOPLE

# SUCCESS STORY

# Community Mobilization for Child Nutrition

## Through USAID-funded programs, Malawi is helping rehabilitate malnourished children

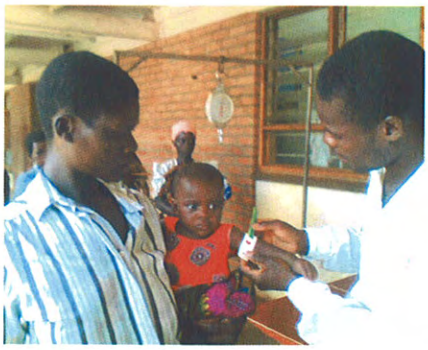

Photo: Margaret Khonje, Management Sciences for Health

Mr. Simoke volunteers his time at the out-patient therapy clinics where he teaches other parents about nutrition and options for treating children for malnutrition.

*Through support by USAID, Mr. Simoke stresses the importance of male caretakers in the community and has helped make the community-based therapeutic care (CTC) program a credible and trusted system of care in his community.*

Three-year-old Grace Simoke was a bouncy toddler until December 2005 when she developed a fever and signs of malaria. Weeks later, Grace's condition worsened when frequent vomiting and loss of appetite left her weak and swollen. Her father, Mr. Simoke, was discouraged by friends from using western medicines, which were thought to cause further harm. For six months, Grace was kept at home because her parents believed the hospital would worsen Grace's illness.

As Grace's condition deteriorated, Mr. Simoke made the difficult decision to take her to the USAID-funded outpatient therapeutic program (OTP) at a nearby hospital. The OTP is part of a newly developed community-based therapeutic care (CTC) program, which provides severely malnourished children with Plumpy Nut peanut butter, a ready-to-use food fortified with essential vitamins, minerals, fats, and calories. Plumpy Nut production in Malawi is the result of a USAID Global Development Alliance project and has been highly successful thus far. Approximately 80% of malnourished children fully recover as a result of Plumpy Nut therapy. The OTP also provides parents with nutritional education on early detection of malnutrition and how to provide their children with nutritious food year round.

At the health center, Mr. Simoke realized that the nutritional program was helpful, not harmful. Mr. Simoke quickly became an advocate of the program in his village. For the next five weeks, he returned to the clinic every Tuesday to replenish his daughter's supplements and learn more about malnutrition, how to detect it, and what the available treatment options are.

Community mobilization is just one component of the holistic, CTC program that is being implemented under USAID to increase the demand of nutritional support in Malawi. In districts where malnutrition rates are very high, entire networks of community members are receiving training and education on nutrition. By expanding the knowledge beyond the health center, children have a better chance of being identified earlier for nutrition programs. With USAID funding, over 1,200 volunteers in the region have been trained on how to identify children with severe and moderate malnutrition and how to manage the children's treatment at home.

Prior to the introduction of the CTC program, a limited number of children were able to access the nutritional rehabilitation units in their districts. Access to the units was limited because they were geographically inaccessible to communities and the programs were too time intensive for most families to commit to. Since the start of the CTC program 4870 children have benefited.

A year later, Grace is a healthy little girl full of energy, but she is not the only person who has benefited. Today, Mr. Simoke is a CTC volunteer who has helped make the program a credible system of care in his community available to everyone.

USAID | MALAWI
FROM THE AMERICAN PEOPLE

# SUCCESS STORY

# Program Saves Malnourished Children

## USAID-funded outpatient therapeutic program provides parents with options to keep their children healthy

Photo: Margaret Khonje, Management Sciences for Health

Mwangodana's mother feeds her Plumpy Nut, or Chiponde, as it's known in Malawi. Plumpy Nut is a ready-to-use food, enriched with nutrients, used to treat children for malnutrition.

*Providing parents with an out patient therapy option for treating their children for malnutrition relieves parents of the burden of traveling long distances, leaving other children with neighbors or friends, and exposing their children to illnesses once at the clinic.*

Just over a year ago, two-and-a-half year old Mwangodana came to her local health center with her mother; she was weak and suffering from malnutrition. After reviewing her symptoms, the medical assistant on staff immediately registered Mwangodana for the center's outpatient therapeutic program (OTP) for malnutrition. The district of Salima in central Malawi, where Mwangodana lives, has some of the highest rates of malnutrition in the country. Luckily for Mwangodana, she and her family now have access to an OTP in her community. Today, with support from USAID, nutrition programs have been decentralized to local health facilities, providing families with much greater access to care and treatment for malnutrition.

Although malnutrition has been a challenge in Malawi for decades, nutrition programs have traditionally been in hard-to-reach locations and have required patients to be admitted for long periods of time. This approach placed a great deal of stress on families who could not travel long distances to nutrition rehabilitation clinics or be away from home for weeks at a time. To address this, Management Sciences for Health, in partnership with District Health Management Teams, local organizations, and with support by USAID, has helped five districts decentralize their nutrition programs from one hospital location to 60 local health centers. Health staff at each location has received updated training on how to identify cases of malnutrition, prioritize referrals based on need, and register children with severe malnutrition but without complications to an OTP which can be implemented at home.

At each health center, parents now have access to up-to-date resources and instruction on how to treat malnutrition at home with the use of Plumpy Nut peanut butter, a ready-to-use food fortified with essential vitamins, minerals, fats, and calories. Plumpy Nut production in Malawi is the result of a USAID Global Development Alliance project and has been highly successful thus far. Approximately 80% of malnourished children fully recover as a result of Plumpy Nut therapy. Shifting treatment for malnutrition from a formal, time-intensive nutritional program to an OTP relieves parents of the burden of traveling long distances, leaving other children with neighbors or friends, and exposing their children to illnesses at the clinic.

In each health center providing OTP, MSH provided staff training on how to examine and classify stages of malnutrition while educating and mobilizing communities to identify malnutrition early. Health staffs were also provided resources to pass on to parents and non-health staff who act as an extension of the health community. Teachers, social welfare workers, religious leaders, and local farmers are all receiving education and information on how to detect and treat malnutrition. By broadening education to larger circles of within the community, early identification and referral of malnourished children becomes more successful.

Subsequent follow-up visits to Mwangodana's local health facility showed steady progress for her. With this new approach, nearly 75% of the Salima population has access to nutrition services, compared to 28% under the traditional approach. Mwangodana and over 4800 more children have combated malnutrition thanks to programs like this one.

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*Closing the gap between what is known about public health problems and what is done to solve them*

# Protecting Vulnerable People in Relief Situations: *Training and Discussion*

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## Workshop Introduction

- Purpose: To familiarize Project Staff with the concepts of protection in humanitarian settings and their application to the project context.

- Module 1: Introduction to Protection
- Module 2: Situation Analysis and Protection Assessment
- Module 3: Protection Planning
- Module 4: Responding to Protection Issues

- *Deliverables:*
  - Plan for protection assessment of project environment
  - Project activity plans with protection elements
  - Increased staff knowledge on how to respond to protection issues in the field

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Module 1

# Introduction to Protection

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## Module 1: Introduction to Protection

- Defining Protection
- The Aspects of Protection
- International Humanitarian Law
- The Protection Framework
- Summary & Questions

- *Learning Objectives:*
  - Understand protection in humanitarian contexts
  - Understand International Laws governing protection
  - Understand the protection aspects & framework

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## Module 1: The Aspects of Protection - Safety

Safety

- From Injury
- From Coercion
- From Abuse

Provide a context of safety for project activities

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## Module 1: The Aspects of Protection - Dignity

Dignity

- Respect
- Self-esteem
- Entitlement

Treat relief recipients as people entitled to respect and aid

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## Module 1: The Aspects of Protection - Integrity

Integrity

- Honesty
- Accountability
- Commitment

Relief recipients deserve to be treated fairly and with integrity

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## Module 1: The Aspects of Protection - Empowerment

Empowerment

- Ability
- Self-Reliance
- Knowledge

Relief recipients have the right and ability to make decisions over their own relief

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# Module 1: International Humanitarian Law

## Geneva Conventions & Additional Protocols

- Right to Life
- Right to legal personality
- Prohibition of torture, slavery, and degrading or inhumane treatment or punishment
- Right to freedom of religion, thought and conscience

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Module 1: International Humanitarian Law

## Who is responsible?

- States
- Mandated Special Agencies
  - Int'l Red Cross
  - High Commissioner for Refugees
  - High Commissioner for Human Rights
- Non-Mandated Agencies

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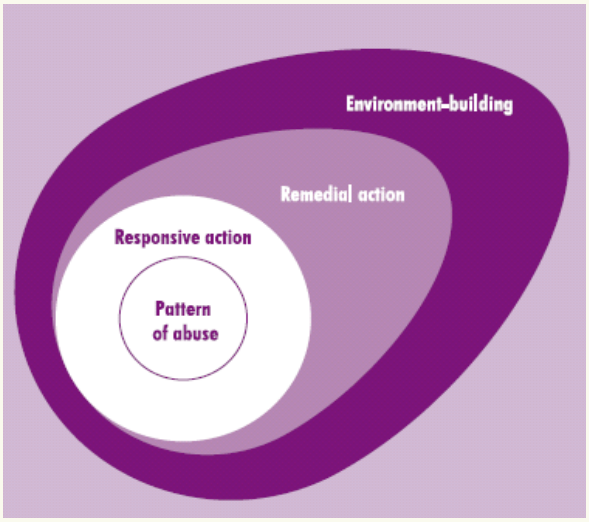
## Module 1: Protection Framework

- Responsive Action
- Remedial Action
- Environment-Building Action

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## Module 1: Key Points

- What is Protection?
- Safety, Dignity, Integrity, Empowerment
- Legal guarantees: Life, Legal Personality, Prohibitions, Freedoms
- Framework: Responsive, Remedial, Environment-Building

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Module 2

# Situation Analysis and Protection Assessment

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## Module 2: Situation Analysis and Protection Assessment

- What is a Threat?
- Introduction to Group Exercise: Protection Assessment
- Group Exercise: Protection Assessment
- Report-Outs from Group
- Summary

- Learning Objectives:
  - Identify specific threats to rights in environment
  - Understand questions to consider in protection assessment

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## Module 2: Situation Analysis and Protection Assessment

- What is a Threat?

Brainstorm on possible definitions & examples

A condition within the environment that could have a negative effect on the rights of the population in need.

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## Module 2: Situation Analysis/Protection Assessment

Key Questions for Information Gathering/Protection Planning (Checklist B)

- Nature, scope, of protection issues
- Who is most vulnerable?
- What are the patterns or motives in the protection issues?
- Who is responsible for protection issues?
- If confronted, what would perpetrators do?

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## Module 2: Situation Analysis/Protection Assessment

Assignment

- Answer the questions on Checklist B
- Discuss process for information gathering on these Protection issues

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## Module 3

# Protection Planning

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## Module 3: Planning for Protection

- Activities, Objectives and Outcomes
- Introduction to Group Exercise: Building Protection into Project Activities
- Group Exercise: Building Protection into Project Activities
- Report-Outs
- Summary

- Learning Objectives:
  - Understand Protection elements in Activities and Outcomes
  - Review and revise project activities

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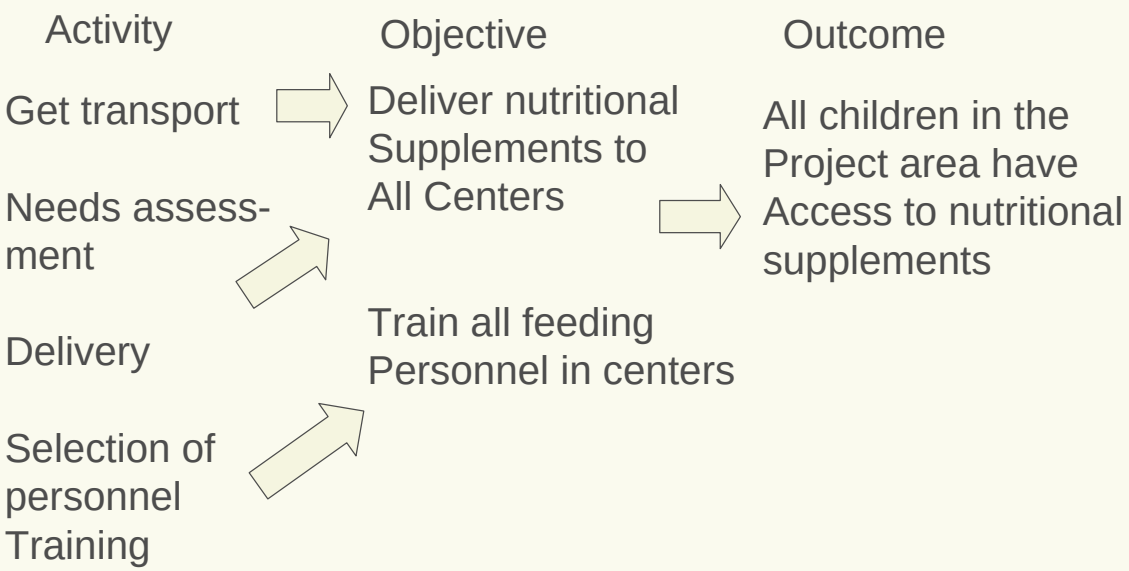
## Module 3: Building in Protection - Example



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## Module 3: Planning Protection Activities - Example

| Activity | Objective | Outcome |
|---|---|---|
| Get transport | Deliver nutritional Supplements to All Centers | All children in the Project area have Access to nutritional supplements |
| Needs assess-ment | | |
| Delivery | | |
| Selection of personnel Training | | |

Assure that recipients are included in the implementation of the needs assessment

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Module 3: Planning Protection Activities - Example

| Activity | Objective | Outcome |
|---|---|---|
| Get transport | Deliver nutritional Supplements to All Centers | All children in the Project area have Access to nutritional supplements |
| | Train all feeding Personnel in centers | |

Assure that traditional authorities are included in decision making for distribution

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## Module 3: Planning Protection Activities – Example

| Activity | Objective | Outcome |
|---|---|---|
| Get transport | Deliver nutritional Supplements to | All children in the Project area have |
| Needs assess-ment | | utritional s |
| Delivery | Personnel in centers | |
| Selection of personnel Training | | |

Assure that local transporters are awarded contracts

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## Module 3: Protection Activities - Example

| Activity | Objective | Outcome |
|---|---|---|
| Get transport | Deliver nutritional Supplements to All Centers | All children in the Project area have Access to nutritional supplements |
| Needs assess-ment | | |
| Delivery | | s |
| Selection o personnel Training | | |

Assure that traditionally underserved groups are included in distribution

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## Module 3: Planning Protection Activities - Exercise

- Break into groups
- Choose five project activities
- Review potential threats to beneficiary rights in these activities
- Review potential opportunities for enhancing safety, dignity, integrity and empowerment

- Return to plenary for report-out

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## Module 3: Planning Protection Activities - Summary

- Each activity, objective or outcome can be structured to enhance one or more aspects of protection for the recipient population

- When building in protection elements to activities, be realistic

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Module 4

# Responding to Protection Issues and Incidents

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## Module 4: Responding to Protection Issues and Incidents

- Modes of Action Framework
- Discussion: Sample Incidents/Case Studies
- Report Back
- Conclusion

- Learning Objectives:
  - Understand the different modes of action when faced with rights violations
  - Understand when to use different response styles when faced with rights violations

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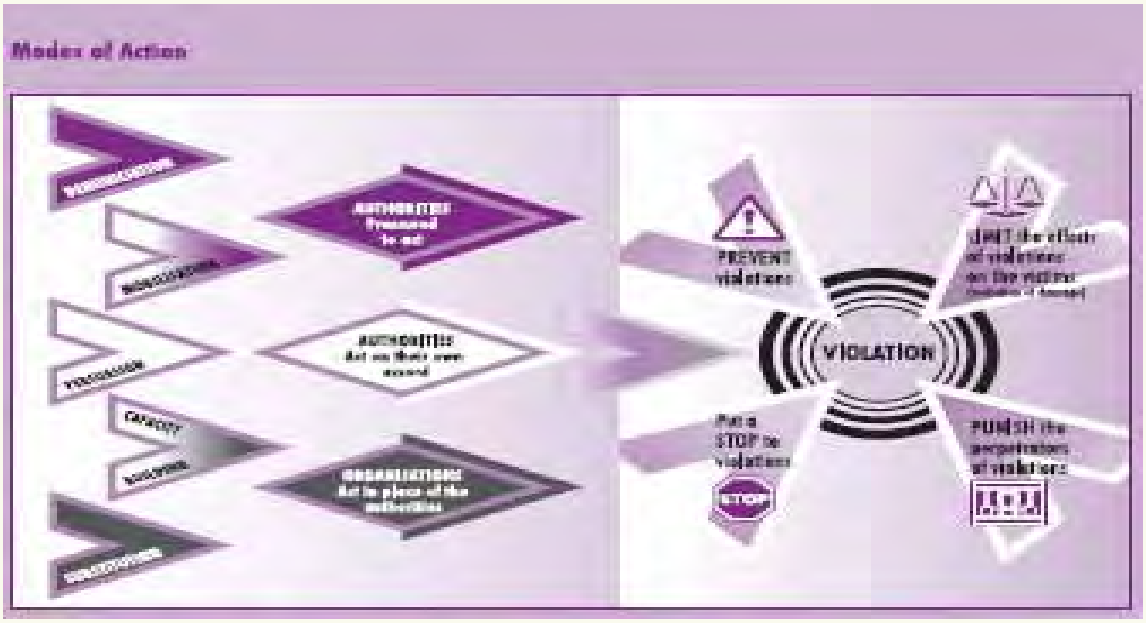
## Module 4: Responding to Protection Issues and Incidents

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## Module 4: Responding to Protection Issues and Incidents

Discussion: Sample Incidents/Case Studies

*Instructions to Group:* Take a case study and answer the following questions:

What mode of action would you use to support the protection of these people's rights?

To whom would you address this mode of action?

What are the negative consequences? For the people? For yourself? For the Project?

## Module 4: Responding to Protection Issues and Incidents

Summary

- The Five Modes of Action
- Response and the Consequences of Response
- Other conclusions from the Discussion

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## Conclusion

Key Points

- Safety, Dignity, Integrity, Empowerment
- Act at Response, Remedial and Environment-Building Levels
- Assess the situation, then plan for protection
- Build protection elements into existing activities
- Protect by denunciation, mobilization, persuasion, building capacity, and substitution

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*Closing the gap between*

*what is known about public health problems*

*and what is done*

*to solve them*

# MALAWI OFDA Project Protection Training – Facilitation Notes for Aforementioned Powerpoint

## *Workshop Introduction*

Powerpoint Slide No. 1-2: Welcome, Introduction to Workshop

## *Module 1: Introduction*

**Learning Outcomes:** At the end of this session, the participant will be able to -

- Demonstrate an understanding of the concept of protection in a humanitarian context
- Demonstrate an understanding of the basic International Laws governing protection
- Cite and explain the four aspects of protection

**Discussion:** This module introduces the conceptual framework for understanding protection as a cross-cutting project activity. The group will work to develop a working definition of protection and a conceptual framework for thinking about protection in relief situations. The facilitator will expose the group to a) the four aspects of protection (Safety, Dignity, Integrity and Empowerment); b) the key International Laws governing the application of these concepts in relief situations, and c) How these elements fit together into a framework for understanding protection.

| Timing | Activities | Notes | Materials/Personnel |
|---|---|---|---|
| | Defining Protection | 1. Introduce Module Activities and Learning Objectives<br>2. Brainstorming: the facilitator elicits free association on what the group's understanding of Protection is; this is captured on a flipchart<br>3. Consolidation: the facilitator works the group through the products of | Powerpoint Slides 3-4<br><br>Flipchart |

| | | | |
|---|---|---|---|
| | | the brainstorming to group the definitions in major categories. The facilitator's assistant captures the categories on a summary chart. | |
| | The Aspects of Protection | 1. Presentation: the facilitator gives an expository talk on the four aspects of Protection (Powerpoint Slides)<br>2. Discussion: facilitator elicits questions and clarifies meanings of aspects<br>3. Linkage: Facilitator goes back to brainstorm summary and connects concepts to what the group came up with. | Powerpoint Slides 5-8 |
| | International Humanitarian Law | 1. Presentation: facilitator gives expository talk on International Humanitarian Law (Powerpoint Slides)<br>2. Discussion: facilitator elicits questions and clarifies meanings of aspects | Powerpoint Slides 9-10 |
| | The Protection Framework | 1. Presentation: facilitator gives expository talk on Protection Framework (Powerpoint Slides)<br>2. Discussion: facilitator elicits questions and clarifies meanings of aspects | Powerpoint Slide 11 |
| | Summary | 1. Facilitator asks group: after what you've heard, what is your definition of Protection?<br>2. Facilitator asks group to summarize | Powerpoint Slide 12 |

| | | | |
|---|---|---|---|
| | | main points and asks for any further clarification | |

## *Module 2: Situation Analysis and Protection Assessment*

**Learning Outcomes:** At the end of this session, the participant will be able to -

- Identify specific threats to basic rights in the project operating environment
- Understand the questions to consider when carrying out a protection assessment

**Discussion:** this session is meant to be very practical, looking at the project operating environment, and identifying possible threats to basic rights as a results of the planned activities.

| Timing | Activities | Notes | Materials/Personnel |
|---|---|---|---|
| | IntroductionL: What is a threat? | Introduction to Module<br>The facilitator leads a discussion that identifies what a threat to basic rights might be. | Powerpoint Slide 13-14, 15 |
| | Introduction to Exercise: Distribute Checklist B | The facilitator makes sure that the group understands the elements of Checklist B | Powerpoint Slide 16-17<br>Handout: Checklist B (Photocopy Page 61 of ALNAP Guide) |
| | Group Exercise: Protection Assessment | The facilitator breaks the group into smaller groups giving them the instructions:<br>Answer checklist questions for project area<br>Come up with process for information gathering to answer questions in the field | Handout: Checklist B<br><br>Flipchart, markers |
| | Group Report-Out | | |

| | | | |
|---|---|---|---|
| | Summary | | |

## *Module 3: Protection Planning*

**Learning Outcomes:** At the end of this session, the participant will be able to –

- Understand the nature of building protection into activities and outcomes
- Review and revise project activities with protection elements

**Discussion:** This session will give the participants a chance to choose what types of protection outcomes are appropriate for the project area and population. These should respond to real needs of the population for protection, and should be within the project's control to bring about.

| Timing | Activities | Notes | Materials/Personnel |
|---|---|---|---|
| | Introduction: Outcomes, Objectives and Activities | Introduce Module<br>Facilitator leads a discussion about what outcomes, objectives and activities are in the context of the project; ask what project activities that are already planned have protection outcomes; how can we ensure that current project activities create protection outcomes | Powerpoint Slides18-19<br>Powerpoint Slides 20-24 |
| | Group exercise: Introduction | Divide the group into small groups; distribute project workplan; work through Powerpoint Example | Powerpoint Slide 25 |
| | Group Exercise | Review Project Workplan and come up with five protection enhancing elements that can be built into existing activities | Flipchart, Markers |
| | Group Exercise: Report-Out | | |
| | Summary | Facilitator summarizes main points of Protection Activity Planning | Powerpoint Slide 26 |

## *Module 4: Responding to Protection Issues and Incidents*

**Learning Outcomes**: At the end of this session, the participant will be able to –

- Understand the different modes of action when faced with rights violations
- Understand when to use different response styles when faced with rights violations

**Discussion:** While protection planning can prevent rights violations from occurring, sometimes it is necessary to deal with rights violations when they do occur. This session will allow the participants to understand the menu of options they have in humanitarian situations for influencing those who violate the rights of vulnerable populations.

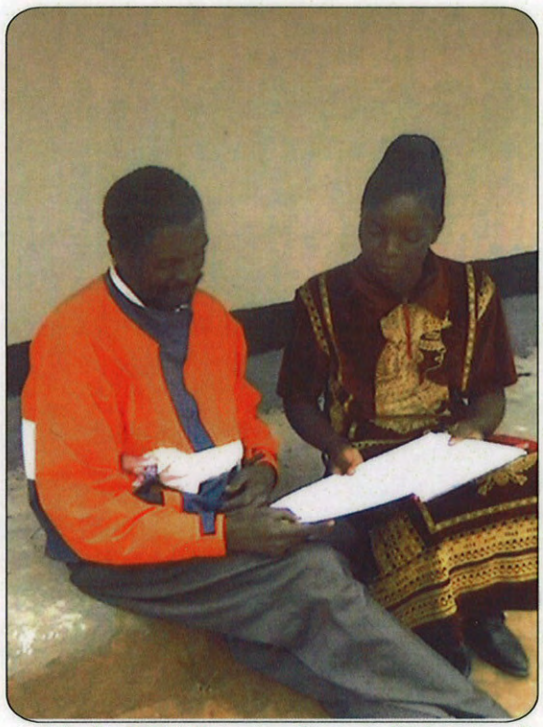
| Timing | Activities | Notes | Materials/Personnel |
|---|---|---|---|
| | Introduction: Modes of Action | Introduce the Module<br>Facilitator walks the group through the different modes of action, and elicits questions on when they might be appropriate in the project context. | Powerpoint Slides 27-28<br>Powerpoint Slide 29 |
| | Group work: Case Studies | Facilitator explains the group assignment, and the questions to answer. | Powerpoint Slide 30 |
| | Report Out | | |
| | Summary | | Powerpoint Slide 31 |

## *Conclusion*

Powerpoint Slide 32 - 33

# Supervising Community Volunteers In a Community Therapeutic Care Programme

Periodic monitoring and supervision is a key element in implementation of a community therapeutic care programme. The HSA is the frontline supervisor of community volunteers. The HSA prepares a programme For supervising CTC implementers in the community. This is done alongside other supervisory duties that need to be undertaken in the same community. This is necessary Because:



*A lady HSA Learns from a Volunteer's CTC Register*

- Joint supervision allows for proper and stronger linkages of interventions targeting the child.
- Joint supervision increases efficiency in time management of the supervisor as one visits covers more than one supervisory areas.

The HSA increases quality of supervision and obtains good results when a check list is used at each visit to the volunteer. The checklist below is suggested and it can be adjusted according To area needs and outcomes of previous supervisory results.

| | | Y | N |
|---|---|---|---|
| 1 | Does the volunteer know the number of <5 children in the area? | | |
| 2 | Does the volunteer know the number of children on OTP in the area? | | |
| 3 | Is the volunteer's register available and correctly used? | | |
| 4 | Does the volunteer have adequate supplies of case finding forms | | |
| 5 | Does the volunteer have adequate supplies of follow up forms | | |
| 6 | Does the volunteer have adequate supplies of referral forms | | |
| 7 | Is the volunteer able to translate information in the register and forms? | | |
| 8 | Does the volunteer get feedback on the referrals they make? | | |
| 9 | Does volunteer take action on defaulters and non-respondents? | | |
| 10 | Does the volunteer assist caretakers in keeping OTP appointments? | | |
| 11 | Is the volunteer able to counsel caretakers well? | | |
| 12 | Does the volunteer send reports to HSAs on time? | | |

# How to manage Chiponde at Home: A Message to the Care-giver

- In the house, keep chiponde on a cool dry place away from insects.
- Before touching the feed, wash your hands with clean water and with soap. also wash hands and face of an older child who self-Feeds.
- Sick children do not like to eat; give small feeds frequently through out the day and at night.
- Ensure child finishes the day's ration as instructed at the hospital.
- Continue to breast feed young child.
- While eating chiponde, child must also drink safe water that has been boiled and cooled or that has been protected with water guard (Chlorinated).
- If diarrhoea develops, continue to feed child with chiponde and give extra water. Take child to hospital immediately if diarrhoea continues.

*District Officers also take the lead in giving messages on managing chiponde at home like Balaka District DPD, Mr. Thyangathyanga and DHO Mr. Moses Mhango*

- Sick children get cold quickly. At all times, ensure child has warm clothing on.
- Carry chiponde with you if you are taking the child away from home for a long period e.g. to prayers, hospital, funeral, weddings.
- Keep chiponde out of reach of older siblings.
- Do not give other foods until instructed by your health worker. Report back to the health worker immediately if child is not eating chiponde well.

**Remember: Chiponde is a medicine to be eaten by the sick child only. Chiponde must not be shared**

# Table 1- Children

## Boys and Girls ( 49.0 cm -130.0cm). Weight for Height Look up Tables

**Weigth-for-Height, in % of the media, for children measuring less than 85 cm (measured in a reclined position) according to NCHS/ CDC/WHO (1982) values**

| | WEIGHT-FOR-LENGTH | | | | | |
|---|---|---|---|---|---|---|
| | | | | Malnutrition | | |
| Heigth | 100% | 85% | 80% | 75% | 70% | 60% |
| (cm) | In kg | in kg | in kg | in kg | in kg | in kg |
| .49.0 | 3.2 | 2.7 | 2.6 | 2.4 | 2.3 | 1.9 |
| 49.5 | 3.3 | 2.8 | 2.6 | 2.5 | 2.3 | |
| 50.0 | 3.4 | 2.9 | 2.7 | 2.5 | 2.4 | 2.0 |
| 50.5 | 3.4 | 2.9 | 2.7 | 2.6 | 2.4 | |
| 51.0 | 3.5 | 3.0 | 2.8 | 2.6 | 2.5 | 2.1 |
| 51.5 | 3.6 | 3.1 | 2.9 | 2.7 | 2.5 | |
| 52.0 | 3.7 | 3.1 | 3.0 | 2.8 | 2.6 | 2.2 |
| 52.5 | 3.8 | 3.2 | 3.0 | 2.8 | 2.6 | |
| 53.0 | 3.9 | 3.3 | 3.1 | 2.9 | 2.7 | 2.3 |
| 53.5 | 4.0 | 3.4 | 3.2 | 3.0 | 2.8 | |
| 54.0 | 4.1 | 3.5 | 3.3 | 3.1 | 2.9 | 2.5 |
| 54.5 | 4.2 | 3.6 | 3.4 | 3.2 | 2.9 | |
| 55.0 | 4.3 | 3.7 | 3.5 | 3.2 | 3.0 | 2.6 |
| 55.5 | 4.4 | 3.8 | 3.5 | 3.3 | 3.1 | |
| 56.0 | 4.6 | 3.9 | 3.6 | 3.4 | 3.2 | 2.8 |
| 56.5 | 4.7 | 4.0 | 3.7 | 3.5 | 3.3 | |
| 57.0 | 4.8 | 4.1 | 3.8 | 3.6 | 3.4 | 2.9 |
| 57.5 | 4.9 | 4.2 | 3.9 | 3.7 | 3.4 | |
| 58.0 | 5.1 | 4.3 | 4.0 | 3.8 | 3.5 | 3.1 |
| 58.5 | 5.2 | 4.4 | 4.2 | 3.9 | 3.6 | |
| 59.0 | 5.3 | 4.5 | 4.3 | 4.0 | 3.7 | 3.2 |
| 59.5 | 5.5 | 4.6 | 4.4 | 4.1 | 3.8 | |
| 60.0 | 5.6 | 4.8 | 4.5 | 4.2 | 3.9 | 3.4 |
| 60.5 | 5.7 | 4.9 | 4.6 | 4.3 | 4.0 | |
| 61.0 | 5.9 | 5.0 | 4.7 | 4.4 | 4.1 | 3.5 |
| 61.0 | 6.0 | 5.1 | 4.8 | 4.5 | 4.2 | |
| 62.0 | 6.2 | 5.2 | 4.9 | 4.6 | 4.3 | 3.7 |
| 62.5 | 6.3 | 5.4 | 5.0 | 4.7 | 4.4 | |
| 63.0 | 6.5 | 5.5 | 5.2 | 4.8 | 4.5 | 3.9 |
| 63.5 | 6.6 | 5.6 | 5.3 | 5.0 | 4.6 | |
| 64.0 | 6.7 | 5.7 | 5.4 | 5.1 | 4.7 | 4.0 |
| 64.5 | 6.9 | 5.9 | 5.5 | 5.2 | 4.8 | |
| 65.0 | 7.0 | 6.0 | 5.6 | 5.3 | 4.9 | 4.2 |
| 65.5 | 7.2 | 6.1 | 5.7 | 5.4 | 5.0 | |
| 66.0 | 7.3 | 6.2 | 5.9 | 5.5 | 5.1 | 4.4 |
| 66.5 | 7.5 | 6.4 | 6.0 | 5.6 | 5.2 | |

| | WEIGHT-FOR-LENGTH | | | | | |
|---|---|---|---|---|---|---|
| | | | | Malnutrition | | |
| Height | 100% | 85% | 80% | 75% | 70% | 60% |
| (cm) | In kg | in kg | in kg | in kg | in kg | in kg |
| 67.0 | 7.6 | 6.5 | 6.1 | 5.7 | 5.3 | 4.6 |
| 67.5 | 7.8 | 6.6 | 6.2 | 5.8 | 5.4 | |
| 68.0 | 7.9 | 6.7 | 6.3 | 5.9 | 5..5 | 4.7 |
| 68.5 | 8.0 | 6.8 | 6.4 | 6.0 | 5.6 | |
| 69.0 | 8.2 | 7.0 | 6.6 | 6.1 | 5.7 | 4.9 |
| 69.5 | 8.3 | 7.1 | 6.7 | 6.2 | 5.8 | |
| 70.0 | 8.5 | 7.2 | 6.8 | 6.3 | 5.9 | 5.1 |
| 70.5 | 8.6 | 7.3 | 6.9 | 6.4 | 6.0 | |
| 71.0 | 8.7 | 7.4 | 7.0 | 6.5 | 6.1 | 5.2 |
| 71.5 | 8.9 | 7.5 | 7.1 | 6.6 | 6.2 | |
| 72.0 | 9.0 | 7.6 | 7.2 | 6.7 | 6.3 | 5.4 |
| 72.5 | 9.1 | 7.7 | 7.3 | 6.8 | 6.4 | |
| 73.0 | 9.2 | 7.9 | 7.4 | 6.9 | 6.5 | 5.5 |
| 73.5 | 9.4 | 8.0 | 7.5 | 7.0 | 6.5 | |
| 74.0 | 9.5 | 8.1 | 7.6 | 7.1 | 6.6 | 5.7 |
| 74.5 | 9.6 | 8.2 | 7.7 | 7.2 | 6.7 | |
| 75.0 | 9.7 | 8.2 | 7.8 | 7.3 | 6.8 | 5.8 |
| 75.5 | 9.8 | 8.3 | 7.9 | 7.4 | 6.9 | |
| 76.0 | 9.9 | 8.4 | 7.9 | 7.4 | 6.9 | 5.9 |
| 76.5 | 10.0 | 8.5 | 8.0 | 7.5 | 7.0 | |
| 77.0 | 10.1 | 8.6 | 8.1 | 7.6 | 7.1 | 6.1 |
| 77.5 | 10.2 | 8.7 | 8.2 | 7.7 | 7.2 | |
| 78.0 | 10.4 | 8.8 | 8.3 | 7.8 | 7.2 | 6.2 |
| 78.5 | 10.5 | 8.9 | 8.4 | 7.8 | 7.3 | |
| 79.0 | 10.6 | 9.0 | 8.4 | 7.9 | 7.4 | 6.4 |
| 79.5 | 10.7 | 9.1 | 8.5 | 8.0 | 7.5 | |
| 80.0 | 10.8 | 9.1 | 8.6 | 8.1 | 7.5 | 6.5 |
| 80.5 | 10.9 | 9.2 | 8.7 | 8.1 | 7.6 | |
| 81.0 | 11.0 | 9.3 | 8.8 | 8.2 | 7.7 | 6.6 |
| 81.5 | 11.1 | 9.4 | 8.8 | 8.3 | 7.8 | |
| 82.0 | 11.2 | 9.5 | 8.9 | 8.4 | 7.8 | 6.7 |
| 82.5 | 11.3 | 9.6 | 9.0 | 8.4 | 7.9 | |
| 83.0 | 11.4 | 9.6 | 9.1 | 8.5 | 7.9 | 6.8 |
| 83.5 | 11.5 | 9.7 | 9.2 | 8.6 | 8.0 | |
| 84.0 | 11.5 | 9.8 | 9.2 | 8.7 | 8.1 | 6.9 |
| 84.5 | 11.6 | 9.9 | 9.3 | 8.7 | 8.2 | |

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# Table 1- Children

## Boys and Girls ( 49.0cm -130.0cm). Weight for Height Look up Tables

**Weigth-for-Height, in % of the media, for children measuring less than 85 cm and above (measured in a standing position) according to NCHS/CDC/WHO (1982)**

| | WEIGHT-FOR-LENGTH | | | | | |
|---|---|---|---|---|---|---|
| | | | Malnutrition | | | |
| | | | Moderate Wasting 70% to 79% | | Severe Wastage, 70% | |
| Heigth | 100% | 85% | 80% | 75% | 70% | 60% |
| (cm) | In kg | in kg | in kg | in kg | in kg | in kg |
| 85.0 | 12.0 | 10.2 | 9.6 | 9.0 | 8.4 | 7.2 |
| 85.5 | 12.1 | 10.3 | 9.7 | 9.1 | 8.5 | |
| 86.0 | 12.2 | 10.4 | 9.8 | 9.1 | 8.5 | 7.3 |
| 86.5 | 12.3 | 10.5 | 9.8 | 9.2 | 8.6 | |
| 87.0 | 12.4 | 10.6 | 9.9 | 9.3 | 8.7 | 7.4 |
| 87.5 | 12.5 | 10.6 | 10.0 | 9.4 | 8.8 | |
| 88.0 | 12.6 | 10.7 | 10.1 | 9.5 | 8.8 | 7.6 |
| 88.5 | 12.8 | 10.8 | 10.2 | 9.6 | 8.9 | |
| 89.0 | 12.9 | 10.9 | 10.3 | 9.7 | 9.0 | 7.7 |
| 89.5 | 13.0 | 11.1 | 10.4 | 9.7 | 9.1 | |
| 90.0 | 13.1 | 11.1 | 10.5 | 9.8 | 9.2 | 7.9 |
| 90.5 | 13.2 | 11.2 | 10.6 | 9..9 | 9.2 | |
| 91.0 | 13.3 | 11.3 | 10.7 | 10.0 | 9.3 | 8.0 |
| 91.5 | 13.4 | 11.4 | 10.8 | 10.1 | 9.4 | |
| 92.0 | 13.6 | 11.6 | 10.8 | 10.2 | 9.5 | 8.2 |
| 92.5 | 13.7 | 11.6 | 10.9 | 10.3 | 9.6 | |
| 93.0 | 13.8 | 11.7 | 11.0 | 10.3 | 9.7 | 8.3 |
| 93.5 | 13.9 | 11.8 | 11.1 | 10.4 | 9.7 | |
| 94.0 | 14.0 | 11.9 | 11.2 | 10.5 | 9.8 | 8.4 |
| 94.5 | 14.2 | 12.0 | 11.3 | 10.6 | 9.9 | |
| 85.0 | 14.3 | 12.1 | 11.4 | 10.7 | 10.0 | 8.6 |
| 95.5 | 14.4 | 12.2 | 11.5 | 10.8 | 10.1 | |
| 96.0 | 14.5 | 12.4 | 11.6 | 10.9 | 10.2 | 8.7 |
| 96.5 | 14.7 | 12.5 | 11.7 | 11.0 | 10.3 | |
| 97.0 | 14.8 | 12.6 | 11.8 | 11.1 | 10.3 | 8.9 |
| 97.5 | 14.9 | 12.7 | 11.9 | 11.2 | 10.4 | |
| 98.0 | 15.0 | 12.8 | 12.0 | 11.3 | 10.5 | 9.0 |
| 98.5 | 15.2 | 12.9 | 12.1 | 11.4 | 10.6 | |
| 99.0 | 15.3 | 13.0 | 12.2 | 11.5 | 10.7 | 9.2 |
| 99.5 | 15.4 | 13.1 | 12.3 | 11.6 | 10.8 | |
| 100.0 | 15.6 | 13.2 | 12.4 | 11.7 | 10.9 | 9.4 |
| 100.5 | 15.7 | 13.3 | 12.6 | 11.8 | 11.0 | |
| 101.0 | 15.8 | 13.5 | 12.7 | 11.9 | 11.1 | 9.5 |
| 101.5 | 16.0 | 13.6 | 12.8 | 12.0 | 11.2 | |
| 102.0 | 16.1 | 13.7 | 12.9 | 12.1 | 11.3 | 9.7 |
| 102.5 | 16.2 | 13.8 | 13.0 | 12.2 | 11.4 | |
| 103.0 | 16.4 | 13.9 | 13.1 | 12.3 | 11.5 | 9.8 |
| 103.5 | 16.5 | 14.0 | 13.2 | 12.4 | 11.6 | |
| 104.0 | 16.7 | 14.2 | 13.3 | 12.5 | 11.7 | 10.0 |
| 104.5 | 16.8 | 14.3 | 13.4 | 12.6 | 11.8 | |
| 105.0 | 16.9 | 14.4 | 13.6 | 12.7 | 11.9 | 10.1 |
| 105.5 | 17.1 | 14.5 | 13.7 | 12.8 | 12.0 | |
| 106.0 | 17.2 | 14.6 | 13.8 | 12.9 | 12.1 | 10.3 |
| 106.5 | 17.4 | 14.8 | 13.9 | 13.1 | 12.2 | |
| 107.0 | 17.5 | 14.9 | 14 | 13.1 | 12.3 | 10.5 |

| | WEIGHT-FOR-LENGTH | | | | | |
|---|---|---|---|---|---|---|
| | | | Malnutrition | | | |
| | | | Moderate Wasting 70% to 79% | | Severe Wastage, 70% | |
| Height | 100% | 85% | 80% | 75% | 70% | 60% |
| (cm) | In kg | in kg | in kg | in kg | in kg | in kg |
| 107.5 | 17.7 | 15.0 | 14.1 | 13.3 | 12.4 | |
| 108.0 | 17.8 | 15.2 | 14.3 | 13.4 | 12.5 | 10.7 |
| 108.5 | 18.0 | 15.3 | 14.4 | 13.6 | 12.7 | |
| 109.0 | 18.1 | 15.4 | 14.5 | 13.6 | 12.7 | 10.9 |
| 109.5 | 18.3 | 15.6 | 14.6 | 13.7 | 12.8 | |
| 110.0 | 18.4 | 15.7 | 14.8 | 13.8 | 12.9 | 11.0 |
| 110.5 | 18.6 | 15.8 | 14.9 | 14.0 | 13.0 | |
| 111.0 | 18.8 | 16.0 | 15.0 | 14.1 | 13.1 | 11.3 |
| 111.5 | 18.9 | 16.1 | 15.1 | 14.2 | 13.3 | |
| 112.0 | 19.1 | 16.2 | 15.3 | 14.3 | 13.4 | 11.5 |
| 112.5 | 19.3 | 16.4 | 15.4 | 14.4 | 13.5 | |
| 113.0 | 19.4 | 16.5 | 15.5 | 14.6 | 13.6 | 11.6 |
| 113.5 | 19.6 | 16.7 | 15.7 | 14.7 | 13.7 | |
| 114.0 | 19.8 | 16.8 | 15.8 | 14.8 | 13.8 | 11.9 |
| 114.5 | 19.9 | 16.9 | 16.0 | 15.0 | 14.0 | |
| 115.0 | 20.1 | 17.1 | 16.1 | 15.1 | 14.2 | 12.1 |
| 115.5 | 20.3 | 17.3 | 16.2 | 15.2 | 14.2 | |
| 116.0 | 20.5 | 17.4 | 16.4 | 15.4 | 14.3 | 12.3 |
| 116.5 | 20.7 | 17.6 | 16.5 | 15.5 | 14.5 | |
| 117.0 | 20.8 | 17.7 | 16.7 | 15.6 | 14.6 | 12.5 |
| 117.5 | 21.0 | 17.9 | 16.8 | 15.8 | 14.7 | |
| 118.0 | 21.2 | 18.0 | 17.0 | 15.9 | 14.9 | 12.7 |
| 118.5 | 21.4 | 18.2 | 17.1 | 16.1 | 15.0 | |
| 119.0 | 21.6 | 18.4 | 17.3 | 16.2 | 15.1 | 13.0 |
| 119.5 | 21.8 | 18.5 | 17.4 | 16.4 | 15,3 | |
| 120.0 | 22.0 | 18.7 | 17.6 | 16.5 | 15.4 | 13.2 |
| 120.5 | 22.2 | 18.9 | 17.8 | 16.7 | 15.5 | |
| 121.0 | 22.4 | 19.1 | 17.9 | 16.8 | 15.7 | 13.4 |
| 121.5 | 22.6 | 19.2 | 18.1 | 17.0 | 15.8 | |
| 122.0 | 22.8 | 19.4 | 18.3 | 17.1 | 16.0 | 13.7 |
| 122.5 | 23.1 | 19.6 | 18.4 | 17.3 | 16.1 | |
| 123.0 | 23.3 | 19.8 | 18.6 | 17.5 | 16.3 | 14.0 |
| 123.5 | 23.5 | 20.0 | 18.8 | 17.6 | 16.5 | |
| 124.0 | 23.7 | 20.2 | 19.0 | 17.8 | 16.6 | 14.2 |
| 124.5 | 24.0 | 20.4 | 19.2 | 18.0 | 16.8 | |
| 125.0 | 24.2 | 20.6 | 19.4 | 18.2 | 16.9 | 14.5 |
| 125.5 | 24.4 | 20.8 | 19.6 | 18.3 | 17.1 | |
| 126.0 | 24.7 | 21.0 | 19.7 | 18.5 | 17.3 | 14.8 |
| 126.5 | 24.9 | 21.2 | 19.9 | 18.7 | 17.5 | |
| 127.0 | 25.2 | 21.4 | 20.1 | 18.90 | 17.6 | 15.1 |
| 127.5 | 25.4 | 21.6 | 20.4 | 19.10 | 17.8 | |
| 128.0 | 25.7 | 21.8 | 20.6 | 19.30 | 18.0 | 15.4 |
| 128.5 | 26.0 | 22.1 | 20.8 | 19.50 | 18.2 | |
| 129.0 | 26.2 | 22.3 | 21.0 | 19.70 | 18.4 | 15.7 |
| 129.5 | 26.5 | 22.5 | 21.2 | 19.90 | 18.6 | |
| 130.0 | 26.8 | 22.8 | 21.4 | 20.10 | 18.7 | 16.1 |

## COMMUNITY PLUMPYNUT RATION

| Weight of child (kg) | Plumpynut per Week | | Plumpynut per Day | |
|---|---|---|---|---|
| | *Sachets* | *Pots* | *Sachets* | *Pots* |
| 4.0 - 4.4 | 10 | 4 | 1.5 | 0.5 |
| 4.5 - 4.9 | 11 | 4 | 1.5 | 0.5 |
| 5.0 - 5.4 | 13 | 5 | 2 | 0.75 |
| 5.5 - 5.9 | 14 | 5 | 2 | 0.75 |
| 6.0 - 6.4 | 15 | 6 | 2 | 0.75 |
| 6.5 - 6.9 | 16 | 6 | 2.5 | 1.0 |
| 7.0 - 7.4 | 17 | 6 | 2.5 | 1.0 |
| 7.5 - 7.9 | 19 | 7 | 3 | 1.0 |
| 8.0 - 8.4 | 20 | 7 | 3 | 1.0 |
| 8.5 - 8.9 | 21 | 8 | 3 | 1.0 |
| 9.0 - 9.4 | 22 | 8 | 3 | 1.0 |
| 9.5 - 9.9 | 24 | 9 | 3.5 | 1.25 |
| 10.0 - 10.4 | 25 | 9 | 3.5 | 1.25 |
| 10.5 - 10.9 | 26 | 9 | 4 | 1.5 |
| 11.0 - 11.4 | 27 | 10 | 4 | 1.5 |
| 11.5 - 11.9 | 28 | 10 | 4 | 1.5 |
| 12.0 - 12.4 | 30 | 11 | 4.5 | 1.5 |
| 12.5 - 12.9 | 31 | 11 | 4.5 | 1.5 |
| 13.0 - 13.4 | 32 | 12 | 4.5 | 1.5 |
| 13.5 - 13.9 | 33 | 12 | 5 | 1.75 |
| 14.0 - 14.4 | 35 | 13 | 5 | 1.75 |
| 14.5 - 14.9 | 36 | 13 | 5 | 1.75 |

# NRU PLUMPYNUT RATION: TRANSITION

| Weight of child (kg) | kcal/day (130kcal/kg) | plumpynut sachets per day | plumpynut pots per day |
|---|---|---|---|
| 4.0 - 4.4 | *546* | 1 sachet | ½ pot |
| 4.5 - 4.9 | *611* | 1¼ sachets | ½ pot |
| 5.0 - 5.4 | *676* | 1½ sachets | ½ pot |
| 5.5 - 5.9 | *741* | 1½ sachets | ½ pot |
| 6.0 - 6.9 | *839* | 1¾ sachets | ¾ pot |
| 7.0 - 7.9 | *969* | 2 sachets | ¾ pot |
| 8.0 - 8.9 | *1099* | 2¼ sachets | 1 pot |
| 9.0 - 9.9 | *1229* | 2½ sachets | 1 pot |
| 10.0 - 10.9 | *1359* | 2¾ sachets | 1 pot |
| 11.0 - 11.9 | *1489* | 3 sachets | 1 pot |
| 12.0 - 12.9 | *1619* | 3¼ sachets | 1¼ pots |
| 13.0 - 13.9 | *1749* | 3½ sachets | 1¼ pots |
| 14.0 - 14.9 | *1879* | 4 sachets | 1½ pots |
| > 15.0 | *2704* | 5½ sachets | 2 pots |

# CHECKLIST for SEVERE MALNUTRITION

| RAPID EXAMINATION | Action | REFERAL CRITERIA to NRU | CAUTION | OKAY: CONTINUE CTC |
|---|---|---|---|---|
| CRITERIA OF ADMISSION | GRADE OEDEMA | grade +++ or ++ | grade + | No oedema |
| | WEIGHT FOR HEIGHT | < 60% | 60% - 70% | > 70% |
| | AGE | <6 months | | |

| | | | | |
|---|---|---|---|---|
| APPETITE / ANOREXIC | TRIAL DOSE PLUMPYNUT | Refuses to eat or has difficulty taking/swallowing the RUTF | Eats with encouragement | Tries and asks for more |
| TEMPERATURE | AXILLIARY TEMPERATURE | Fever: >= 39°C<br>Hypothermia: < 35.5°C | Between (36.5°C and 39°C) | Normal range (35.5 - 36.5°C) |
| RESPIRATION RATE (rr) | RR FOR ONE MINUTE | > 60 respirations/minute for under 2-months<br>> 50 respirations/minute from 2 to 12 months<br>> 40 respirations/minute from 1 to 5 years<br>> 30 respirations/minute for over 5 year-olds | | Normal range |
| HYDRATION STATUS | CHECK URINE OUTPUT, RECENT D&V, FONTANELLE, MOUTH DRY, RECENT EYE CHANGES | No urine output, no tears<br>Fontanelle depressed<br>Mouth dry, Eyes recently sunken<br>History of acute diarrhoea & vomiting | mouth a little dry | Normal urine, mouth not dry |
| ANAEMIA | Hb READING<br>CHECK NAILS, EYES | < 7 g/100ml<br>Very pale, difficulty breathing | Between 7 and 9 g/100ml<br>Slightly pale - prescribe ferrous-folate | >9 g/100ml<br>Colouration |
| SUPERFICIAL INFECTION | CHECK EARS, BODY FOR DISCHARGE/PUS, INFECTION, ABCESS | Discharges from ears, extensive absesses, extensive sores | Slight skin irritations eg scabies, small abcess easy to drain, small sores not associated wth oedema | No infections |
| WEIGHT CHANGES | CONSIDER LAST 3 WEIGHTS | Weight loss | Static weight or weight fluctuating bewteen small gains and loss | Weight gained |
| ALERTNESS | REGARD BEHAVIOUR | Very weak, apathetic, unconscious<br>Fitting/convulsions | Drowsy, quiet | Alert, conscious |

| CARETAKER HISTORY | | | | |
|---|---|---|---|---|
| EPISODES ILLNESS | Diarrhoea & vomiting<br>Fever<br>Cough | Evaluate severity considering above symptoms | 1 or more | None |
| VISITS TO HEALTH POST | Any visits required other than weekly scheduled visit | >1 visit | 1 visit | None |

# ROUTINE MEDICINES for SEVERE MALNUTRITION: NRU/OTP

| NAME OF PRODUCT | ADMISSION | AGE | PRESCRIPTION | POSOLOGY | LENGTH OF TREATMENT |
|---|---|---|---|---|---|
| **VITAMIN A** (curative dose) | YES | < 6 months | **50 000 IU** | 1 drops (1/4 capsule) | One dose at admission, day 2 and day 14 |
| | | 6 months to < 1 year | **100 000 IU** | 3 drops (1/2 capsule) | |
| | | > = 1 year, adolescent (>8kg) | **200 000 IU** | 6 drops (one capsule) | |
| **FOLIC ACID** | YES | All beneficiaries | **5 mg** | Single dose | Single dose at admission |
| **AMOXYCILLIN** | YES | All beneficiaries **EXCEPT under 2 kg** | **60 mg/kg/day** | 3 times / day | 7 days (or 10 days if needed) |
| **FANSIDAR** | YES | All beneficiaries **EXCEPT less than 4 kg** | **25 mg/kg** | Single dose | Single dose at admission |
| **ALBENDAZOLE*** | YES | < 1 year | DO NOT USE | NOTHING | XXX |
| | | 1 to < 2 years | **200 mg** | Single dose | Single dose at discharge from NRU or immediately on admission if OTP direct |
| | | > = 2 years | **400 mg** | Single dose | |

**Do not repeat the dosage of vitamin A if the child is readmitted or has already received curative dose of Vitamin A during the LAST 30 days**

*** IF USING MEBENDAZOLE: <1 year: nothing 1 - <2 years: 250mg >=2 years: 500mg unique dose**

**IRON:** **This should NOT be given immediately as contained in Plumpynut.**

**If child is diagnosed with anaemia then treat from week 3 of admission according to the MoH protocol for the treatment of anaemia.**

## Appendix 1 : Case-finding Checklist for Volunteers

### Case Finding Checklist

1. **Name of the Volunteer** :.....
2. **Village** :.....
3. **TA** :.....

**U/5 Child Information**

| | | Tick(√) Yes | No |
|---|---|---|---|
| 4 | Name : SEX: (circle) F/M | | |
| 5 | Age : | | |
| 6 | Village: TA: | | |
| 7 | Name of Care taker : | | |
| 8 | Relationship with child: | | |
| 9 | Distance to nearest HF: | | |
| 10 | Does the child have a health passport | | |
| 11 | Is child *Gaining weight | | |
| | *Losing weight | | |
| | *Weight constant | | |
| 12 | Date last card updated | | |
| 13 | Is it the first time for the child to be malnourished | | |
| 14 | # of Children in the family | | |
| 15 | Any other malnourished children in the family | | |
| 16 | Is there enough food in the family | | |
| 17 | Has caretaker already visited the Health Facility | | |
| 18 | Does the child have other medical complications i.e. loss of appetite | | |
| | TB | | |
| | Malaria | | |
| | Anaemia | | |
| | oedema, | | |
| | diarrhoea, | | |
| | vomiting, | | |
| | others(specify) | | |
| 19 | Any Child deaths | | |
| 20 | If yes, possible cause of death | | |
| 21 | Age of when death occurred - 0-5 years | | |
| | - over 5yrs | | |

## Appendix 2 : Follow up Checklist for Volunteers

**1. Name of the Volunteer** :.....
**2. Village** :.....
**3. TA** :.....

**Child Information**

| | | Tick(√) | Yes | No |
|---|---|---|---|---|
| 4 | Name: | | | |
| 5 | Age: Sex: M.....F..... | | | |
| 6 | Name of Caretaker: | | | |
| 7 | Relationship with child | | | |
| 8 | Is the child improving | | | |
| 9 | Is the child Gaining weight (check on Card)<br>Losing weight<br>Weight constant | | | |
| 10 | Is the child eating Chiponde well? | | | |
| 11 | Is Chiponde available ? (check for remaining pots/satchets and empty ones) | | | |
| 12 | Is Chiponde being shared | | | |
| 13 | Is the child also eating other foods apart from Chiponde | | | |
| 14 | Does the caretaker follow the appointment schedule at the OTP Site(check on OTP card) | | | |
| 15 | Did the caretaker find Chiponde at the HF during the last visit | | | |
| 16 | Does the child have other medical complications i.e.<br>loss of appetite | | | |
| | TB | | | |
| | Malaria | | | |
| | Anaemia | | | |
| | oedema, | | | |
| | diarrhea, | | | |
| | vomiting, | | | |
| | others(specify) | | | |
| 17 | Advice given | | | |

**Additional Comments**

.....
.....
.....
.....
.....

## Appendix 3: Information in Volunteer's Register

**First Page of Register Book:**

Name of OTP Center
Name of Extension worker of catchment area
Name of Volunteer
Village and TA
Village Demography
- No. of Households
- Overall population
- Number of women of child bearing age
- Under five population
- Under one Population

**Inside Pages of Register Book** (all under five children in the village registered)

| Serial. No. | Date child Registered | Date child admitted in OTP | Name of child | Age | Sex | Vge | TA | Status of Child |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

**District Name:**

| MANAGEMENT SYSTEMS COMPONENT | DATA ELEMENTS TO REPORT ON QUANTITATIVELY | July/ September Quarter |
|---|---|---|
| Infection Prevention | Average assessment score during the quarter | |
| Malaria | Number of women received two or more doses of SP in the quarter | |
| | First ANC visits in the quarter | |
| | Functional multisectoral ITN Committee exists (circle one) | Yes / No |
| Maternal Death Audit | Number of hospital based maternal death audited in the quarter | |
| | Total hospital based Maternal deaths in the quarter | |
| HIV/AIDS: | To use data from the HIV VCT monthly report | |
| Nutrition | Number of children received chiponde in the quarter | |
| | Number of children admitted in the OTP programme in the quarter | |
| | Number of children discharged from the OTP programme in quarter | |
| | Number of deaths of children while on OTP in the quarter | |
| | Number of children referred to NRU from the OTP programme in the quarter | |
| | Number of children referred to OTP from the NRU programme in the quarter | |
| | Number of defaulters from the OTP programme | |
| | Amount of chiponde ditributed in the quarter | |
| District level: | Number of health facilities with documented supervisory visit in the quarter | |
| District planning: | District conducted DIP review in the **quarter** (Circle one) | Yes / No |
| Reporting: | Number of Health Facilities reporting HMIS data according to schedule in the quarter | |
| | Number of Health Facilities conducting quarterly HMIS reviews | |
| | District has a defined set of indicators in use (Circle one) | Yes / No |
| | Number of Health Facilities demonstrating use of data from the defined set of indicators in the quarter | |
| Community ITNs: | District implementing ITN financial management procedures | Yes / No |
| Essential drugs | Number of Health Facilities without stockouts of identified child health tracer drugs in the quarter | |
| | District has a functioning Drug and Therapeutic Committees | Yes / No |
| VCT test kits | District had no stockout of determine HIV and unigold/bioline for more than seven days in the quarter (Circle One) | Yes / No |
| Financial management & accounting: | Accounts submit ORT report to DHMT (DHO, DNO, DHSA and DEHO) monthly (Circle One) | Yes / No |
| Transport management: | Percentage achieved on "needs satisfaction" in the quarter | |
| | Adminstration staff submits fuel and vehicle maintainance reports to DHMT monthly | |
| | Number of Health Facilities maintaining registers for monitoring transport management in the quarter | |
| Communications: | Number of health facilities with functioning communication equipment (telephone or radio) | |
| Human resource management | District maintains a proper filing system for personnel records (Circle One) | Yes / No |
| Equipment maintenance | Number of health facilities with all basic child health equipment (EPI refrigerator, thermometer, timer and weighing scale) | |
| Working Denominator for some indicators | Total Number of **operational** Health Facilities in the District | |

# CTC - OTP MONTHLY REPORTING FORM

**Facility Name:** _____ **Facility Code:** _____ **District:** _____ **Month:** _____

| Data Element | Previous Admissions | | New Admissions (OTP) | | | | | | Total Admissions (I)=A+B+H | Discharges | | | | | | TOTAL Discharges (P)= J+K+L+M+N | TOTAL Admissions at the end of the month (Q)=(I)-(P) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total at the beginning of the month (OTP) (A) | Returns from NRU (B) | Discharged from NRU (Referred to OTP) (C) | Oedema ( D) | W/H< 70% and MUAC<11cm (E) | Relapses (F) | Others (G) | Total New (H)=C+D+E+F+G | | Cured (J) | Deaths (K) | Default (L) | Medical Transfers (M) | Transfers Out (N) | Referrals from OTP to SFP (O) | | |
| 6-<12 months | | | | | | | | | | | | | | | | | |
| 12-<24 months | | | | | | | | | | | | | | | | | |
| 24-<36 months | | | | | | | | | | | | | | | | | |
| 36-<48 months | | | | | | | | | | | | | | | | | |
| 48- 59 months | | | | | | | | | | | | | | | | | |
| **TOTAL** | | | | | | | | | | | | | | | | | |
| | | **Calcurate Cure, death and default rates against targets** | | | | | | | | | | | | | | | |
| | | | | | | | | | Target | >75% | <10% | <15% | | | | | |

| | | |
|---|---|---|
| Number of children admitted into SFP | | *(check in SFP register)* |
| Number of children followed up in the community | | *(check in volunteer reports or HSAs reports)* |

**Admissions into OTP (Parenthood)**

| | **Male** | **Female** |
|---|---|---|
| Without Mother | | |
| Without Father | | |
| Without both parents | | |
| With both parents | | |
| **Total** | | |

| **CHIPONDE** | |
|---|---|
| Total at the beginning of the month | |
| Total Receipts in the month | |
| Total Distributed | |
| Losses /Adjustments | |
| Stock on Hand at end of month | |
| Any Stock Outs during the month | Yes / No |

**Checked By:** _____ **Position:** _____ **Date:** _____ **Signature:** _____

**Compiled By:** _____ **Position:** _____ **Date:** _____ **Signature:** _____