Module 8
Part 1 - Supplementary Feeding Programme

CONTENTS

ILLUSTRATED GUIDES

Supplementary Feeding Programme (SFP)

INTRODUCTION

This module outlines the monitoring requirements for the following nutritionally at-risk groups, most commonly targeted for supplementary feeding in refugee operations:

1. Moderately malnourished children
2. Pregnant and lactating women
3. Medical cases

The types, objectives and criteria of each Supplementary Feeding Programme (SFP) should be clearly defined and standardised among all health partners within each country (see Country Considerations Box). Internationally accepted weight-for-height (Z-score or %median) and/or MUAC criteria should be used as the basis for admission and discharge of all beneficiaries in the programme. There are many types of SFP and the admission and discharge criteria vary widely. The internationally recommended criteria are listed in this manual.

8.1 WHAT ARE THE TOOLS USED FOR DATA COLLECTION?

The data collection tools used in the SFP are shown below. They are classified as follows:

Primary Tools

Primary data sources are essential to routine monitoring within the HIS and are a prerequisite to the calculation of indicators. They form the basis of the guidance and training within this manual, and are described in detail in the Illustrated Guides at the end of the module.

Secondary Tools

Secondary data sources have important functions within the HIS but are not used to directly calculate indicators. They play vital roles informing clinical decision-making and promoting service quality and performance. They are described in information boxes in the supporting text.

> Data collection and monitoring tools

Supplementary Feeding Programme

Primary Tools
1. Moderate Malnutrition Register
2. Pregnant and Lactating Register
3. Medical Register
4. Nutrition Report

Secondary Tools
1. SFP ration card
2. SFP record card
3. Road to Health Card
4. ANC Card
5. NCHS/WHO Reference Values

8.2 WHO IS RESPONSIBLE FOR COLLECTING THE DATA?

SFP staff are responsible for recording all beneficiaries in a register and ensuring that records are updated at each visit. Each staff member should understand how to accurately record each visit and should take responsibility for maintaining neat and legible records.

At the end of each week, the Nutrition supervisor should coordinate the compilation of the weekly nutrition report and ensure that respective sections have made their submission in full and on time. The Nutrition supervisor is also responsible for monitoring the upkeep of the registers, and for certifying the completeness of record entries each day.

8.3 WHAT DATA SHOULD BE COLLECTED AND HOW?

8.3.1 Moderate Malnutrition Register

> At the time of admission, basic identifying information should be recorded and each child assigned a unique identifying code. The same code should be used throughout admission (including during referral to TFP or CTC). This identifier must also be recorded on the Road to

> Country Considerations

What are the types, objectives and criteria of the supplementary feeding programme?

Each SFP should be designed according to the nutritional situation on the ground. The types, objectives and criteria of each programme will vary from country to country, but all should remain in line with the common UNHCR/WFP Guidelines on Selective Feeding Programmes.

There are usually insufficient resources to assist all vulnerable groups in a population, and it is necessary to identify and prioritise certain groups. This can be done through two types of supplementary feeding intervention:

- Blanket supplementary feeding. In which a supplementary ration is provided to everyone in an identified vulnerable group (e.g. children under five or women of child-bearing age) for a defined period in order to prevent deterioration in nutritional status.

- Targeted supplementary feeding. In which a supplementary ration is targeted on specific members of vulnerable groups whose requirements may not be met by the general ration (e.g. moderately malnourished children under five years or pregnant and lactating women).

Targeted SFPs should only be implemented when anthropometric surveys have been conducted or are planned, and if the underlying causes of moderate malnutrition are being addressed simultaneously.

The objectives and criteria of each SFP should be clear and documented from the onset of implementation in a Nutrition Protocol. This should be standardised among partners and made available to feeding centre staff in every camp. For each population group targeted within the programme, the protocol should define:

- admission, discharge, referral and closure criteria
- nutrition feeding regime*
- medical treatment protocol**

* In areas where there is a high prevalence of particular diseases (e.g. HIV/AIDS), the feeding regime should give special consideration to the quality and quantity of the supplementary food distributed.

** The medical treatment protocol should include the provision of antihelminths, vitamin A supplementation and

Health card (see Secondary Tools: Road To Health Card) to facilitate the easy referencing of register entries at repeat visits. The definitions of SFP admission categories for children under 5 are shown in Table 1 below.

> At each subsequent visit, weight and/or MUAC measurements should be recorded, depending on the admission/discharge criteria in use. Height/length should be recorded at admission and discharge and, for children, once a month if possible.

> At the time of exit, the number of weeks between admission and discharge date should be calculated for all moderately malnourished children in SFP. A calendar should be used, particularly if this period is of long duration and extends over more than one month. Length of stay is inclusive of both the week of admission and the week of discharge.

Table 1 SFP admission category definitions: children under 5

New admission	• MUAC <125mm • Less than 80% median / -2 Z-score WFH • Discharged from the OTP/SC
Re-admission	• Admission within 2 months of being discharged cured from SFP

The recommended length of stay for moderately malnourished children in SFP is 12 weeks. Therefore, each page of the register is sufficient to record up to and including this length of admission. If length of stay exceeds 12 weeks, then week 13 should be recorded in the next available row. The same identifying code number should be used and an explanatory remark made in the original row. Length of stay should be calculated for all malnourished exits, but only reported for refugee children under five who are successfully discharged (see 8.4 How and when to report the data?).

The reason for exit must be stated for every entry in the register and only reasons given in the legend on each register page should be recorded. The definitions of SFP exit categories for children under 5 are shown in Table 2 opposite.

An Illustrated Guide to the SFP Registers and an explanation of the information that should be recorded in each is given at the end of the module.

8.3.2 Pregnant and Lactating Register

> At the time of admission, basic identifying information should be recorded and the antenatal number of each mother logged in a register based on information in the antenatal card (see Secondary Tools: Antenatal Card, in Module 9). The date of first visit should be registered according to gestational age and number of weeks post-delivery for pregnant women and lactating mothers, respectively. To ensure that expected dates of discharge are comparable it is essential that the date of first visit is recorded accurately. The definitions of SFP admission categories for pregnant and lactating women are shown in Table 3 opposite.

> At each subsequent visit, the date of attendance and/or the MUAC should be recorded. For pregnant women these dates will record advancing gestation until the time of delivery. For lactating mothers, they will record the post-delivery period until the time of discharge.

> At the time of exit, the length of stay and reason for exit should be documented.

Table 2 SFP exit category definitions: children under 5

Discharged cured	• More than 85% median WFH / -1.5 Z-score WFH for two consecutive weighings (for MUAC admissions a fixed length of stay may be required, as for OTP) • After being discharged from OTP, have received at least 8 weeks (two months) follow up in the SFP and have been more than 85% median / -1.5 Z-score WFH for two consecutive weighings*
Death	• Died during time registered in SFP
Default	• Absent for three consecutive weeks
Referral	• Have to be transferred to a stabilisation centre or hospital due to severe medical complications • Repatriation is considered under the category of referral as a reason for exit.
Non-cured	• Are non-responding, i.e. the child does not reach the target weight after three months of treatment**

* All OTP discharges should be sent to the SFP where they stay for a minimum of two months (longer if they have not attained the SFP discharge criteria by that time). MUAC admissions may also need a minimum length of stay as a discharge criteria.

** Before this time, children must have been followed-up at home and should be transferred to inpatient care for investigations where indicated. Discharged non-cured children should be sent home with close follow-up by community health workers. They should be readmitted to the SFP/OTP if they fulfil entry criteria again. No child should be discharged as non-cured if their MUAC is still <115mm.

Table 3 SFP admission category definitions: pregnant and lactating women

New admission	• MUAC <210mm and second or third trimester (visibly pregnant) or • MUAC <210mm and the baby is under six months of age
Re-admission	• Admission within 2 months of being discharged cured from SFP

The reason for exit must be stated for every entry in the register and only reasons given in the legend on each register page should be recorded. The definitions of SFP exit categories for pregnant and lactating women are shown in Table 4 below.

Table 4 SFP exit category definitions: pregnant and lactating women

Discharged cured	• MUAC ≥ 230mm or when their baby reaches six months of age
Death	• Died during time registered in SFP
Default	• Absent for three consecutive weeks
Referral	• Have to be transferred to a hospital due to severe medical complications • Repatriation is considered under the category of referral as a reason for exit

8.3.3 Medical Register

Individuals other than those who meet anthropometric criteria defining malnutrition may also be enrolled for supplementary feeding. The HIS will therefore need to be adjusted according to the numbers and types of cases included within this category (see Country Considerations box opposite). Eligibility criteria for each group should be objective and explicitly defined in the country Nutrition Protocol.

> At the time of admission, all medical admissions should have basic identifying information recorded at registration, and be assigned a unique identifying number (with the exception of HIV/AIDS cases; see box). It is recommended that all are logged in the same Medical Register.

> At each visit, the date of attendance should be recorded. Other information (e.g. weight, BMI, haemoglobin) can also be recorded depending on the admission criteria. The maximum capacity of each register is up to and including one year of admission. If length of stay exceeds one year, then the start of the second year should be recorded in the next available row. The same serial number should be used and an explanatory remark should be entered next to the reason for exit in the original entry.

> At the time of exit, the reason for exit should be documented and only reasons given in the legend on each register page should be recorded.

> Country Considerations

What are the categories for medical admission in SFP?

a. Moderate Anaemia
Admission and discharge criteria should be based upon objective measurement of haemoglobin level. Progress towards the discharge criteria should be closely monitored at each visit, and hemoglobin recorded during each week of admission.

b. TB
Admission and discharge criteria for TB patient should be time bound, and based upon phase of medical treatment. Date of attendance should be recorded each week and, due to their increased nutritional requirements, weight and/or body mass index (BMI) should also be monitored.

c. HIV/AIDS
To protect individual confidentiality, the names and addresses of persons living with HIV must not be recorded in the register. HCT or PMTCT code numbers should be used instead of this identifying information (for more details on protecting confidentiality of Health Information, see Module 10: HIV/AIDS).

Persons living with HIV often receive nutritional support over a long period of time, sometimes lifelong. The date of each visit should be entered at each week of admission. Weight/BMI measurement should also be monitored at periodic intervals during admission, for example monthly or quarterly.

d. Others (including those with disability)
Admission and discharge criteria must be as objective as possible for individuals in this miscellaneous section, and reason for admission must be always be specified in the register. The date should be recorded at each visit or, if applicable to the reason for admission, other variables such as weight/BMI should be entered.

8.4 HOW AND WHEN SHOULD THE DATA BE REPORTED?

At the end of each week, the SFP registers should be used to compile the Nutrition Report.

The dates of each reporting week are shown in the Reporting Calendar. It is important that all staff are aware of these dates, and that copies the calendar are distributed to all nutrition centres.

The Nutrition supervisor is responsible for completing the report. A weekly report in each feeding centre is essential to permit the accurate calculation of the balance of beneficiaries in each unit. The table keeps a rolling total of the number registered at the beginning and the end of each week, and should be updated with records of admissions and discharges made during the reporting period. An Illustrated Guide to the Nutrition report is given at the end of the module.

Feeding centre staff must understand the purpose of collecting the information. Each entry

should be carefully retrieved from the registers and appropriately disaggregated by age (<5, ≥5), sex, status (refugee or national) and reason for admission. The weekly reporting form also contains 'free-cells' to allow programmes to customise reasons of admission. Some example categories which may be monitored using these 'free-cells' are given in the Country Considerations box. These

should be agreed upon in close coordination with all health agencies, to guarantee the consistency and comparability of information within each country operation.

During the reporting of information from the register, length of stay should only be reported for refugee children under five who are successfully discharged. This important to ensure the indicator is correctly calculated and interpreted.

8.5 HOW SHOULD THE DATA BE INTERPRETED AND USED?

An Excel Reporting Form is the first stage of data entry into the computer. If resources are available, then paper report forms can be entered into the computer each week. The database will then automatically combine these into a monthly report composed of 4 or 5 weekly reports (depending on the reporting calendar). If the data cannot be entered into the computer each week it should be aggregated manually using a calculator and entered into the computer at the end of each month. More information on data management and is given in Part 3 of the manual.

The indicators for SFP are shown below. Each is classified according the five core objectives of the HIS. A summary of each indicator, including formulae, units of expression, and the corresponding standard (where available) is given in the Standard and Indicator Guide.

It is essential that staff are familiar with how these indicators are calculated, and understand how they should be used to evaluate programme performance and to inform public health decision-making. An exercise on how to calculate and interpret the indicators, using sample data, is given on the CD-ROM which accompanies this manual.

> Indicator Summary

Supplementary Feeding Programme

Objective	Indicator	Source
3. Evaluate the effectiveness of interventions and service coverage	Coverage of SFP (< 5)	UNHCR/WFP
	Coverage of SFP (Pregnant and Lactating)	UNHCR/WFP
	Proportion of beneficiaries who are host nationals	HIS
4. Ensure that resources are correctly targeted to the areas and groups of greatest need	Proportion of new admissions due to HIV/AIDS	HIS
	Proportion of new admissions due to TB	HIS
5. Evaluate the quality of health interventions	Mean length of stay	UNHCR/WFP
	Recovery rate*	UNHCR/WFP
	Death rate*	UNHCR/WFP
	Default rate*	UNHCR/WFP

* Disaggregated by refugee and national

> Illustrated Guide to Moderate Malnutrition Register

A

B

Serial No.	SFP No.	Name	Age	Sex (M / F)	Status (Ref / Nat)	Address	Date of admission	Re-adm. (Y / N)	From OTP/TFP (Y / N)	Wk 1				Wk 2		
										Height	Weight	WFH	MUAC	Weight	WFH	MUAC

A REGISTRATION:

Serial No.:
> Enter sequence number in register

SFP No:
> Enter unique identifying number

Name:
> Print name

Age:
> Enter age (in years/months)

Sex:
> Enter Male (M) / Female (F)

Status:
> Classify as Refugee (Ref) / National (Nat)

Address:
> Enter Camp Address (Refugee) / Nearest Village (National)

Date of admission:
> Enter date (dd/mm/yy)

Re-adm:
> Enter Yes (Y) if previous admission / No (N) if new admission.

From OTP/TFP:
> Enter Yes (Y) if referral from OTP/TFP / No (N) if direct admission from OPD/community

B ADMISSION HISTORY:

On each week of admission:

1. Height:
> Enter Height / Length measurement (cm)

2. Weight
> Enter Weight (kg)

3. Weight-for-Height (WFH)
> Use NCHS/WHO reference tables to calculate weight-for-height Z-score or %median.

Enter value that defines the upper range of admission/discharge criteria
(e.g. < -2 ZS / <80%; < -3 ZS/ <70%)

4. Mid-upper arm circumference (MUAC)
> Enter MUAC (mm)

NOTES

Height is requested once every 4 weeks. The most recent height measurement should be used to calculated Z-score or %median in the intervening weeks.

The term 'length' is generally used for children below 85 cm, and 'height' for children 85 cm and above.

C

Wk 3			Wk 4			Wk 5			Wk 6			Wk 7			Wk 8			Wk 9			Wk 10			Wk 11			Wk 12			Height on discharge	Date of exit	Length of stay (weeks)	Reason for exit *
Weight	WFH	MUAC	Weight	WFH	MUAC	Weight	WFH	MUAC	Weight	WFH	MUAC	Weight	WFH	MUAC	Weight	WFH	MUAC	Weight	WFH	MUAC	Weight	WFH	MUAC	Weight	WFH	MUAC	Weight	WFH	MUAC				

C

EXIT DETAILS:

Height on discharge:
> Enter Height / Length measurement on discharge(cm)

Date of exit:
> Enter date (dd/mm/yy)

Length of stay:
> Enter number of weeks between admission and discharge

Reason for exit:
> Enter reason for exit, using options provided in legend.

Record as Discharge cured / Death / Default / Referral / Non-cured

NOTES

Use calendar to calculate length of stay. The number of weeks is inclusive of both week of admission and week of discharge.

Reasons for exit are listed in the legend on each register page. Enter reasons listed in the key ONLY.

Repatriation is included within referral as reason for exit.

NOTES

Internationally accepted WFH (% median or Z-score) or MUAC criteria should be the basis for admission and discharge of all children in the programme.

In countries where WFH criteria are used, standardised NCHS/WHO reference values should be provided to interpret anthropometric measurements of malnourished children.

NCHS/WHO reference tables should be available in all nutrition centres, and all feeding staff should be trained in their correct use and application (see Illustrated Guide to NCHS/WHO reference table).

> Illustrated Guide to NCHS/WHO Reference Values

NOTE This manual presents WFH reference criteria expressed as % of the median and Z-scores. In addition, MUAC is increasingly recognized as a valid criteria for screening and admission of children within selective feeding programmes. The exact criteria used should be selected in close consultation with UNHCR, the Ministry of Health, and other nutrition partners.

Health Information System

NCHS / WHO normalized reference values for weight for height by sex

Weight-for-length (49-84 cm) and weight-for-height (85-110 cm)

C

B

A

Boys' weight (kg)						Girls' weight (kg)				
- 4 ZS	- 3 ZS	- 2 ZS	- 1 ZS	Median	Length (cm)	Median	- 1 ZS	- 2 ZS	- 3 ZS	- 4 ZS
1.8	2.1	2.5	2.8	3.1	49	3.3	2.9	2.6	2.2	1.8
1.8	2.2	2.5	2.9	3.3	50	3.4	3	2.6	2.3	1.9
1.8	2.2	2.6	3.1	3.5	51	3.5	3.1	2.7	2.3	1.9
1.9	2.3	2.8	3.2	3.7	52	3.7	3.3	2.8	2.4	2
1.9	2.4	2.9	3.4	3.9	53	3.9	3.4	3	2.5	2.1
2	2.6	3.1	3.6	4.1	54	4.1	3.6	3.1	2.7	2.2
2.2	2.7	3.3	3.8	4.3	55	4.3	3.8	3.3	2.8	2.3
2.3	2.9	3.5	4	4.6	56	4.5	4	3.5	3	2.4
2.5	3.1	3.7	4.3	4.8	57	4.8	4.2	3.7	3.1	2.6
2.7	3.3	3.9	4.5	5.1	58	5	4.4	3.9	3.3	2.7
2.9	3.5	4.1	4.8	5.4	59	5.3	4.7	4.1	3.5	2.9
3.1	3.7	4.4	5	5.7	60	5.5	4.9	4.3	3.7	3.1
3.3	4	4.6	5.3	5.9	61	5.8	5.2	4.6	3.9	3.3
3.5	4.2	4.9	5.6	6.2	62	6.1	5.4	4.8	4.1	3.5
3.8	4.5	5.2	5.8	6.5	63	6.4	5.7	5	4.4	3.7
4	4.7	5.4	6.1	6.8	64	6.7	6	5.3	4.6	3.9
4.3	5	5.7	6.4	7.1	65	7	6.3	5.5	4.8	4.1
4.5	5.3	6	6.7	7.4	66	7.3	6.5	5.8	5.1	4.3
4.8	5.5	6.2	7	7.7	67	7.5	6.8	6	5.3	4.5
5.1	5.8	6.5	7.3	8	68	7.8	7.1	6.3	5.5	4.8
5.3	6	6.8	7.5	8.3	69	8.1	7.3	6.5	5.8	5
5.5	6.3	7	7.8	8.5	70	8.4	7.6	6.8	6	5.2
5.8	6.5	7.3	8.1	8.8	71	8.6	7.8	7	6.2	5.4
6	6.8	7.5	8.3	9.1	72	8.9	8.1	7.2	6.4	5.6
6.2	7	7.8	8.6	9.3	73	9.1	8.3	7.5	6.6	5.8
6.4	7.2	8	8.8	9.6	74	9.4	8.5	7.7	6.8	6
6.6	7.4	8.2	9	9.8	75	9.6	8.7	7.9	7	6.2
6.8	7.6	8.4	9.2	10	76	9.8	8.9	8.1	7.2	6.4
7	7.8	8.6	9.4	10.3	77	10	9.1	8.3	7.4	6.6
7.1	8	8.8	9.7	10.5	78	10.2	9.3	8.5	7.6	6.7
7.3	8.2	9	9.9	10.7	79	10.4	9.5	8.7	7.8	6.9
7.5	8.3	9.2	10.1	10.9	80	10.6	9.7	8.8	8	7.1
7.6	8.5	9.4	10.2	11.1	81	10.8	9.9	9	8.1	7.2
7.8	8.7	9.6	10.4	11.3	82	11	10.1	9.2	8.3	7.4

The WFH reference standards most commonly used to standardize anthropometric measurements of children were developed by the US National Center for Health Statistics (NCHS) and are recommended for international use by the World Health Organization WHO). They are commonly known under the acronym the 'NCHS/WHO' reference standards.

The observed WFH measurements of all children in the selective feeding programmes should be compared with the median (or average) measure for children at the same age and sex in the reference tables, and expressed as the percentage (%) or range of Z-score values from the median.

A **HEIGHT / LENGTH (CM):**

FIRST

find the row which corresponds to observed height / length of the child.
Measurements should be rounded to the nearest centimetre to match given values in the tables.

B **WEIGHT (KG):**

SECOND

find the column(s) which contain the observed weight of the child (in kg).
The reference tables are normalised according to sex. The values for boys are shown on the right-hand side of the median, and the value for the girls on the left-hand side.

C **WEIGHT-FOR-HEIGHT Z-SCORE:**

THIRD

THIRD determine the corresponding Z-score range, by matching the observed weight with the Z-scores in the column headings.
This expresses the variation of the observed weight of the child from the median or expected value, at the given height / length.

NOTES

The relationship between the percentage of median value and the SD-score or Z-score varies with age and height, particularly in the first year of life, and beyond 5 years.

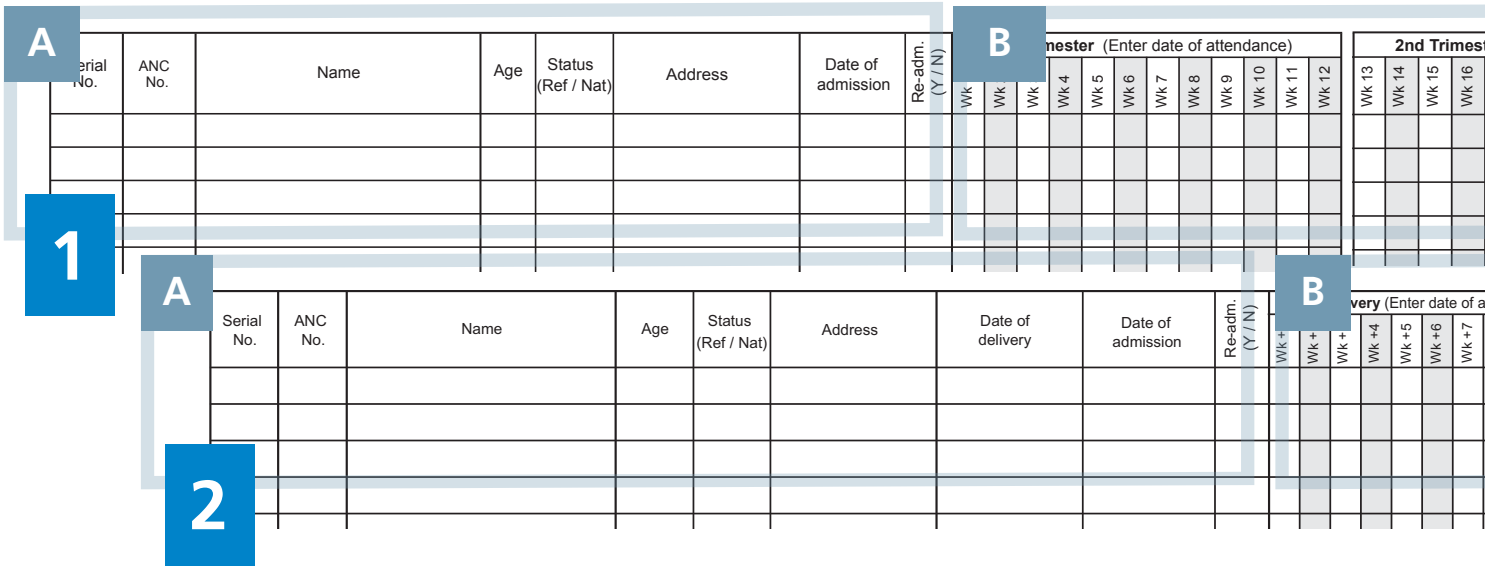
Between 1 and 5 years median –1 SD and median –2 SD correspond to approximately 90% and 80% of median (weight-for-length/height, and weight-for-age), respectively.

Beyond 5 years of age or 110 cm (or 100 cm in stunted children) this equivalence is not maintained; median –2 SD is much below 80% of median. Hence the use of "percentage-of-median" is not recommended, particularly in children of school age.

Somewhere beyond 10 years or 137 cm, the adolescent growth spurt begins and the time of its onset is variable. The correct interpretation of weight-for-height data beyond this point is therefore difficult.

Therefore, despite NCHS/WHO reference standards being available for children up to 18 years old, they are most accurate when limited to use with children up to the age of 10 years.

> Illustrated Guide to Pregnant and Lactating Registers



KEY

This Illustrated Guide considers monitoring requirements for both Pregnant and Lactating mothers.

1 **Pregnant Register**

2 **Lactating Register**

A REGISTRATION:

Serial No.:
> Enter sequence number in register

ANC. No:
> Enter unique identifying number

Name:
> Print name of expectant / lactating mother

Age:
> Enter age (in years)

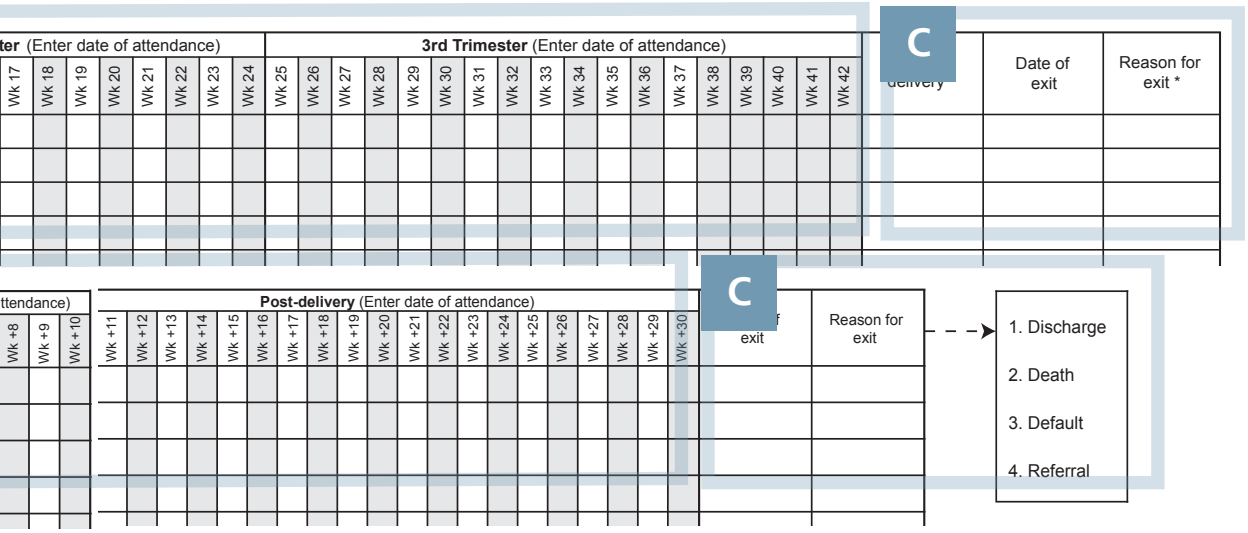
Status:
> Classify as Refugee (Ref) / National (Nat)

Address:
> Enter Camp Address (Refugee) / Nearest Village (National)

Date of delivery:
> Enter date (Lactating Register only) (dd/mm/yy)

Date of admission:
> Enter date (dd/mm/yy)

Re-adm:
> Enter Yes (Y) if previous admission / No (N) if new admission.



B ADMISSION HISTORY:

On each week of admission:

1. Date:
> Enter Date of attendance (dd/mm/yy)

NOTES

Date of first visit must be registered correctly:

- For pregnant women, the date of first visit should be registered according to gestational age. Subsequent visits then record advancing gestation until the time of delivery.

- For lactating women, the date of first visit should be registered according to number of weeks post-delivery. Subsequent visits then record the post-delivery period until the time of discharge.

Eligibility for admission and discharge should be clearly defined within nutrition policy in each country.

C EXIT DETAILS:

Date of delivery:
> Enter date (Pregnant Register only) (dd/mm/yy)

Date of exit:
> Enter date (dd/mm/yy)

Reason for exit:
> Enter reason for exit, using options provided in legend.

Record as Discharge / Death / Default / Referral

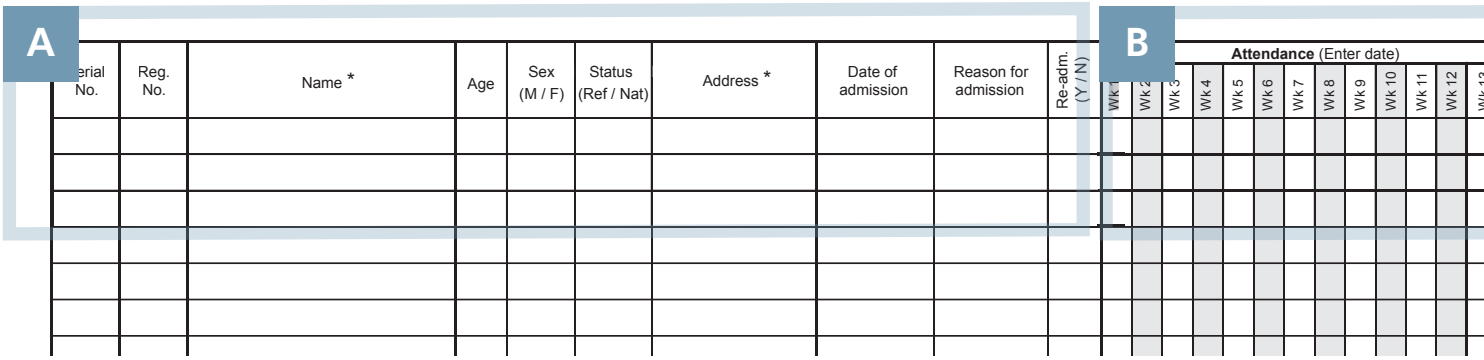
NOTES

Length of stay is not required for pregnant and lactating admissions.

Reasons for exit are listed in a key on each register page. Enter reasons listed in the key ONLY.

Repatriation is included within referral as reason for exit.

> Illustrated Guide to Medical Register (SFP)



KEY

This Illustrated Guide considers monitoring requirements for following medical admission categories:

1. **Anaemia**
2. **HIV/AIDS**
3. **TB**
4. **Other Medical Conditions**

It is recommended that all are logged within the same Medical Admissions Register.

The data recorded each week should take into consideration the reason for admission, and the admission and discharge criteria of each group.

The weekly reporting form contains 'free-cells' to permit Nutrition Programme Managers to customise reasons of admission. Careful coordination is required between Nutrition supervisors in each camp, to ensure that the same reasons are reported from the register and entered into the free-cells in the weekly reporting forms in all nutrition centres.

A REGISTRATION:

Serial No.:
> Enter sequence number in register

Reg. No:
> Enter unique identifying number

Name:
> Print Name of patient

Age:
> Fill Age (in years)

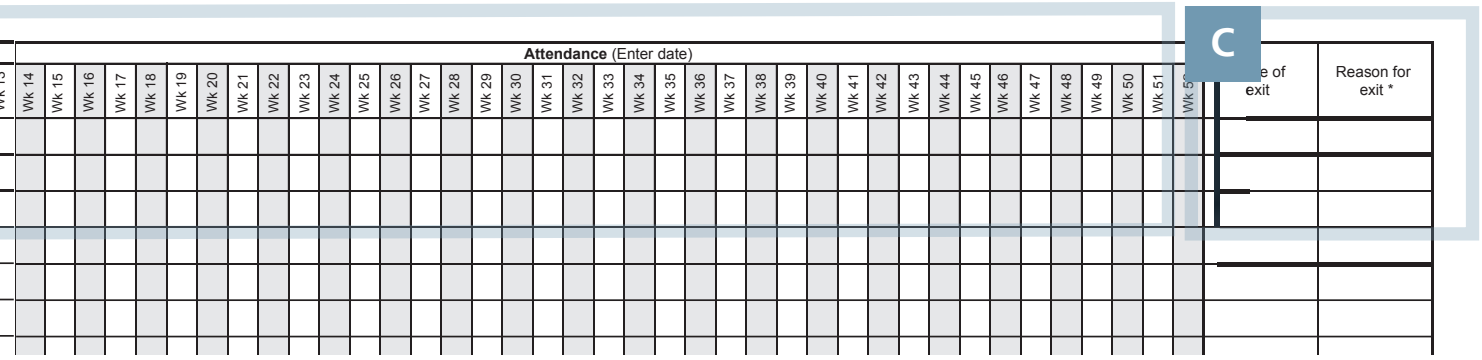
Sex:
> Enter Male (M) / Female (F)

Status:
> Classify as Refugee (Ref) / National (Nat)

Address:
> Print Camp Address (Refugee) / Nearest Village (National)

Date of admission:
> Enter date (dd/mm/yy)

Re-adm:
> Enter Yes (Y) if previous admission / No (N) if new admission.



B ADMISSION HISTORY:

On each week of admission:

1. Date:
> Enter Date of attendance (dd/mm/yy)

2. For Anaemia patients:
> Enter Hb (g/dl) at each visit

3. For HIV/AIDS and TB patient:
> Enter weight (kg) and/or BMI at each visit

4. For Other Medical Conditions section:
> Enter date of attendance at each visit (dd/mm/yy); or if relevant factor in reason for admission, weight / BMI can be monitored at each visit

NOTES

For reasons of confidentiality, the names and addresses of HIV positive individuals must not be recorded in the HIV/AIDS section of the supplementary feeding register.

For more details on protecting the confidentiality in health information, see Module 10: HIV/AIDS.

Eligibility for admission and discharge should be clearly defined within nutrition policy in each country.

C EXIT DETAILS:

Date of exit:
> Enter date (dd/mm/yy)

Reason for exit:
> Discharge / Death / Default / Referral

NOTES

Use calendar to calculate length of stay. The number of day is inclusive of both day of admission and day of discharge.

Reasons for exit are listed in a key on each register page. Enter reasons listed in the key ONLY.

Repatriation is included within referral as reason for exit.

Module 8
Part 2 - Therapeutic Feeding Programme

CONTENTS

ILLUSTRATED GUIDES

Therapeutic Feeding Programme (TFP)

INTRODUCTION

This module outlines the monitoring requirements for the following nutritionally at-risk groups, most commonly targeted for therapeutic feeding in emergency operations:

1. Severely malnourished children
2. Medical cases

The types, objectives and criteria of each Therapeutic Feeding Programme (TFP) should be clearly defined and standardised among all health partners within the country (see Country Considerations Box). Internationally accepted weight-for-height (Z-score or %median) and/or MUAC criteria should be used as the basis for admission and discharge of all beneficiaries in the programme. There are many types of TFP and the admission and discharge criteria vary widely. The internationally recommended criteria are listed in this manual.

> Data collection and monitoring tools

Therapeutic Feeding Programme

Primary Tools
1. Severe Malnutrition Register
2. Medical Register
3. Severe Malnutrition Patient Record Form
4. Nutrition Report

Secondary Tools
1. TFP ration card
2. TFP record card
3. Road to Health Card
4. NCHS/WHO Reference Values
5. Clinical Notes

8.6 WHAT ARE THE TOOLS USED FOR DATA COLLECTION?

The data collection tools used in the TFP are shown below. They are classified as follows:

Primary Tools

Primary data sources are essential to routine monitoring within the HIS and are prerequisite to the calculation of indicators. They form the basis of the guidance and training within this manual and are described in detail in the Illustrated Guides at the end of the module.

Secondary Tools

Secondary data sources have important functions within the HIS but are not directly used to calculate indicators. They play vital roles informing clinical decision-making and promoting service quality and performance. They are described in information boxes in the supporting text.

8.7 WHO IS RESPONSIBLE FOR COLLECTING THE DATA?

TFP staff are responsible for recording all beneficiaries in a register and ensuring that records are updated at each visit. Each staff member should understand how to accurately record each visit and should take responsibility for maintaining neat and legible records.

At the end of each week, the Nutrition supervisor should coordinate the compilation of the nutrition report and ensure that respective sections have made their submission in full and on time. The Nutrition supervisor is also responsible for monitoring the upkeep of the registers and for certifying the completeness of record entries each day.

8.8 WHAT DATA SHOULD BE COLLECTED AND HOW?

8.8.1. Severe Malnutrition Register

> At the time of admission, basic identifying information should be recorded and each child assigned a unique identifying code. The same code number should be used throughout admission (including subsequent referral to SFP). This identifier must also be recorded on the Road to Health card (see Secondary Tools: Road To Health Card) to facilitate the easy retrieval of register entries at repeat visits. The definitions of TFP admission categories for children under 5 are shown in Table 1.

The weight-for-height (WFH) or MUAC should be recorded on admission (depending on the admission/discharge criteria being used). The presence/absence of bilateral, pitting oedema and

the target weight of each severely malnourished child should should be also recorded if indicated. Target weight cannot be calculated for children with kwashiorkor or in programmes which used MUAC for admission/discharge criteria. Discharge criteria should instead be modified in these instances and adopt criteria which are markers of satisfactory clinical progress (e.g. regaining of appetite and absence of co-morbidity). For cases of marasmic kwashiorkor, WFH criteria and target weight can be calculated as for marasmus.

Table 1 TFP admission category definitions: children under 5

New admission	• MUAC <115mm • Less than 70% median / -3 Z-score WFH
Re-admission	• Admission within 2 weeks of being discharged cured from TFP

> At each subsequent visit, weight measurements should updated in the register each day. Height / length measurements are required once per month, due to the stability of this variable.

When a child is registered in the Severe Malnutrition Register a new Patient Record Form should be started. Weight measurements, temperature, and observations of oedema should be recorded in this form regularly each day. The Patient Record Form is designed to assist feeding centre staff to monitor clinical status and weight gain of each severely malnourished child in TFP. Weight is plotted in a graph, which acts a visual aid to monitor advancement towards the target weight. It also assists in the calculation of average weight gain and length of stay at the time of discharge (for a step-by-step guide on how to calculate average weight gain see the Illustrated Guide to the Severe Malnutrition Patient Record Form at the end of this module).

The Patient Record Form should be used in conjunction with the Severe Malnutrition Register and both should be kept updated daily during feeding centre ward rounds. It does not replace the need to keep detailed clinical history, examination and progress notes for each severely malnourished child. These are an essential aspect of clinical care and are important in informing correct treatment and management decisions (see Secondary Tools: TFP Clinical Notes).

> At the time of exit, the number of days between the date of admission and discharge should be determined. A calendar should be used, particularly if this period extends over more than one month. The length of stay is inclusive of both the day of admission and the day of discharge.

The recommended mean length of stay for severely malnourished children in TFP is 30 days. Each row in the register is sufficient to record up to 31 days of admission. If length of stay exceeds this period then on day 32 the child should be transferred into the next available row. The same serial number should be used and an explanatory remark given next to the original entry.

Average weight gain during admission should also be determined at discharge. The Patient Record Form should be used to facilitate accurate calculation (for a step-by-step guide on how to calculate average weight gain, see the Illustrated Guide to the Severe Malnutrition Patient Record Form).

Length of stay and Average Weight Gain should be calculated for all exits, though only reported at the end of the week for refugee children under five who are discharged.

> Secondary Tools

TFP Clinical Notes

The Patient Record Form is designed to assist feeding centre staff to monitor clinical progress and weight gain of each severely malnourished child. It is a tool to facilitate data collection and reporting at the end of each week.

The form does NOT replace the need to keep detailed clinical history and examination records for each child. Clinical notes should be kept for the duration of any in-patient admission and appended to the TFP Patient Form.

A checklist for taking the child's medical history and conducting the physical examination is given below*. Additional continuation sheets should also be filled to document clinical progress as required.

Medical history	Physical examination
• Usual diet before current episode of illness • Breastfeeding history • Food and fluids taken in past few days • Recent sinking of eyes • Duration and frequency of vomiting or diarrhoea, appearance of vomit or diarrhoeal stools • Time when urine was last passed • Contact with people with measles or tuberculosis • Any deaths of siblings • Birth weight • Milestones reached (sitting up, standing, etc.) • Immunizations	• Weight and length or height • Oedema • Enlargement or tenderness of liver, jaundice • Abdominal distension, bowel sounds • Severe pallor • Signs of circulatory collapse: cold hands and feet, weak radial pulse, diminished consciousness • Temperature: hypothermia or fever • Thirst • Eyes: corneal lesions indicative of vit. A deficiency • Ears, mouth, throat: evidence of infection • Skin: evidence of infection or purpura • Respiratory rate and type of respiration: signs of pneumonia or heart failure

* Management of Severe Malnutrition: A Manual for Physicians and Other Senior Health Workers. WHO (1999)

The reason for exit must be stated for every entry in the register. The defintions for TFP exit categories for children under 5 are shown in Table 2.

An Illustrated Guide to the TFP Registers and an explanation of the information that should be recorded in each is given at the end of the module.

Table 2 TFP exit category definitions: children under 5

Discharged cured	• More than 80% median / -2 Z-score WFH for two consecutive weighings (for MUAC admissions a fixed length of stay may be required, as for OTP) • At least 15% weight gain
Death	• Died during time registered in TFP
Default	• Absent for three consecutive days
Referral	• Have to be transferred to a stabilisation centre or hospital due to severe medical complications • Repatriation is considered under the category of referral as a reason for exit.

8.8.2 Medical Register

Individuals other than those who meet anthropometric criteria defining malnutrition may benefit from therapeutic feeding. The HIS will need to be adjusted according to the numbers and types of cases included within this category, and eligibility criteria for each group should be objective and explicitly defined in the country Nutrition Protocol.

> At the time of admission, all medical admissions should have basic identifying information recorded at registration and be assigned a unique identifying number. It is recommended that all are logged in the same Medical Register.

> At each visit, the date of attendance should be recorded. Other information (e.g. weight, BMI, haemoglobin) can also be recorded depending on the admission criteria. Length of stay for medical admissions in TFP is variable and will depend on criteria defined in the Nutrition Protocol. The maximum capacity of each register is up to and including 46 days of admission. If length of stay exceeds this period, then the start of day 47 should be recorded in the next available row. The same serial number should be used. An explanatory remark should be entered next to the reason for exit in the original entry.

> At the time of exit, the reason for exit should be documented and only reasons given in the legend on each register page should be recorded.

> Country Considerations

What are the categories for medical admission in TFP?

a. Severe Anaemia
Admission and discharge criteria should be based upon objective measurement of haemoglobin levels. Progress towards pre-defined discharge criteria should be closely monitored and haemoglobin level recorded daily.

b. Low Birth Weight / Premature Babies
WFH Z-score or %median index is not applicable to babies under 6 months of age. Admission and discharge criteria should instead be based upon birth weight measurement in grams (the accepted cut-off is 2500 g). Progress towards the discharge criteria should be closely monitored at each visit. Weight should be checked and recorded daily.

c. Others
Admission and discharge criteria must be as objective as possible for individuals in this section, and reason for admission must be always be specified in the register. The date should be recorded at each visit and, if appropriate to the reason for admission, other variables such as weight/BMI should be entered.

8.9 HOW AND WHEN SHOULD THE DATA BE REPORTED?

At the end of each week, the TFP registers should be used to compile the nutrition report.

The dates of each reporting week are shown in the Reporting Calendar. It is important that all staff are aware of these dates, and that copies the calendar are distributed to all nutrition centres.

The Nutrition supervisor is responsible for completing the report. A weekly report in each feeding centre is essential to permit the accurate calculation of the balance of beneficiaries in each unit. The table keeps a rolling total of the number registered at the beginning and the end of each week, and should be updated with records of admissions and discharges made during the reporting period.

Feeding centre staff must understand the purpose of collecting the information. Each entry should be carefully retrieved from the registers, and appropriately disaggregated by age (<5, ≥ 5), sex, status (refugee or national) and reason for admission.

During the reporting of information from the register, length of stay and average weight gain should only be reported for refugee children under five who are successfully discharged. This important to ensure the indicator is correctly calculated and interpreted.

8.10 HOW SHOULD THE DATA BE INTERPRETED AND USED?

An Excel Reporting Form is the first stage of data entry into the computer. If resources are available, then paper report forms can be entered into the computer each week. The database will then automatically combine these into a monthly report composed of 4 or 5 weekly reports (depending on the reporting calendar). If the data cannot be entered into the computer each week it should be aggregated manually using a calculator and entered into the computer at the end of each month. More information on data management and is given in Part 3 of the manual.

The indicators for TFP are shown below. Each is classified according the five core objectives of the HIS. A summary of each indicator, including formulae, units of expression, and the corresponding standard (where available) is given in the Standard and Indicator Guide.

It is essential that staff are familiar with how these indicators are calculated, and understand how they should be used to evaluate programme performance and to inform public health decision-making. An exercise on how to calculate and interpret the indicators, using sample data, is given on the CD-ROM which accompanies this manual.

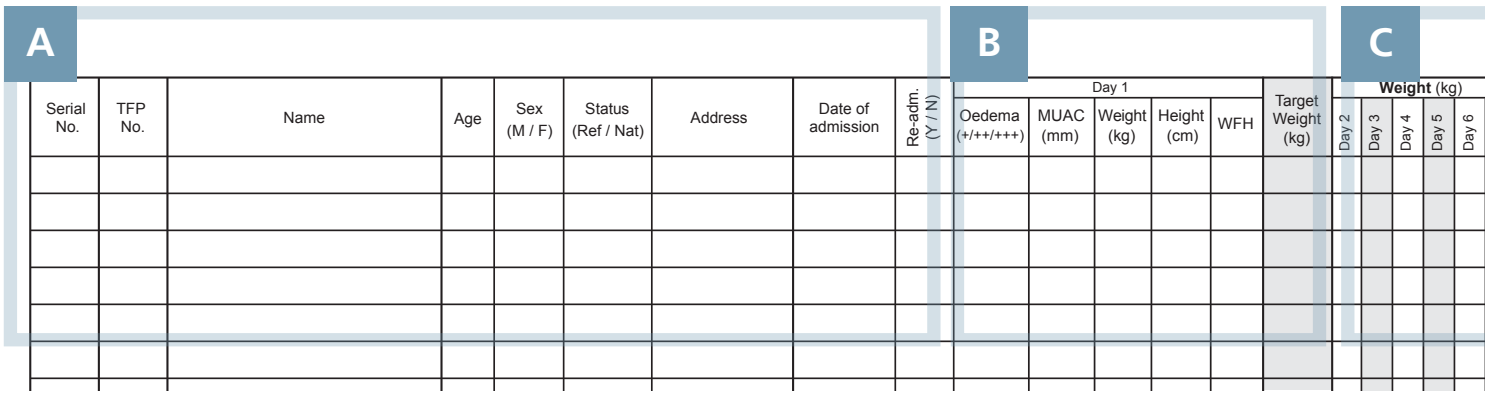
> Indicator Summary

Therapeutic Feeding Programme

Objective	Indicator	Source
3. Evaluate the effectiveness of interventions and service coverage	Coverage of TFP	UNHCR/WFP
	Proportion of beneficiaries who are host nationals	HIS
4. Ensure that resources are correctly targeted to the areas and groups of greatest need	Proportion of new admissions due to Kwashiorkor	HIS
	Proportion of new sev maln. admissions (under 5 female)	HIS
	Proportion of admissions due to "Other"	HIS
5. Evaluate the quality of health interventions*	Mean length of stay	UNHCR/WFP
	Average weight gain	UNHCR/WFP
	Recovery rate**	UNHCR/WFP
	Death rate**	UNHCR/WFP
	Default rate**	UNHCR/WFP

* Disaggregated by marasmus and kwashiorkor
** Disaggregated by refugee and national

> Illustrated Guide to Severe Malnutrition Register



A REGISTRATION:

Serial No.:
> Enter sequence number in register

TFP No:
> Enter unique identifying number

Name:
> Print name of child

Age:
> Enter age (in years)

Sex:
> Enter Male (M) / Female (F)

Status:
> Classify as Refugee (Ref) / National (Nat)

Address:
> Enter Camp Address (Refugee) / Nearest Village (National)

Date of admission:
> Enter date (dd/mm/yy)

Re-adm:
> Enter Yes (Y) if previous admission / No (N) if new admission.

B NUTRITIONAL STATUS:

At the time of registration, enter:

Oedema
> Enter +/++/+++ to indicate presence or absence of oedema

Mid-upper arm circumference (MUAC)
> Enter MUAC (mm)

Weight:
> Enter Weight measurement (kg)

Height:
> Enter Height / Length measurement (cm)

Weight-for-Height (WFH)
> Use NCHS/WHO reference tables to calculate WFH Z-score / %median.

Enter value that defines upper range
(e.g. < -3ZS / <70%)

Target Weight
> Enter target weight (kg) using NCHS/WHO reference tables and based on discharge criteria in nutrition guidelines.

NOTES

Height is requested once at registration. This height measurement should be used throughout admission.

The term 'length' is generally used for children below 85 cm, and 'height' for children 85 cm and above.

D

Weight (kg)																									Date of exit	Length of stay (days)	Average weight gain (g / kg / day)	Reason for exit *	Notes
Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20	Day 21	Day 22	Day 23	Day 24	Day 25	Day 26	Day 27	Day 28	Day 29	Day 30	Day 31					

C ADMISSION HISTORY:

On each day of admission:

Weight:
> Enter weight (in kg)

Clinical progress should also be documented in separate medical records.

Summarised information should be entered on the reverse of the Patient Record Form.

NOTES

Weight should be monitored daily and updated in both the Severe Malnutrition Register and the TFP Patient Record Form (see Illustrated Guide).

Detailed clinical and examination notes should be kept in separate continuation sheets.

D EXIT DETAILS:

On each week of admission:

Date of exit:
> Enter date of exit (dd/mm/yy)

Length of stay:
> Enter number of days between admission and discharge

Average weight gain:
> Enter average weight gain during admission (g / kg / day)

Reason for exit:
> Enter reason for exit, using options provided in legend.

Record as Discharge cured to SFP / Death / Default / Referral)

NOTES

Use calendar to calculate length of stay. The number of day is inclusive of both day of admission and day of discharge.

Average weight gain should be calculated using step-by-step guide on reverse of TFP Patient Record form.

Reasons for exit are listed in a key on each register page. Enter reasons listed in the key ONLY.

Repatriation is included within referral as reason for exit.

> Illustrated Guide to Severe Malnutrition Patient Record Form (FRONT)

Health Information System

Severe Malnutrition - Patient Record Form

A

Name: _____ Serial No.: _____ Name of mother: _____

Age: _____ Reg. No.: _____ Address: _____

Sex (M / F): _____ Date of admission: ___/___/___ Status (Ref / Nat): _____

B

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
MUAC (mm)																															
Weight (kg)																															
Height (cm)																															
Temp (°C)																															

Target Weight (kg):
(use NCHS / WHO reference) _____

C

Oedema (+/++/+++)																															
Weight (kg)																															

D

Date of exit: ___/___/___ Length of stay (days): _____

Reason for exit *: _____ Average weight gain (g / kg / day) ** _____

* Reason for exit: **1.** Discharge cured to SFP **2.** Death **3.** Default **4.** Referral ** See guide on reverse

SAM CLINICAL_EN_090109

The Severe Malnutrition Patient Record Form is designed to assist feeding centre staff to monitor clinical progress and weight gain of each severely malnourished child. It is a tool to facilitate data collection and reporting at the end of each week. The form does NOT replace the need to keep detailed clinical history and examination records for each child. Clinical notes should be kept for the duration of any in-patient admission and appended to the Patient Record Form.

A ADMISSION:

Name:
> Enter name of child

Age:
> Enter age (in years)

Sex:
> Enter Male (M) / Female (F)

Serial No.:
> Enter sequence number in register

Reg. No:
> Enter unique identifying number

Date of admission:
> Enter date (dd/mm/yy)

Name of mother:
> Print Name of child's mother

Address:
> Print Camp Address (Refugee) / Nearest Village (National)

Status:
> Classify as Refugee (Ref) / National (Nat)

C GRAPH OF WEIGHT GAIN:

Name:
> Observe for oedema daily and indicate presence by entering Yes (Y) or No (N)

Daily weight should be plotted in the graph and the points joined with straight ruled line.
Each column in the graph represents the date of admission as entered in section B.
The units for the Y-axis should be customised to the weight of the child. The bold lines should be used to indicate intervals of .0 kg and .5 kg.

B DAILY OBSERVATIONS:

Date:
> Enter day (dd/mm)

Weight:
> Enter weight (kg)

Height:
> Enter height / length (cm)

Temperature:
> Enter temperature (°C)

Target Weight should be established at registration, based on the weight and height measurements taken on admission.

Target weight should correspond to discharge criteria defined in the Nutrition Policy Guidelines.

D DISCHARGE:

Date of exit:
> Enter weight (dd/mm/yy)

Reason for exit:
> Enter reason for exit, using options provided in legend: Discharge cured to SFP / Death / Default / Referral

Length of stay:
> Enter number of time between admission and discharge (days)

Average weight gain:
> Enter average weight gain during admission (g / kg / day) (see below)

> Illustrated Guide to Severe Malnutrition Patient Record Form (REVERSE)

The reverse of each form provides step-by-step guidance on how average weight gain should be calculated at the time of exit.

A summary of the clinical history and treatment provided can also be entered.

E CLINICAL NOTES:

Enter summary of important clinical observations in space provided.

Detailed notes should be kept in individual patient records.

F AVERAGE WEIGHT GAIN:

To calculate average weight gain (g / kg / day):

Step 1

Calculate the maximum weight gain during admission. This is (weight on exit) - (lowest weight recorded during recovery) in GRAMS (g)

Step 2

Divide by lowest weight recorded during recovery in KILOGRAMS (kg)

Step 3

Divide by total number of DAYS between exit and lowest weight recorded during recovery.

Step 4

Enter figure in discharge information section on front of form (section D) AND in Severe Malnutrition Register.

NOTES

Average Weight Gain should only be reported for REFUGEE CHILDREN UNDER FIVE who are DISCHARGED.

Lowest weight gain during admission is NOT always the same as weight on admission.

Number of days between discharge and lowest weight gain recorded is NOT always the same as length of stay.

E

Clinical Notes

F

Note:

To calculate average weight gain (g / kg / day):

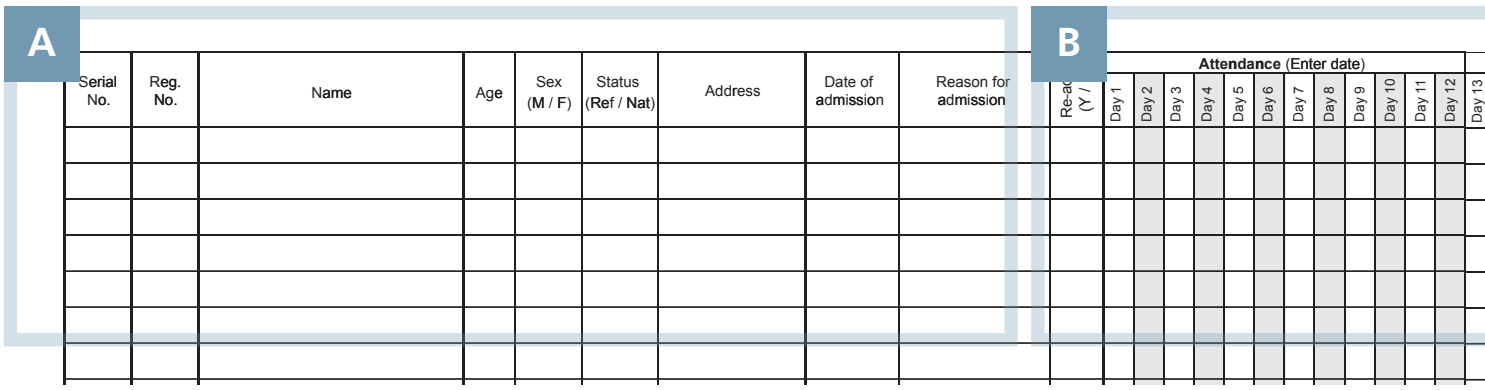
1. Calculate the maximum weight gain during admission [in grams (g)]
   (= weight on exit - lowest weight recorded during recovery)

2. Divide by lowest weight recorded during recovery [in kilograms (kg)]

3. Divide by total number of days between exit and lowest weight recorded during recovery
   (this is NOT always the same as length of stay).

4. Enter figure on reverse and in Severe Malnutrition Register. At end of the week, calculate the sum average weight gain for all refugee discharges under 5 and enter into weekly report.

> Illustrated Guide to Medical Register (TFP)



KEY

This Illustrated Guide considers monitoring requirements for following categories of medical admissions:

Section 1. Severe anaemia

Section 2. Low birth weight

Section 3. Other Medical Conditions

It is recommended that all are logged in individual sections within the same Medical Admissions Register

The design and layout of each section should be adapted to each country and take into consideration the admission and discharge criteria of each group.

The weekly reporting form contains a category "Other" to permit miscellaneous reasons for admission to be recorded.

A REGISTRATION:

Serial No.:
> Enter sequence number in register

Reg. No:
> Enter unique identifying number

Name:
> Print name of patient

Age:
> Enter Age (in years)

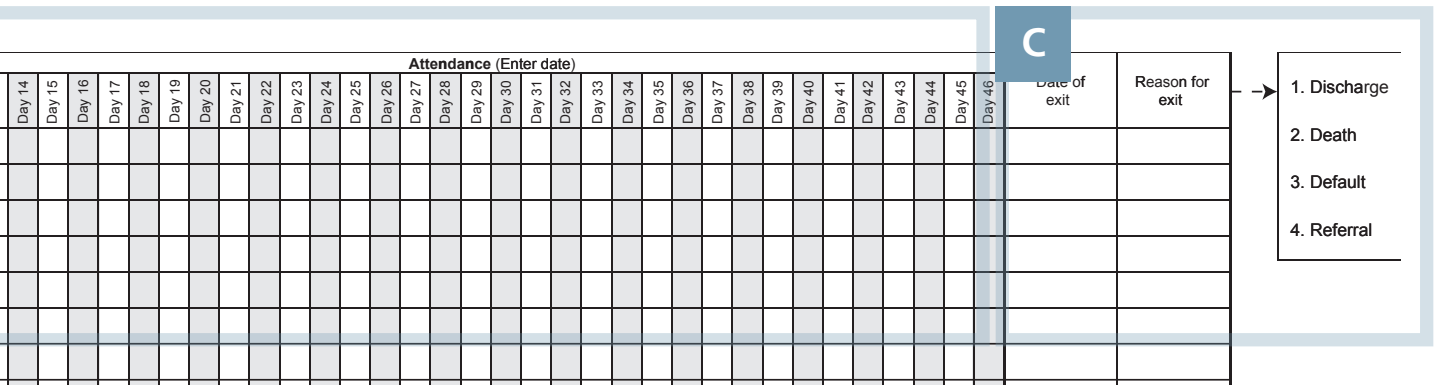
Sex:
> Enter Male (M) / Female (F)

Status:
> Classify as Refugee (Ref) / National (Nat)

Address:
> Print Camp Address (Refugee) / Nearest Village (National)

Date of admission:
> Enter date (dd/mm/yy)

Re-adm:
> Enter Yes (Y) if previous admission / No (N) if new admission.



B ATTENDANCE HISTORY:

On each week of admission:

1. Date:
> Enter Date of attendance (dd/mm/yy)

2. For Severe anaemia patients:
> Enter Hb (g/dl) at each visit

3. For low birth weight babies:
> Enter weight (kg)

4. For Other Medical Conditions section:
> Enter date of attendance at each visit (dd/mm/yy); or weight / BMI if a relevant factor in reason for admission

NOTES

For reasons of confidentiality, the names and addresses of HIV positive individuals must not be recorded in the HIV/AIDS section of the medical register.

For more details on protecting the confidentiality in health information, see Module 10: HIV/AIDS.

Eligibility for admission and discharge should be clearly defined within nutrition policy in each country.

C EXIT DETAILS:

Date of exit:
> Enter date (dd/mm/yy)

Reason for exit:
> Discharge / Death / Default / Referral

NOTES

Use calendar to calculate length of stay. The number of day is inclusive of both day of admission and day of discharge.

Reasons for exit are listed in a key on each register page. Enter reasons listed in the key ONLY.

Repatriation is included within referral as reason for exit.

Health Information System

Reporting Form

8.0 Nutrition

A

Organisation: _____

Location: _____

Reporting period: _____

B

8.1 Supplementary Feeding Program

		Refugee							National							SFP Total
		< 5		≥ 5					< 5		≥ 5					
		M	F	M	F	Total	Preg.	Lact.	M	F	M	F	Total	Preg.	Lact.	
Number at beginning of period (a)	*Moderate malnutrition*															
	Other															
Number of new admissions	*1. Moderate malnutrition*															
	2.															
	3.															
	4.															
	5. from OTP/TFP															
	6. Other															
Number of re-admissions	*Moderate malnutrition*															
	Other															
Total Admissions (b)	*Moderate malnutrition*															
	Other															
Number of exits — *Mod. malnutrition*	*discharge cured*															
	death															
	default															
	referral															
	non-cured															
Number of exits — *Other*	*discharge cured*															
	death															
	default															
	referral															
	non-cured															
Total Exits (c)	*Moderate malnutrition*															
	Other															
Number at end of period (a + b - c)	*Moderate malnutrition*															
	Other															

Enter refugee data ONLY

Moderate malnutrition	Sum no. of weeks stay for discharged children (< 5)	

NUTRITION_EN_090109

A HEADER:

Organisation:
Print Name of health implementing partner

Location:
Print Name of Camp and/or Reporting Unit

Reporting period:
Enter number of week and month (e.g. Week 1 March)

NOTES

The dates of each reporting week are shown in the Reporting Calendar. It is important that all staff are aware of these dates, and that copies the calendar are distributed to all antenatal clinics.

The feeding supervisor is responsible for coordinating the complete and timely submission of all sections contributing to the weekly report.

B SUPPLEMENTARY FEEDING PROGRAMME:

Complete Table 8.1, using the supplementary feeding registers.

Enter the sum number of days stay for exits into the blank box below the table, ONLY for beneficiaries who meet the following criteria:

> refugee

> under five

> reason for admission was moderate malnutrition

> reason for exit was discharge cured

New admissions numbers 2, 3 and 4 are 'free-cells' which permit additional reason to be added to the list and monitored. These should be agreed upon in close coordination with all health agencies to guarantee the consistency and comparability of information within each country operation.

NOTES

It is important to regularly monitor the number of beneficiaries registered in the feeding programme at any one time. This moving total should be calculated each week, according to the following classification:

> moderate malnutrition

> other

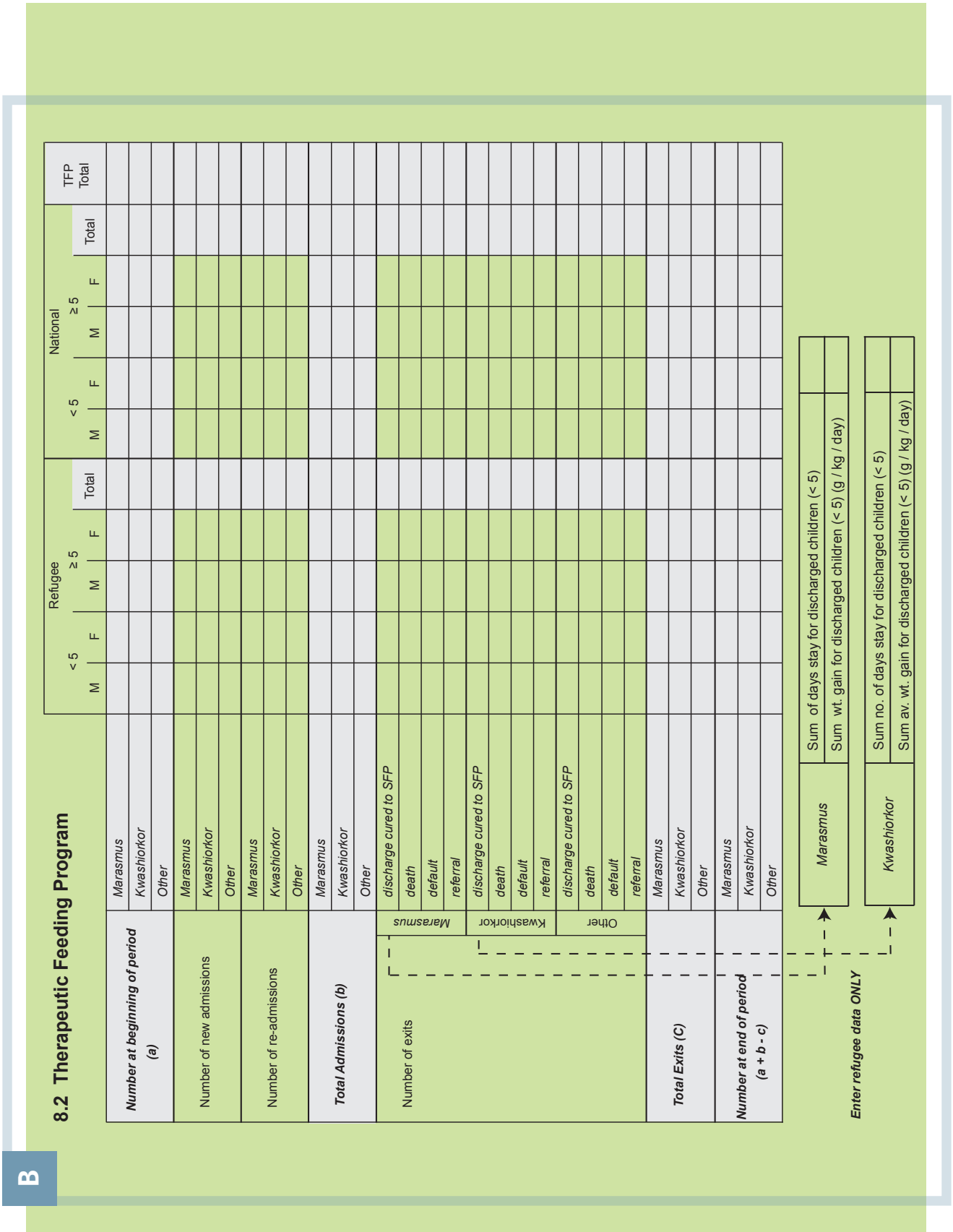
Open the balance for the current week, by transferring the number of beneficiaries registered at the end of the previous week into the grey totals rows (Section A).

Using a calculator, add the total number of admissions and exits during the week and enter into the grey totals rows (Sections B and C, respectively).

Using a calculator, work out the closing balance of beneficiaries registered at the end of the week (Section D) as follows:

> D = A + B - C

> Illustrated Guide to Nutrition Report (REVERSE)



C THERAPEUTIC FEEDING PROGRAMME:

Complete Table 8.2, using the therapeutic feeding registers.

Enter the sum number of days stay and sum average weight gain into the blank boxes below the table, ONLY for exits who meet the following criteria:

> refugee

> under five

> reason for admission was severe malnutrition*

> reason for exit was discharge

* The figures are disaggregated by marasmus and kwashiorkor.

NOTES

It is important to regularly monitor the number of beneficiaries registered in the feeding programme at any one time. This moving total should be calculated each week, according to the following classification:

> marasmus

> kwashiorkor

> other

Open the balance for the current week, by transferring the number of beneficiaries registered at the end of the previous week into the grey totals rows (Section A).

Using a calculator, add the total number of admissions and exits during the week and enter into the grey totals rows (Sections B and C, respectively).

Using a calculator, work out the closing balance of beneficiaries registered at the end of the week (Section D) as follows:

> D = A + B - C

Module 8
Part 3 - Community-based Therapeutic Care

CONTENTS

ILLUSTRATED GUIDES

Guidance in this module is referenced from *Community-based Therapeutic Care (CTC) A Field Manual*. First Edition, 2006. Valid International.

Community-based Therapeutic Care (CTC)

INTRODUCTION

Severe malnutrition has traditionally been managed in inpatient facilities using therapeutic feeding centres (see Module 8 Part 2: Therapeutic Feeding Programme). However, this approach can have a number of limitations; notably in terms of low access, poor coverage, and high costs to families in staying at centres and leaving other children and family members at home.

In response, community-based therapeutic care (CTC) offers an alternative form of care. It provides simple, effective outpatient care for those who can be treated at home and clinical care for those who need inpatient treatment. This is often more appropriate and acceptable means of providing nutritional rehabilitation and can help to extend programme coverage and access.

Acutely malnourished children are identified through screening of the affected population or by community or self-referral. Three forms of treatment are provided according to the severity of the child's condition:

- Those with moderate acute malnutrition and no medical complications are supported in a supplementary feeding programme (SFP) which provides dry take-home rations and simple medicines (see Module 8 Part 1: Supplementary Feeding Programme).
- Those with severe acute malnutrition (SAM) with no medical complications are treated in an Outpatient Therapeutic Programme (OTP), which provides ready-to-use therapeutic food (RUTF) and routine medicines to treat simple medical conditions. These are taken at home, and the child attends an OTP site weekly for check ups and more supplies of RUTF.
- Those who are acutely malnourished and have medical complications are treated in an inpatient stabilisation centre (SC) until they are well enough to continue with outpatient care.

8.11 WHAT ARE THE TOOLS USED FOR DATA COLLECTION?

The data collection tools used in the CTC are shown below. They are classified as follows:

Primary Tools

Primary data sources are essential to routine monitoring within the HIS and are prerequisite to the calculation of indicators. They form the basis of the guidance and training within this manual and are described in detail in the Illustrated Guides at the end of the module.

Secondary Tools

Secondary data sources have important functions within the HIS but are not directly used to calculate indicators. They play vital roles informing clinical decision-making and promoting service quality and performance. They are described in information boxes in the supporting text.

> Data collection and monitoring tools

Community-based Therapeutic Care

Primary Tools
1. Stabilisation Centre Register
2. Outpatient Therapeutic Programme Register
3. Severe Malnutrition Patient Record Form
4. CTC Report

Secondary Tools
1. CTC ration card
2. CTC record card
3. Road to Health Card
4. NCHS/WHO Reference Values
5. Clinical Notes

8.12 WHO IS RESPONSIBLE FOR COLLECTING THE DATA?

CTC consists of two phases of care: inpatient (within a stabilisation centre) and outpatient (within an outpatient therapeutic programme). For purposes of monitoring it is important for CTC indicators to be calculated across both phases of care so that programme performance can be comprehensively reviewed. Depending on the country, this may or may not be a simple task. SC and OTP may be provided in the different locations and by different organizations. Therefore, the process of data collection can be challenging and require close coordination between different partners.

To facilitate data collection it is recommended that a lead nutrition agency is designated and to take responsibility for data management within the CTC programme. Individiual organisations remain responsible for data management within their specific phase of care. However, at the end of each week, the lead nutrition agency should coordinate the compilation of the CTC report and ensure that data from both phases have been submitted in full and on time across different nutrition partners.

8.13 WHAT DATA SHOULD BE COLLECTED AND HOW?

8.13.1 Stabilisation Centre Register

> At the time of admission, basic identifying information should be recorded and each child assigned a unique identifying code. The same code number should be used throughout admission (including subsequent referral to OTP and SFP). This identifier must also be recorded on the Road to Health card (see Secondary Tools: Road To Health Card) to facilitate the easy retrieval of register entries at repeat visits. The definitions of CTC admission categories for children under 5 are shown in Table 1.

The weight-for-height (WFH) or MUAC should be recorded on admission (depending on the admission/discharge criteria being used). The presence/absence of bilateral, pitting oedema and the target weight should be also recorded if indicated. Note that for cases of marasmic kwashiorkor, WFH criteria and target weight can be calculated as for marasmus.

Table 1 SC admission category definitions: children under five

New admission	• Bilateral oedema grade +++ • MUAC <125mm or WFH less than 80% median / -2 Z-score or bilateral oedema grade + or ++ AND no appetite/severe medical complications* • Severely malnourished infants <6 months
Re-admission	• Admission within 2 weeks of being discharged cured from CTC
Transfer	Discharged from the OTP due to: • Severe medical complication or anorexia • Worsening oedema • Weight loss for three weeks • Non recovery after three months in the OTP programme From SFP due to: • Severe medical complications**

* See box: Definitionof severe medical complications

** Before admission to the SC, the reasons for non-recovery in the OTP should be investigated by discussion with the carer at the programme site and through home visits by the outreach team.

> Definitions of severe medical complications

1. Intractable vomiting.
2. Fever > 39°C or hypothermia < 35°C.
3. Lower respiratory tract infection according to IMCI guidelines for age:
   - ≥ 60 respirations/minute for under two-months.
   - ≥ 50 respirations/minute from two to twelve months.
   - ≥ 40 respirations/minute from one to five years.
   - ≥ 30 respirations/minute for over five years.
4. Any chest in-drawing.
5. Severe anaemia – very pale (severe palmar pallor), difficulty breathing.
6. Extensive superficial infection requiring intramuscular (IM) treatment.
7. Very weak, apathetic, unconscious, convulsions. Severe dehydration based primarily on recent history of diarrhoea, vomiting, fever or sweating and on recent appearance of clinical signs of dehydration as reported by the carer.

> At each subsequent day of admission, weight measurements should be regularly updated in the register. When a child is registered in the Stabilisation Centre Register, a new Patient Record Form should also be started (see Illustrated Guide to Severe Malnutrition Patient Record Form). Weight measurements, temperature, and observations of oedema should be recorded in this form regularly, each day.

The Patient Record Form is designed to assist feeding centre staff to monitor clinical status and weight gain of each severely malnourished child in CTC. Weight is plotted in a graph, which acts a visual aid to monitor advancement towards the target weight. It also assists in the calculation of average weight gain and length of stay at the time of discharge. The form should be used in conjunction with the Stabilisation Centre Register and both should be kept updated daily during admission. It does not replace the need to keep detailed clinical history, examination and progress notes for each severely malnourished child. These are an essential aspect of clinical care and are important in informing correct treatment and management decisions (see Secondary Tools: TFP Clinical Notes).

Table 2 SC exit category definitions: children under 5

Discharge to OTP	• Appetite returned (eats at least 75% of RUTF) • Medical complications controlled • Oedema resolving
Death	• Died during time registered in SC
Default	• Absent for three consecutive days
Referral	• Have to be transferred to a different stabilisation centre or hospital due to severe medical complications

> At the time of exit, the number of days between the date of admission and discharge should be determined. The recommended mean length of stay for severely malnourished children in SC is 5 to 7 days. Each row in the register is sufficient to record up to 14 days of admission. If length of stay exceeds this period, then on day 15 the child should be transferred into the next available row. The same code number should be used, and an explanatory remark added next to the original entry.

Average weight gain during admission should also be determined at discharge. The Patient Record Form should be used to facilitate accurate calculation (for a step-by-step guide on how to calculate average weight gain, see the Illustrated Guide to the Severe Malnutrition Patient Record Form).

Length of stay and average weight gain should be calculated for all exits, though only reported at the end of the week for refugee children under five who are discharged.

The reason for exit must be stated for every entry in the register and only reasons given in the legend on each register page should be recorded. The definitions of SC exit categories for children under 5 are shown in Table 2.

Table 3 OTP admission category definitions: children under five

New admission	• Bilateral oedema grade + or ++ • MUAC < 115mm or WFH less than 70% median / -3 Z-score* • Carer refuses inpatient care despite advice
Re-admission	• Admission within 2 months of being discharged cured from CTC
Transfer	• From inpatient care (SC/TFC/nutrition rehabilitation unit (NRU)/ hospital) after 'stabilisation' treatment**

* In addition, infants <6 months who have been discharged from the SC can be admitted to the OTP so that their weight and general medical condition can continue to be monitored. They do not receive RUTF.

** Before admission to the SC, the reasons for non-recovery in the OTP should be investigated by discussion with the carer at the programme site and through home visits by the outreach team.

8.13.2 Outpatient Therapeutic Programme (OTP) Register

> At the time of admission, basic identifying information should be recorded and each child assigned a unique identifying code. The same code should be used throughout admission (including subsequent referral to SFP). This identifier must also be recorded on the Road to Health card (see Secondary Tools: Road To Health Card) to facilitate the easy retrieval of register entries at repeat visits. The definitions of OTP admission categories for children under 5 are shown in the table 3.

The WFH or MUAC should be recorded on admission (depending on the admission/discharge criteria being used). The presence/absence of bilateral, pitting oedema and the target weight should be also recorded if indicated. For cases of marasmic kwashiorkor, WFH criteria and target weight can be calculated as for marasmus.

> At each subsequent visit, weight or MUAC measurements should updated in the register each day. Height measurements should be taken on admission and again on discharge.

> At the time of exit, the number of weeks between the date of admission and discharge should be determined. A calendar should be used, particularly if this period is of long duration and extends over more than one month. Length of stay is inclusive of both the week of admission and the week of discharge. The recommended mean length of stay for children in OTP is 8 weeks (2 months). Each row in the register is sufficient to record up to 12 weeks (3 months) of admission. If length of stay exceeds this period, then on week 13 the child should be transferred into the next

Table 4 OTP exit category definitions: children under 5

Discharged cured*	• Minimum stay of two months in the programme, MUAC >110mm or WFH greater than 80% median / -2 Z-score, no oedema for two consecutive weighings, sustained weight gain** and clinically well • At least 15% weight gain
Death	• Died during time registered in OTP
Default	• Absent for three consecutive weeks
Referral	• Condition has deteriorated and requires inpatient therapeutic (SC/TFC/NRU) or hospital care
Non-cured	• Has not reached discharge criteria within three months***

* All OTP discharges should be sent to the SFP where they stay for a minimum of two months (longer if they have not attained the SFP discharge criteria by that time).

** Sustained weight gain is a gain in weight every week for two consecutive weeks.

*** Before this time, children must have been followed-up at home and should be transferred to SC inpatient care for investigations where possible. Discharged non-cured children should be sent to the SFP; they can be readmitted to the OTP if they fulfil entry criteria again and are therefore once more at high risk of mortality. No child should be discharged as non-cured if their MUAC is still <115mm.

available row. The same serial number should be used, and an explanatory remark made next to the original entry.

Average weight gain during admission should also be determined at discharge (for a step-by-step guide on how to calculate average weight gain, see the Illustrated Guide to the Severe Malnutrition Patient Record Form).

Length of stay and average weight gain should be calculated for all exits, though only reported at the end of the week for refugee children under five who are discharged.

The reason for exit must be stated for every entry in the register and only reasons given in the legend on each register page should be recorded. The definitions of OTP exit categories for children under 5 are shown in Table 4.

8.14 HOW AND WHEN SHOULD THE DATA BE REPORTED?

At the end of each week the CTC Registers should be used to compile the CTC Report.

The dates of each reporting week are shown in the Reporting Calendar. It is important that all staff are aware of these dates, and that copies the calendar are distributed to all nutrition centres.

The Nutrition supervisor is responsible for completing the report. A weekly report in each feeding centre is essential to permit the accurate calculation of the balance of beneficiaries in each unit. The table keeps a rolling total of the number registered at the beginning and the end of each week, and should be updated with records of admissions and discharges made during the reporting period. An Illustrated Guide to the nutrition report is given at the end of the module.

Feeding centre staff must understand the purpose of collecting the information. Each entry should be carefully retrieved from the registers, and appropriately disaggregated by age (<5, ≥5), sex, status (refugee or national) and reason for admission.

During the reporting of information from the register, length of stay and average weight gain should only be reported for refugee children under five who are successfully discharged. This important to ensure the indicator is correctly calculated and interpreted.

8.15 HOW SHOULD THE DATA BE INTERPRETED AND USED?

An Excel Reporting Form is the first stage of data entry into the computer. If resources are available, then paper report forms can be entered into the computer each week. The database will then automatically combine these into a monthly report composed of 4 or 5 weekly reports (depending on the reporting calendar). If the data cannot be entered into the computer each week it should be aggregated manually using a calculator and entered into the computer at the end of each month. More information on data management and is given in Part 3 of the manual.

The indicators for CTC are shown below. Each is classified according the five core objectives of the HIS. A summary of each indicator, including formulae, units of expression, and the corresponding standard (where available) is given in the Standard and Indicator Guide.

It is essential that staff are familiar with how these indicators are calculated, and understand how they should be used to evaluate programme performance and to inform public health decision-making. An exercise on how to calculate and interpret the indicators, using sample data, is given on the CD-ROM which accompanies this manual.

> Indicator Summary

Community-based Therapeutic Care

Objective	Indicator	Source
3. Evaluate the effectiveness of interventions and service coverage	Coverage of CTC	HIS
	Proportion of beneficiaries who are host nationals	HIS
4. Ensure that resources are correctly targeted to the areas and groups of greatest need	Proportion of new admissions due to Kwashiorkor	HIS
	Proportion of new sev maln. admissions (under 5 female)	HIS
	Proportion of admissions due to "Other"	HIS
5. Evaluate the quality of health interventions*	Mean length of stay	HIS
	Average weight gain	HIS
	Recovery rate**	HIS
	Death rate**	HIS
	Default rate**	HIS

* Disaggregated by marasmus and kwashiorkor
** Disaggregated by refugee and national

> Illustrated Guide to Stabilisation Centre Register

A										B						
										FIRST ADMISSION*						
Serial No.	SAM No.	Name	Age	Sex (M / F)	Status (Ref / Nat)	Address	Date of admission to CTC	Re-adm. (Y / N)	Transfer from OTP? (enter date)	Oedema (+/++/+++)	MUAC (mm)	Weight (kg)	Height (cm)	WFH	Day 2

A REGISTRATION:

Serial No.:
> Enter sequence number in register

SAM No:
> Enter unique identifying number

Name:
> Print name of child

Age:
> Enter age (in years)

Sex:
> Enter Male (M) / Female (F)

Status:
> Classify as Refugee (Ref) / National (Nat)

Address:
> Enter Camp Address (Refugee) / Nearest Village (National)

Date of admission to CTC:
> Enter date of the FIRST admission to CTC programme (dd/mm/yy)

Re-adm:
> Enter Yes (Y) / No (N) to indicate if re-admission.

Transfer from OTP:
> For transfers into SC, enter date of transfer from Outpatient Therapeutic Programme (OTP)

B NUTRITIONAL STATUS:

Using the admission criteria defined in the Country Nutrition Protocol, record relevant anthropometric information from the following:

Oedema:
> Enter + / ++ / +++ to indicate severity of oedema

MUAC:
> Enter MUAC measurement (mm)

Weight:
> Enter Weight measurement (kg)

Height:
> Enter Height measurement (cm)

Weight-for-Height (WFH):
> Use NCHS/WHO reference tables to calculate WFH Z-score / %median.

Enter value that defines upper range
(e.g. < -3ZS / <70%)

NOTES

Height is requested once at registration. This height measurement should be used throughout admission.

The term 'length' is generally used for children below 85 cm, and 'height' for children 85 cm and above.

C

Weight (kg)											
Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14

D

Date of exit	Length of stay (days)	Average weight gain (g / kg / day)	Reason for exit*	Notes

C ADMISSION HISTORY:

On each day of admission:

Weight:
> Enter weight (in kg), WFH and MUAC (mm) as applicable

Clinical progress should also be documented in separate medical records.

NOTES

Weight should be monitored daily.

Detailed clinical and examination notes should be kept in separate continuation sheets.

D EXIT DETAILS:

Date of exit:
> Enter date of exit (dd/mm/yy)

Length of stay:
> Enter number of days between admission and discharge

Average weight gain:
> Enter average weight gain during admission (g / kg / day)

Reason for exit:
> Enter reason for exit, using options provided in legend:

Discharge to OTP / Death / Default / Referral

Notes:
> Enter any important clinical or nutritional observations

NOTES

The length of stay is inclusive of both day of admission and day of discharge.

Reasons for exit are listed in a key on each register page. Enter reasons listed in the key ONLY.

Repatriation is included within referral as reason for exit.

> Illustrated Guide to Outpatient Therapeutic Programme Register

A

Serial No.	SAM No.	Name	Age	Sex (M / F)	Status (Ref / Nat)	Address	Date of admission to CTC	Readm. (Y / N)	Transfer from SC? (enter date)

B

FIRST ADMISSION*				
Oedema (+/++/+++)	MUAC (mm)	Weight (kg)	Height (cm)	WFH

A REGISTRATION:

Serial No.:
> Enter sequence number in register

SAM No:
> Enter unique identifying number

Name:
> Print name of child

Age:
> Enter age (in years)

Sex:
> Enter Male (M) / Female (F)

Status:
> Classify as Refugee (Ref) / National (Nat)

Address:
> Enter Camp Address (Refugee) / Nearest Village (National)

Date of admission to CTC:
> Enter date of the FIRST admission to CTC programme (dd/mm/yy)

Re-adm:
> Enter Yes (Y) / No (N) to indicate if re-admission.

Transfer from SC:
> For transfers into SC, enter date of transfer from Stabilisation Centre (SC)

B NUTRITIONAL STATUS:

Using the admission criteria defined in the Country Nutrition Protocol, record relevant anthropometric information from the following:

Oedema:
> Enter + / ++ / +++ to indicate severity of oedema

MUAC:
> Enter MUAC measurement (mm)

Weight:
> Enter Weight measurement (kg)

Height:
> Enter Height measurement (cm)

Weight-for-Height (WFH):
> Use NCHS/WHO reference tables to calculate WFH Z-score / %median.

Enter value that defines upper range
(e.g. < -3ZS / <70%)

NOTES

Height is requested once at registration. This height measurement should be used throughout admission.

The term 'length' is generally used for children below 85 cm, and 'height' for children 85 cm and above.

C

D

Wk 2			Wk 3			Wk 4			Wk 5			Wk 6			Wk 7			Wk 8			Wk 9			Wk 10			Wk 11			Wk 12			D				
Weight	WFH	MUAC	Weight	WFH	MUAC	Weight	WFH	MUAC	Weight	WFH	MUAC	Weight	WFH	MUAC	Weight	WFH	MUAC	Weight	WFH	MUAC	Weight	WFH	MUAC	Weight	WFH	MUAC	Weight	WFH	MUAC	Weight	WFH	MUAC	Height on discharge	Date of exit	Length of stay (days)	Average weight gain (g / kg / day)	Reason for exit *

C ADMISSION HISTORY:

On each day of admission:

Weight:
> Enter weight (in kg), WFH and MUAC (mm) as applicable

Clinical progress should also be documented in separate medical records.

NOTES

Weight should be monitored daily.

Detailed clinical and examination notes should be kept in separate continuation sheets.

D EXIT DETAILS:

On each week of admission:

Date of exit:
> Enter date of exit (dd/mm/yy)

Length of stay:
> Enter number of days between admission and discharge

Average weight gain:
> Enter average weight gain during admission (g / kg / day)

Reason for exit:
> Enter reason for exit, using options provided in legend:

Discharge cured to SFP / Death / Default / Referral / Non-cured / Transfer to SC

NOTES

The length of stay is inclusive of both day of admission and day of discharge.

Reasons for exit are listed in a key on each register page. Enter reasons listed in the key ONLY.

Repatriation is included within referral as reason for exit.

A

Health Information System

Reporting Form

8.3 Community-based Therapeutic Care

Organisation: _____

Location: _____

Reporting period: _____

B

8.3a Stabilisation Centre (SC)

			Refugee					National					SC Total
			< 5		≥ 5		Total	< 5		≥ 5		Total	
			M	F	M	F		M	F	M	F		
Number at beginning of period (a)		*Marasmus*											
		Kwashiorkor											
		Other											
Number of new admissions		*Marasmus*											
		Kwashiorkor											
		from OTP											
		Other											
Number of re-admissions		*Marasmus*											
		Kwashiorkor											
		Other											
Total Admissions (b)		*Marasmus*											
		Kwashiorkor											
		Other											
Number of exits	*Marasmus*	*discharge to OTP*											
		death											
		default											
		referral											
	Kwashiorkor	*discharge to OTP*											
		death											
		default											
		referral											
	Other	*discharge to OTP*											
		death											
		default											
		referral											
Total Exits (c)		*Marasmus*											
		Kwashiorkor											
		Other											
Number at end of period (a + b - c)		*Marasmus*											
		Kwashiorkor											
		Other											

Enter refugee data ONLY

Marasmus :	Sum no. of days stay for discharged children (< 5)	
	Sum wt. gain for discharged children (< 5) (g / kg / day)	

Kwashiorkor :	Sum no. of days stay for discharged children (< 5)	
	Sum wt. gain for discharged children (< 5) (g / kg / day)	

XXXXX XXXXX_EN_ddmmyy

A HEADER:

Organisation:
Print Name of health implementing partner

Location:
Print Name of Camp and/or Reporting Unit

Reporting period:
Enter number of week and month (e.g. Week 1 March)

NOTES

The dates of each reporting week are shown in the Reporting Calendar. It is important that all staff are aware of these dates, and that copies the calendar are distributed to all antenatal clinics.

The feeding supervisor is responsible for coordinating the complete and timely submission of all sections contributing to the weekly report.

B STABILISATION CENTRE:

Complete Table 8.3a, using the SC register.

Enter the sum number of days stay and sum average weight gain into the blank boxes below the table, ONLY for exits who meet the following criteria:

> refugee

> under five

> reason for admission was severe malnutrition*

> reason for exit was discharge

* The figures are disaggregated by marasmus and kwashiorkor.

NOTES

It is important to regularly monitor the number of beneficiaries registered in the feeding programme at any one time. This moving total should be calculated each week, according to the following classification:

> marasmus

> kwashiorkor

> other

Open the balance for the current week, by transferring the number of beneficiaries registered at the end of the previous week into the grey totals rows (Section A).

Using a calculator, add the total number of admissions and exits during the week and enter into the grey totals rows (Sections B and C, respectively).

Using a calculator, work out the closing balance of beneficiaries registered at the end of the week (Section D) as follows:

> D = A + B - C

C

8.3b Out-patient Therapeutic Program (OTP)

			Refugee					National					OTP Total
			< 5		≥ 5			< 5		≥ 5			
			M	F	M	F	Total	M	F	M	F	Total	
Number at beginning of period (a)		*Marasmus*											
		Kwashiorkor											
		Other											
Number of new admissions		*Marasmus*											
		Kwashiorkor											
		from SC											
		Other											
Number of re-admissions		*Marasmus*											
		Kwashiorkor											
		Other											
Total Admissions (b)		*Marasmus*											
		Kwashiorkor											
		Other											
Number of exits	*Marasmus*	*discharge cured to SFP*											
		death											
		default											
		referral											
		non-cured											
		transfer to SC											
	Kwashiorkor	*discharge cured to SFP*											
		death											
		default											
		referral											
		non-cured											
		transfer to SC											
	Other	*discharge cured to SFP*											
		death											
		default											
		referral											
		non-cured											
		transfer to SC											
Total Exits (c)		*Marasmus*											
		Kwashiorkor											
		Other											
Number at end of period (a + b - c)		*Marasmus*											
		Kwashiorkor											
		Other											

Enter refugee data ONLY

Marasmus :	Sum no. of days stay for discharged children (< 5)	
	Sum wt. gain for discharged children (< 5) (g / kg / day)	

Kwashiorkor :	Sum no. of days stay for discharged children (< 5)	
	Sum wt. gain for discharged children (< 5) (g / kg / day)	

C OUTPATIENT THERAPEUTIC PROGRAMME:

Complete Table 8.3b, using the OTP register.

Enter the sum number of days stay and sum average weight gain into the blank boxes below the table, ONLY for exits who meet the following criteria:

> refugee

> under five

> reason for admission was severe malnutrition*

> reason for exit was discharge

* The figures are disaggregated by marasmus and kwashiorkor.

NOTES

It is important to regularly monitor the number of beneficiaries registered in the feeding programme at any one time. This moving total should be calculated each week, according to the following classification:

> marasmus

> kwashiorkor

> other

Open the balance for the current week, by transferring the number of beneficiaries registered at the end of the previous week into the grey totals rows (Section A).

Using a calculator, add the total number of admissions and exits during the week and enter into the grey totals rows (Sections B and C, respectively).

Using a calculator, work out the closing balance of beneficiaries registered at the end of the week (Section D) as follows:

> D = A + B - C