Field Guide

for

Management of Moderate Acute Malnutrition

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&
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Somalia

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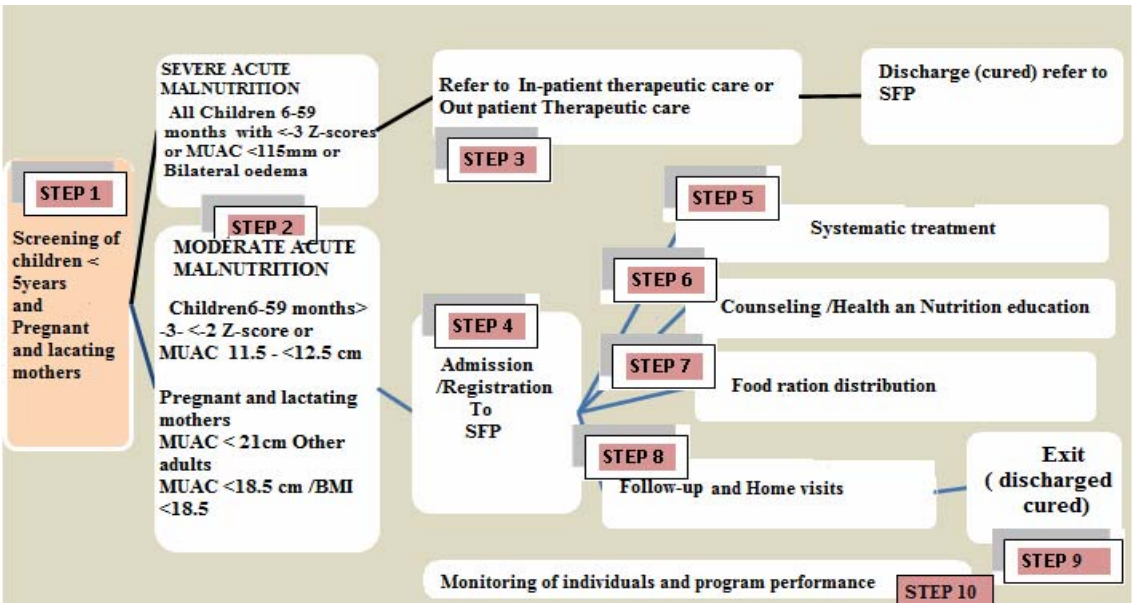
Introduction

Malnutrition is a chronic problem in all areas in Somalia, but acute forms are more prevalent in the South and Central zone where drought, floods, chronic insecurity and clan conflicts have subjected the social caring system to a lot of pressures and left majority of households food insecure. Children and women are increasingly at risk of morbidity and mortality related to malnutrition.

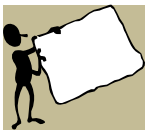
In these affected regions of Somalia, efforts have been put in place by UN agencies and NGOs partners to address moderate acute malnutrition particularly for children, pregnant and lactating women through supplementary feeding program. However, the implementation of food supplementation programs has not been very effective largely because of lack of operational protocols for program staff at a supplementary feeding centre. To address this need, the Somalia's IASC Nutrition Cluster and Nutrition Working Group of the Somalia Support Secretariat recommended the development of a step by step field guide to assist staff working in a clinic or SFP site manage moderate acute malnutrition. This field guide were developed with technical support from Emily Teshome, UNICEF Consultant for the Nutrition Cluster. A detailed MAM guideline and training materials are available and can be downloaded from: (http://ochaonline.un.org/somalia/Clusters/Nutrition/tabid/2825/language/en-US/Default.aspx)



The guide is an extract from the National guidelines for management of moderate acute malnutrition. For effective use of this field guide, the users must be trained in the management of moderate acute malnutrition to enable them understand the concept and processes of managing moderate acute malnutrition. The user must also be aware that with the rapid changes in the field of nutrition in emergencies, due to increased new findings from research, this field guide will often be updated to reflect these changes.

Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
BMI	Body Mass Index
BSFP	Blanket Supplementary Feeding Program
CSB	Corn Soya Blend
FBF	Fortified Blended Food e.g. CSB and UNIMIX
GAM	Global Acute Malnutrition
H/A	Height for Age
HIV	Human Immunodeficiency Virus
IMCI	Integrated Management of Childhood Illnesses
MAM	Moderate Acute Malnutrition
MCH	Mother and Child Health
MUAC	Mid -Upper Arm Circumference
NGO	Non Governmental Organisation
ORS	Oral Rehydration Solution
OTP	Out-patient Therapeutic Program
PLW	Pregnant and Lactating Women
PLWHA	People Living with HIV and AIDS
RUF	Ready to use foods.
RUSF	Ready to Use Supplementary Food
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SC	Stabilization centre
SFP	Supplementary Feeding Program
TB	Tuberculosis
TFC	Therapeutic Feeding Centre
TSF	Targeted Supplementary Feeding
TSFP	Targeted Supplementary Feeding Program
UN	United Nations
UNICEF	United Nations Children's Fund
W/A	Weight for Age
W/H	Weight for Height
WFP	World Food Program
WHO	World Health Organisation



Why set up a Supplementary feeding program?

The main reason for setting up supplementary feeding programs during nutritional emergencies is to prevent individuals that are at-risk of malnutrition and those that are moderately malnourished from becoming severely malnourished as well as treat those with moderate malnutrition.

What influences the decision to start? A program can be started when*:*

- ✓ Results of a nutrition survey reveal a critical situation with global acute malnutrition rate of over 15% or a serious situation when the prevalence of global acute malnutrition is 10-15%, or 5-9% with aggravating factors.

- ✓ The supplementary food ration is necessary to supplement nutrients not provided by the general food ration either due to inadequate quantity and/or quality.

- ✓ When an assessment indicates high crude death rates of more than 1 death per 10,000 per day and high morbidity rates of specific diseases such as *measles* and whooping cough, vitamin A and Iron deficiencies.

- ✓ When an implementing agency has adequate capacity such as food rations, materials and equipment, trained/skilled personnel and logistical factors like transport and warehouse are in place.

What influences the decision to close program?

Before the closure of a MAM program, an assessment should be done to determine if the general nutritional status of the vulnerable group has improved and cause(s) of malnutrition has been addressed. The assessment should also check whether appropriate strategies have been put in place to sustain the nutritional status of the affected population. A program that is managing moderate acute malnutrition can be closed when most of the following conditions are attained.

When the results of nutritional survey conducted at end or mid program indicate a prevalence of malnutrition among children to be less or equal to 10% with improvements in the general food and health situation and the Crude mortality rate is <1 death per 10,000 per day. The results of nutritional assessment should be considered in conjunction with the following factors;

- ✓ When there is adequate and reliable general food distribution
- ✓ That effective public health and disease control measures are in place e.g WASH program, Malaria control program
- ✓ When the general population has gained some stability in livelihood.
- ✓ When the number of beneficiaries is small enough to be handled by the existing health facility *(Usually proposed at 30 but this will depend on the capacity of the health facility)*
- ✓ When a BSFP has been in operation for 4 months, a critical technical review of the BSFP is undertaken to either consider continuation or adjusting it to an TSFP

Types of supplementary feeding programmes

There are two main types of Supplementary feeding programs, blanket supplementary feeding program (BSFP) and targeted supplementary feeding programs (TSFP).

1. Blanket Supplementary Feeding Program (BSFP).

Blanket supplementary feeding program is set so as to provide a food supplement to all members of a particular group like all children under 5 years, pregnant and lactating women.

When to implement BSFP? Usually started when 20% or more of children are malnourished or assessment results show GAM levels of 15% or more with aggravating factors and sufficient resources including food, personnel, and logistics are available[1]. In addition, when:

- ✓ General food distribution systems are not adequately in place and/or not covering the needs of certain vulnerable groups
- ✓ There are problems in delivering/distributing the general ration
- ✓ There are large numbers of mild and moderately malnourished individuals and likely to become severe due to aggravating factors
- ✓ There is anticipated increase in rates of malnutrition due to seasonally induced epidemics
- ✓ There are reported cases of micronutrient deficiency outbreaks, to provide micronutrient-rich food to the target population

How do you select beneficiaries for BSFP? Select all children under five years or under ten year (less than 110cm or 130 cm in height respectively), all pregnant mothers, and lactating mothers, the chronically ill, disabled and the elderly (>60 years). The number of beneficiaries admitted in the program will depend on availability of resources. If resources are very limited blanket feeding can be targeted to children under 2 or 3 years old.

2. Targeted supplementary feeding programs (TSFP).

TSFP provides food supplement to the general population of mild and/or moderately malnourished children, pregnant and lactating women and other nutritionally vulnerable groups.

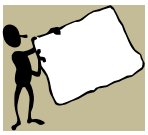
When can we implement TSFP? *TSFP is implemented w*hen malnutrition rates are 10-14% or 5-9% with aggravating factors. Aggravating factors include; general food rations below the mean energy requirement, crude mortality rate more than 1 per 10000per day, epidemic of measles or whooping cough and high incidence of diarrhoeal diseases. Other additional reasons for implementing TSFP include;

- ✓ When resources for implementing blanket distribution are scarce
- ✓ When there are discharges from Therapeutic Feeding Programs
- ✓ When there are large numbers of mild and moderately malnourished individuals reported
- ✓ When large numbers of children are likely to become mild or moderately malnourished due to aggravating factors
- ✓ High prevalence of micronutrient deficiencies in the target area

How do we select beneficiaries for TSFP[2]? Select beneficiaries that meet any of the following criteria. The number and category of beneficiaries selected for admission will depend on the resources available.

[1] WHO 2000. The Management of Nutrition in Major emergencies

- ✓ Malnourished children under five years and sometimes under three years depending on availability of resources (All children that fall between >-3- <-2 Z-score are admitted into program)
- ✓ All discharges from the Therapeutic feeding programs (both in-patient therapeutic care and out-patient therapeutic care)
- ✓ Pregnant and lactating mothers who are malnourished
- ✓ Individuals with social disorders - orphans, unaccompanied children, the disabled, and female headed households
- ✓ Discharges from the therapeutic feeding programmes



What are the essential activities of a supplementary feeding program?

The steps below outline the basic steps of conducting SFP activities on site by field staff. All the 10 steps can be applied to a TSFP whereas Steps 1, 5, 7, 9 and 10 can be applied to a BSFP.

Step 1: Conduct screening at community level

At the community level, the screener should select all vulnerable individuals; children, pregnant and lactating mother, elderly (>60 years) and the individuals with social disorders. This can be referred to the nearest SFP site or health facility for admission to BSFP or TSFP depending on the selection criteria discussed in sections above.

Step 2: Identifying malnutrition and decision making

1. After identifying the vulnerable persons at community level, those that are moderately malnourished by taking their anthropometric measurements.
2. Before taking anthropometric measurement for children 6-59 months, check for bilateral oedema, if present do not take MUAC, weight and height, instead refer to the nearest therapeutic feeding centre. All infants <6 months should not be admitted in the program but their mothers are eligible for admission if malnourished. Mother should be counselled to continue exclusive breastfeeding.
3. Use table 1 to establish the appropriate measurement for each group of people.

Table 1: Target population and type of measurements

Target group	Type of measurement
Children 6 to 59 months (65-110cm) Children 5-10 years (110-130cm)	1. Take Weight and length if child is less than 24months or less than 87cm, 2. Take height if child is 24months and above or more than 87cm 3. Take MUAC measurement for children 6 months and above using child MUAC tape
Pregnant and lactating women	Take MUAC measurement using adult MUAC tape
Elderly (>60 Years)	Take MUAC measurement using adult MUAC tale

1. After taking height and weight measurements, use the reference tables (Annex 1) to determine Z-scores and record. Also use Table 2 to determine cut-off points for admission.
2. Those children that fall between >-3 and <-2 Z-score should be referred to the registration section. Those that are >-2 Z-score should have their caregivers counselled on proper nutrition and health practices and allowed to go back home.
3. Children 5-10 years with MUAC showing between 115-125mm should be referred to registration section for admission. All caregivers of children with MUAC showing between 125-

[2] For chronically ill individuals like people living with HIV/AIDS, Tuberculosis patients refer to the respective disease treatment protocols and the supportive interventions outlined.,

135mm should be counselled on proper nutrition and health practices and allowed to go back home.

4. Pregnant and lactating mothers with MUAC <21cm should be referred to registration section for admission.
5. Elderly with MUAC <18.5cm cm should be referred to registration section for admission
6. Select most appropriate program for beneficiary. If moderately malnourished admit to a targeted supplementary feeding program. If severely malnourished refer to a therapeutic feeding program. See steps 3 and 4 in flow chart in figure 1.

Figure 1: Activities of a Targeted Supplementary Feeding Program

Table 2: Admission and discharge criteria for the moderately malnourished cases

Category	Indicator	Admission of Moderately Malnourished cases	Discharge (cured
Children 6 months to 10 years (Height from 65cm to 130 cm)	W/H Z-score	Between -3 to <-2 Z score Discharge from OTP	≥ -2 Z scores
	MUAC (cm)	≥11.5 & <12.5	≥ -2 Z scores on 2 consecutive times and MUAC ≥ 12.5
	Odema	Oedema absent	N/A
	MUAC (cm) and other physiological indicators	**Pregnant mother** in 2nd or 3rd trimester and MUAC 18.5 – 21.0 **Lactating mother** with child< 6 months and MUAC 18.5 – 21.0	**Pregnant mothers** Delivered: MUAC ≥ 23.0 **Lactating mothers** Child is > 6 months MUAC ≥ 23.0
Pregnant and lactating women	MUAC (cm)	16 -18.5 with no relevant clinical signs Few relevant social criteria	MUAC> 18.5cm Good clinical condition
Adults (older than 18 years); including the elderly (>60 years)	BMI	16 – 17	BMI>18.5 Good clinical conditions
	Oedema	Oedema absent	

NOTE: *On average, the therapy in a TSFP should take about 3 months, with the patient receiving regular ration, systematic treatment and appropriate complementary support*

Step 3: Refer severely malnourished children

Nurse should examine the children that are identified to be sick and severely malnourished and refer them to the nearest TFP, OTP, SC or hospital for in-patient care. A referral form should be filled and given to caretaker. The caretaker should be informed on the importance of taking the child to the health facility explaining to him/her that the child is at risk of immediate death and will be given special food and medical treatment.

Step 4: Admission/ Registration of Beneficiaries to SFP

The Registrar should gather all the necessary beneficiary information from the screeners, register the malnourished individual and issue out a ration card. The program can have separate registers; one for pregnant and lactating mothers and another one for children under-five years. A simple register can be designed at the field level. Key components of a register are as shown in figures 2 and 3.

Figure 2: Sample of register for Children under five years

Serial No.	Card No.	Name	Address	Sex	Age	Admission					Vitamin A		De-worming		Others		Round 2		Round 3				
						Date	Weight	Height	Z-scores	Target Weight	Date	Dose	Date	Dose	Date	Dose	Date	Wt	Date	Wt	Ht	W/H Zs	Target wt
1																							
2																							

Figure 3: Sample of register for Pregnant and Lactating mothers

Card No.	Name	Address (Name of village and location)	Age of mother	Age infant (<6 months)	Months of Pregnancy	Vitamin A		Iron/Folic acid		Deworming		Admission			Round 2		Round 3	
						Date	Dose	Date	Dose	Date	Dose	Date	MUAC	Target MUAC	Date	MUAC	Date	MUAC
1																		
2																		
3																		

After recording all the information, direct beneficiary for systematic treatment.

STEP 5: Administer systematic Treatment

In TSFP a nurse should check medical conditions, immunization status, anaemia and common infections then record the information. All beneficiaries must receive systematic treatment to cure any infections as well as minimize chances of becoming infected. In the absence of a nurse/ clinician, all beneficiaries with common ailments should be referred to the nearest health facility.

1. Check for common ailments such as ear, eye and skin infections and give appropriate treatment.
2. Give treatment for uncomplicated malaria. This should be in-line with the national protocols.
3. Administer systematic treatment such as de-worming, Iron and vitamin A supplementation or multiple vitamin supplementation and measles vaccination according to protocols. (**Note:** Type and dosage of treatment for the moderately malnourished individuals is outlined in Annexes 3, 4 and 5.)
4. Record all treatment in the register and ration card. Indicate in the ration card if there is follow up treatment and inform the beneficiary of the date and place. Explain to him/her the reason for follow-up treatment.
5. Direct beneficiaries to step 6 (counselling and nutrition education sessions)

In BSFP, beneficiaries should receive systematic treatment such as de-worming, vitamin A supplementation or multiple vitamin supplementation and measles vaccines according to protocols outlined in Annexes 3, 4 and 5.

STEP 6: Nutritional counselling/Health and Nutrition education

1. *Counselling sessions* should be arranged for those caretakers or individuals that need additional information to improve their nutritional and health status. Counsel caregiver and explain the meaning of the systematic treatment as well as additional food ration that will be given. For effective counselling, use the GATHER approach to relay nutritional and health related messages to the beneficiary.

   - ✓ **G**reet the patient and offer them a seat, introduce each other and know their well being
   - ✓ **A**sk their feeling about their nutritionals status, symptoms, nutritional problems and concerns.
   - ✓ **T**ell patient of different options that can be used to address the nutritional problems, at this point the counsellor can refer to key messages and action points (Annex 7).
   - ✓ **H**elp patient make informed choices and together develop action plan on how best to address the identified problem
   - ✓ **E**xplain fully the choices and actions and possible barriers
   - ✓ **R**eassure and give the **R**eturn date of the next visit

2. Health and nutrition educational messages and demonstration sessions should be conducted by the nutrition educator and assisted by outreach workers. The educator can use annex 7 to develop messages and key action points for the beneficiaries.

Simple steps for developing appropriate educational message

Step 1: Identify the problem affecting the beneficiary. A problem can be identified through counselling or after needs assessment has been conducted. For example if the main problem identified among breastfeeding mother is poor breastfeeding practices, messages on breastfeeding and care of lactating mother should be the main focus.

Step 2: From annex 7 choose the topic on optimal breastfeeding and use the key action design messages; the messages can be translated into the local language. In addition pictures or posters can be used to stress the main points of the message. The education session should be brief can last between 15-30 minutes.

Step 3: Allow for questions and comments, interactive discussions should be encouraged

Step 4: Inform the beneficiaries that an outreach worker is likely to visit their homes before the next visit.

Step 5: Agree with outreach workers what they should look out for during home visits to determine if the message has been helpful.

Demonstration sessions-

Time allocated for each sessions can vary depending on the topic. Successful demonstrations rely a lot on preparation prior to the session. All equipment and ingredients required for the demonstration must be in place before the session begins. Different topics for demonstrations include;

1. ORS preparation – simple steps for preparing ORS are outlined under the topic dehydration in annex 7.
2. CSB/UNIMIX preparation (Annex 6)
3. How to treat and store drinking water
4. How to use water purifiers (e.g. aqua tabs)
5. How to wash and store kitchen utensils

6. How to store cooked food

After these sessions, direct the beneficiaries to the food distribution area.

STEP 7: Distribute food ration to program beneficiaries

Food rations should be distributed either as "dry" take home ration or "wet"/ on-site feeding ration. Most supplementary feeding programs, especially BSFP distribute dry ration as it is easy and requires less resource. On-site feeding is however justified when there is extreme short supply of household food, firewood, water and cooking utensils or even when the security situation does not allow beneficiaries to carry food rations home. Regardless of the type of food ration, program supervisors/nutritionists must ensure that there is an adequate food ration for all beneficiaries. Program outreach workers and community volunteers with the help of mothers should be responsible for distributing the food.

1. Types of food commodities

There are various types of food commodities that can be distributed to moderately malnourished individuals. Table 3 gives a summary of the type of food items and recommended quantities. Program supervisors should calculate the amount of food per beneficiary and share the information with the food distribution team.

Table 3: Food commodities for supplementary feeding program

Food commodity	Description	Quantity/person/day
Recommended food commodities for supplementary feeding programmes		
CSB/UNIMIX	Both based on a cereal (usually maize), soya blend. The blend is fortified with micronutrients each product has slightly different micronutrient profile and suitable for malnourished children, pregnant and lactating women. International guidelines recommend that Sweet CSB/UNIMIX are mixed with oil (and sugar if not already included) prior to distribution to ensure the high energy density of the resulting porridge. Hygiene conditions must strictly be observed during pre-mixing and packing.	200-250g for dry ration and between 100-150g for wet rations. If distributed as premix for dry ration mix 200g CSB+25g oil+20g sugar. For wet ration combine 125g CSB +10g oil +10g sugar
Supplementary Plumpy®	New ready to use product designed specifically for the management of moderate acute malnutrition with the similar advantages to RUTF (Plumpynut) e.g. high energy density. Has important logistical advantages, small risk of microbial contamination, does not require pre-mixing and can be used at home. Recommended for children 6 – 59 months	Give the child one sachet (92g) to eat every day in addition to breast milk and other food the child eats at home. Clean drinking Water must be offered with the Supplementary Plumpy
Alternative food commodities for supplementary feeding programmes		
Plumpynut®	High quality fortified food that is designed for the treatment of severe acute malnutrition. It is can be used at home without pre-mixing and can be used as a temporary option in the absence of a Ready to use Supplementary Food (RUSF) or Fortified blended foods (recommended food)	Similar to RUSF, give one sachet to eat per day. Water must be offered with the Plumpy Nut
BP5	This is a fortified compressed food which is eaten directly from the package as a biscuit or can be crushed and used as porridge.	Six bars of BP5 biscuits (330g) will provide all the

	Can be used as a replacement for CSB/UNIMIX but not specifically designed for this purpose, thus should not be used as replacement for more than three months. 100g of BP5 provides minimum 458kcal,15.5g fat and 16g protein *NB: BP5 should not be provided to the severely malnourished cases. Its not recommended in high severe malnutrition prevalence areas*	necessary nutrients. Provide 100-150 mls water for every two biscuits consumed.

2. Distribute non- food items

Non- food items such as mosquito nets, soap, blankets tents, buckets can also be distributed depending on availability and the need of the beneficiary. For instance in malaria endemic areas, pregnant and lactating mothers and children under five years will need to sleep under mosquito nets as a preventive measure against malaria. Most non- food items are distributed on admission, except for consumable items such soaps that can be provided to beneficiary on each visit.

3. Storage and handling of food items

The storekeeper is responsible for stock inventory and maintenance and should work closely with the program supervisor.

- He/she must be aware of the UNICEF/WFP guidelines on storage and handling of supplementary food commodities
- Any food item/supplies coming into or leaving the stores must be recorded.
- The store must constantly remain under lock and key and guards deployed to enforce security
- The store keeper should check for damaged or expired food items and separates them from the good items
- A stock control system must be put in place and reviewed regularly by the program supervisor
- The store keeper should prepare periodic stock reports (usually monthly) and submit to the supervisor and/or donor

STEP 8: Follow-up and home visits

1. Next appointment

The registrar and screeners should:

1. Inform the beneficiary about the next appointment
2. Explain to the beneficiary how long they are likely to be enrolled in the program
3. Explain to the beneficiary why it is important not to miss the next visits
4. Ask the beneficiary if they have any problems attending the next visit and together seek for a solution

2. Follow-up visit

When the beneficiary returns on the appointment day the flow of activities is repeated and information recorded in the registry and ration card.

1. Check for weight, height, MUAC, oedema. If nutritional condition of the beneficiary has deteriorated below the lower cut-off point of admission (<-3Zscore or <115mm) or has medical complication, transfer to nearest therapeutic feeding program or nearest health facility.
2. Otherwise, record anthropometric measurement in registration book and ration card. If nutrition status has improved congratulate the beneficiary. Encourage and counsel if there is no improvement or slight decline in nutritional status.
3. Give systematic treatment if not received before or if not finished
4. Treat any infection such as skin infection or eye infection.
5. Give health and nutrition education messages
6. Give food rations

7. Inform of the next visit

3. Home-visits:

Program outreach workers /community volunteers should take up the responsibility of following up program beneficiaries that are recorded as absent or defaulted. A patient that misses an appointment is considered an absentee and must be followed by the outreach worker and reasons for lack of visit established. This patient should be encouraged to return to program. A patient is reported to be an absentee if he/she fails to attend a follow-up visit once and said to be a defaulter if absent for more than 3 consecutive visits for bi-weekly distribution and 2 consecutive visits for monthly distribution.

STEP 9: Discharge beneficiary from program

There are several ways of discharging a beneficiary from a program, these are;

- **Cured:** Fully recovered or does not show any signs of malnutrition according to the discharge criteria shown in Table 2. If the beneficiary has not recovered, an immediate investigation should be done to determine causes of delay in responding to treatment. The causes of these delays could range from irregular food distributions, medical problems to social related problems.
- **Died:** died after admission in program
- **Defaulted:** Absent from program for 3 consecutive visits for bi-weekly distribution and absent from 2 consecutive visits for monthly distribution.
- **Transfer:** Condition of the patient deteriorated and transferred to hospital (SC/OTP) or transferred to another SFP site
- **Non-response:** If beneficiary has not attained cured criteria for discharge after 3 months, conduct investigation and continue treatment for another one month, discharge as non-respondent if does not recover by the 4^{th} month.

Step 10: Monitoring

1. Monitoring of beneficiaries

In a TSFP the progress of the beneficiaries should be monitored during each visit and at home.

- The outreach worker should visit the beneficiary at home to monitor household care practices and observe preparation and consumption of food rations especially after demonstration sessions. Sometimes follow-up may be done to see if the child is responding to medication and nutrition therapy; this is common especially for sick (diarrhoea) and malnourished children or individuals with chronic illnesses.

- At the SFP site beneficiary progress should be monitored by taking anthropometric measurement to check any improvement in nutritional status. Growth (increase in Weight and Height or MUAC) shows that the beneficiary is responding to nutrition therapy and routine treatment. This information is very useful to determine if the program is achieving its purpose, challenges, gaps and opportunities for improvement.

In BSFP, no individual monitoring or registration is required. A general report on geographic location, date of distribution, number of beneficiaries and ration composition is required for accounting purposes and feedback. Beneficiaries should be in program for 4 months

2. Monitoring of program performance

All essential data that is recorded in the ration card and register should be used to establish the overall performance of the program. On a monthly basis the program supervisor should use this information to determine, numbers of beneficiaries admitted, number discharged cured, number defaulted, number that did not respond to treatment and number that died. This information can be filled out the periodic reporting format in Annex 6.

- The following formulas can be used to determine progress of program

Proportion of reached cases =
Number admitted in program X100
Number planned (or eligible in program area)

Proportion of re-admission =
Number re-admitted in program X100
Number of total admitted

Proportion of exits defaulted=
Number of defaulters in program X100
Number exits

Proportion of exits non-respondent=
No. of non-cured discharged from program X100
Number exits

Proportion of exits died=
Number that died in program X10
Number exits

Proportion of exits recovered=
No. Discharged cured from program X 100
Number exits

Proportion of exits transferred =
Number of transfers in program X100
Number exits

NB: Proportion of children reached is prepared periodically, e.g. quarterly

The success of the program can be gauged against internationally accepted cut off point listed in the table 4.

Table 4: Reference values for assessing program performance

Exit criteria	SFP expected performance indicator
Recovered	>75% of beneficiaries
Deaths	< 3 % of beneficiaries
Defaulters	<15% of beneficiaries

- Supervisors should share reports with other stakeholders in the area as well as donors

Other performance indicators include;

- ✓ **Attendance rate:** number of children who attend the program as a proportion of the number of children enrolled in program. Calculated as: No. attending in a given day/No. expected for that day x 100); ideally should be > or = 75%
- ✓ **Length of stay:** The monthly ration provision accompanied by systematic treatment, in the TSFP is expected to last for 3 months. Based on individual's monitoring indicators (weight, clinical signs etc), a case review is done.
- ✓ **No. of Supervisions –** Total number of supervisions conducted per site and actions taken
- ✓ **Total number of training sessions** held and topics covered per month (included in report as addendum)

- ✓ **Total number of counselling sessions** held by category of beneficiary per month (included in report as addendum)
- ✓ **Absentee:** Absent from program for one visit.

Annex 1: WHO growth standards Reference table combined boys and girls:

Weight-for-Height Reference Card

Boys' weight (kg)					Length[a]	Girls' weight (kg)				
-4SD	-3SD	-2SD	-1SD	Median	(cm)	Median	-1SD	-2SD	-3SD	-4SD
1.7	1.9	2.0	2.2	2.4	45	2.5	2.3	2.1	1.9	1.7
1.8	2.0	2.2	2.4	2.6	46	2.6	2.4	2.2	2.0	1.9
2.0	2.1	2.3	2.5	2.8	47	2.8	2.6	2.4	2.2	2.0
2.1	2.3	2.5	2.7	2.9	48	3.0	2.7	2.5	2.3	2.1
2.2	2.4	2.6	2.9	3.1	49	3.2	2.9	2.6	2.4	2.2
2.4	2.6	2.8	3.0	3.3	50	3.4	3.1	2.8	2.6	2.4
2.5	2.7	3.0	3.2	3.5	51	3.6	3.3	3.0	2.8	2.5
2.7	2.9	3.2	3.5	3.8	52	3.8	3.5	3.2	2.9	2.7
2.9	3.1	3.4	3.7	4.0	53	4.0	3.7	3.4	3.1	2.8
3.1	3.3	3.6	3.9	4.3	54	4.3	3.9	3.6	3.3	3.0
3.3	3.6	3.8	4.2	4.5	55	4.5	4.2	3.8	3.5	3.2
3.5	3.8	4.1	4.4	4.8	56	4.8	4.4	4.0	3.7	3.4
3.7	4.0	4.3	4.7	5.1	57	5.1	4.6	4.3	3.9	3.6
3.9	4.3	4.6	5.0	5.4	58	5.4	4.9	4.5	4.1	3.8
4.1	4.5	4.8	5.3	5.7	59	5.6	5.1	4.7	4.3	3.9
4.3	4.7	5.1	5.5	6.0	60	5.9	5.4	4.9	4.5	4.1
4.5	4.9	5.3	5.8	6.3	61	6.1	5.6	5.1	4.7	4.3
4.7	5.1	5.6	6.0	6.5	62	6.4	5.8	5.3	4.9	4.5
4.9	5.3	5.8	6.2	6.8	63	6.6	6.0	5.5	5.1	4.7
5.1	5.5	6.0	6.5	7.0	64	6.9	6.3	5.7	5.3	4.8
5.3	5.7	6.2	6.7	7.3	65	7.1	6.5	5.9	5.5	5.0
5.5	5.9	6.4	6.9	7.5	66	7.3	6.7	6.1	5.6	5.1
5.6	6.1	6.6	7.1	7.7	67	7.5	6.9	6.3	5.8	5.3
5.8	6.3	6.8	7.3	8.0	68	7.7	7.1	6.5	6.0	5.5
6.0	6.5	7.0	7.6	8.2	69	8.0	7.3	6.7	6.1	5.6
6.1	6.6	7.2	7.8	8.4	70	8.2	7.5	6.9	6.3	5.8
6.3	6.8	7.4	8.0	8.6	71	8.4	7.7	7.0	6.5	5.9
6.4	7.0	7.6	8.2	8.9	72	8.6	7.8	7.2	6.6	6.0
6.6	7.2	7.7	8.4	9.1	73	8.8	8.0	7.4	6.8	6.2
6.7	7.3	7.9	8.6	9.3	74	9.0	8.2	7.5	6.9	6.3
6.9	7.5	8.1	8.8	9.5	75	9.1	8.4	7.7	7.1	6.5
7.0	7.6	8.3	8.9	9.7	76	9.3	8.5	7.8	7.2	6.6
7.2	7.8	8.4	9.1	9.9	77	9.5	8.7	8.0	7.4	6.7
7.3	7.9	8.6	9.3	10.1	78	9.7	8.9	8.2	7.5	6.9
7.4	8.1	8.7	9.5	10.3	79	9.9	9.1	8.3	7.7	7.0
7.6	8.2	8.9	9.6	10.4	80	10.1	9.2	8.5	7.8	7.1
7.7	8.4	9.1	9.8	10.6	81	10.3	9.4	8.7	8.0	7.3
7.9	8.5	9.2	10.0	10.8	82	10.5	9.6	8.8	8.1	7.5
8.0	8.7	9.4	10.2	11.0	83	10.7	9.8	9.0	8.3	7.6
8.2	8.9	9.6	10.4	11.3	84	11.0	10.1	9.2	8.5	7.8
8.4	9.1	9.8	10.6	11.5	85	11.2	10.3	9.4	8.7	8.0
8.6	9.3	10.0	10.8	11.7	86	11.5	10.5	9.7	8.9	8.1
8.7	9.5	10.2	11.1	12.0	87	11.7	10.7	9.9	9.1	8.3
8.9	9.7	10.5	11.3	12.2	88	12.0	11.0	10.1	9.3	8.5
9.1	9.9	10.7	11.5	12.5	89	12.2	11.2	10.3	9.5	8.7
9.3	10.1	10.9	11.8	12.7	90	12.5	11.4	10.5	9.7	8.8
9.5	10.3	11.1	12.0	13.0	91	12.7	11.7	10.7	9.9	9.0
9.7	10.5	11.3	12.2	13.2	92	13.0	11.9	10.9	10.1	9.2
9.8	10.7	11.5	12.4	13.4	93	13.2	12.1	11.1	10.2	9.4
10.0	10.8	11.7	12.6	13.7	94	13.5	12.3	11.3	10.4	9.5
10.2	11.0	11.9	12.8	13.9	95	13.7	12.6	11.5	10.6	9.7
10.3	11.2	12.1	13.1	14.1	96	14.0	12.8	11.7	10.8	9.9
10.5	11.4	12.3	13.3	14.4	97	14.2	13.0	12.0	11.0	10.1
10.7	11.6	12.5	13.5	14.6	98	14.5	13.3	12.2	11.2	10.2
10.8	11.8	12.7	13.7	14.9	99	14.8	13.5	12.4	11.4	10.4
11.0	12.0	12.9	14.0	15.2	100	15.0	13.7	12.6	11.6	10.6

[a] Length is measured for children below 87 cm. For children 87 cm or more, height is measured. Recumbent length is on average 0.5 cm greater than standing height; although the difference is of no importance to individual children, a correction may be made by subtracting 0.5 cm from all lengths above 86.9 cm if standing height can not be measured.

Weight-for-Height Reference Card

Boys' weight (kg)					Height[a] (cm)	Girls' weight (kg)				
-4SD	-3SD	-2SD	-1SD	Median		Median	-1SD	-2SD	-3SD	-4SD
5.4	5.9	6.3	6.9	7.4	65	7.2	6.6	6.1	5.6	5.1
5.6	6.1	6.5	7.1	7.7	66	7.5	6.8	6.3	5.8	5.3
5.7	6.2	6.7	7.3	7.9	67	7.7	7.0	6.4	5.9	5.4
5.9	6.4	6.9	7.5	8.1	68	7.9	7.2	6.6	6.1	5.6
6.1	6.6	7.1	7.7	8.4	69	8.1	7.4	6.8	6.3	5.7
6.2	6.8	7.3	7.9	8.6	70	8.3	7.6	7.0	6.4	5.9
6.4	6.9	7.5	8.1	8.8	71	8.5	7.8	7.1	6.6	6.0
6.5	7.1	7.7	8.3	9.0	72	8.7	8.0	7.3	6.7	6.1
6.7	7.3	7.9	8.5	9.2	73	8.9	8.1	7.5	6.9	6.3
6.8	7.4	8.0	8.7	9.4	74	9.1	8.3	7.6	7.0	6.4
7.0	7.6	8.2	8.9	9.6	75	9.3	8.5	7.8	7.2	6.6
7.1	7.7	8.4	9.1	9.8	76	9.5	8.7	8.0	7.3	6.7
7.3	7.9	8.5	9.2	10.0	77	9.6	8.8	8.1	7.5	6.8
7.4	8.0	8.7	9.4	10.2	78	9.8	9.0	8.3	7.6	7.0
7.5	8.2	8.8	9.6	10.4	79	10.0	9.2	8.4	7.8	7.1
7.7	8.3	9.0	9.7	10.6	80	10.2	9.4	8.6	7.9	7.2
7.8	8.5	9.2	9.9	10.8	81	10.4	9.6	8.8	8.1	7.4
8.0	8.7	9.3	10.1	11.0	82	10.7	9.8	9.0	8.3	7.6
8.1	8.8	9.5	10.3	11.2	83	10.9	10.0	9.2	8.5	7.7
8.3	9.0	9.7	10.5	11.4	84	11.1	10.2	9.4	8.6	7.9
8.5	9.2	10.0	10.8	11.7	85	11.4	10.4	9.6	8.8	8.1
8.7	9.4	10.2	11.0	11.9	86	11.6	10.7	9.8	9.0	8.3
8.9	9.6	10.4	11.2	12.2	87	11.9	10.9	10.0	9.2	8.4
9.1	9.8	10.6	11.5	12.4	88	12.1	11.1	10.2	9.4	8.6
9.3	10.0	10.8	11.7	12.6	89	12.4	11.4	10.4	9.6	8.8
9.4	10.2	11.0	11.9	12.9	90	12.6	11.6	10.6	9.8	9.0
9.6	10.4	11.2	12.1	13.1	91	12.9	11.8	10.9	10.0	9.1
9.8	10.6	11.4	12.3	13.4	92	13.1	12.0	11.1	10.2	9.3
9.9	10.8	11.6	12.6	13.6	93	13.4	12.3	11.3	10.4	9.5
10.1	11.0	11.8	12.8	13.8	94	13.6	12.5	11.5	10.6	9.7
10.3	11.1	12.0	13.0	14.1	95	13.9	12.7	11.7	10.8	9.8
10.4	11.3	12.2	13.2	14.3	96	14.1	12.9	11.9	10.9	10.0
10.6	11.5	12.4	13.4	14.6	97	14.4	13.2	12.1	11.1	10.2
10.8	11.7	12.6	13.7	14.8	98	14.7	13.4	12.3	11.3	10.4
11.0	11.9	12.9	13.9	15.1	99	14.9	13.7	12.5	11.5	10.5
11.2	12.1	13.1	14.2	15.4	100	15.2	13.9	12.8	11.7	10.7
11.3	12.3	13.3	14.4	15.6	101	15.5	14.2	13.0	12.0	10.9
11.5	12.5	13.6	14.7	15.9	102	15.8	14.5	13.3	12.2	11.1
11.7	12.8	13.8	14.9	16.2	103	16.1	14.7	13.5	12.4	11.3
11.9	13.0	14.0	15.2	16.5	104	16.4	15.0	13.8	12.6	11.5
12.1	13.2	14.3	15.5	16.8	105	16.8	15.3	14.0	12.9	11.8
12.3	13.4	14.5	15.8	17.2	106	17.1	15.6	14.3	13.1	12.0
12.5	13.7	14.8	16.1	17.5	107	17.5	15.9	14.6	13.4	12.2
12.7	13.9	15.1	16.4	17.8	108	17.8	16.3	14.9	13.7	12.4
12.9	14.1	15.3	16.7	18.2	109	18.2	16.6	15.2	13.9	12.7
13.2	14.4	15.6	17.0	18.5	110	18.6	17.0	15.5	14.2	12.9
13.4	14.6	15.9	17.3	18.9	111	19.0	17.3	15.8	14.5	13.2
13.6	14.9	16.2	17.6	19.2	112	19.4	17.7	16.2	14.8	13.5

[a] Length is measured for children below 87 cm. For children 87 cm or more, height is measured. Recumbent length is on average 0.5 cm greater than standing height; although the difference is of no importance to individual children, a correction may be made by subtracting 0.5 cm from all lengths above 86.9 cm if standing height can not be measured.

Example of length/height correction: If a child's length reads 89 cm, the correct measurement will be 88.5cm, when corrected.

Annex 2: SFP Staffing position and Roles

Category of staff	Main Tasks
1 Supervisor/ Qualified Nurse or Nutritionist	• Manage the Human Resource and supplies, • Train other staff and provide supportive supervision • Monitor performance of the SFP, review monthly report and disseminate to partners,
1 Nurse Aid	• explain to the mothers the reason of admission, • give routine medicines according to the protocol, • check if there are any clinical signs, • Refer to the nearest health facility if there are any medical problems.
1 Vaccinator	• Check and update vaccination status of persons enrolled • Prepare vaccination report
2. Nutrition educators	• Educate the caretakers and community members on health and nutrition topics • Conduct cookery demonstration • Assist nutrition/nurse counsel caretakers • Write report • Investigate causes of malnutrition and prepare appropriate education message
Storekeeper/logistician	•
3 Assistants for screening /measurers and 3 Registrar	• Take the measurement, • Fill out and maintain the SFP register, • Explain purpose of admission • Fix a bracelet with an identification number, • Monitor weight gain/recovery of persons enrolled • identify absentees/defaulters and inform the outreach workers, • Prepare the monthly report on weight gain, length of stay, recovery rate, death rate, defaulter rate etc. • Refer severe cases to the nearest hospital/TFC
4 Community Volunteers/ Mothers	• Control the quality of the food commodities, • Ensure proper hygiene standards • Weigh the different food ingredients for premixes • Mix the different ingredients with cleaned materials, • Put the individual ration in a cleaned plastic bag. • Keep utensils clean • Distribute the rations • Ensure proper storage of food commodities
2 Community Outreach workers	• Follow up absentees/defaulters • Monitor household care practices • Make regular demonstrations of "how to make a nutritious porridge". • Find the defaulter and try to understand why he/she abandoned the program and ask her to come back. • Screen children at household level and refer if necessary.
2 Guards	• Check the people going in and out of the centre, • Ensure the security of the centre, day and night.

Annex 3: Systematic treatment for moderately malnourished

Name of Product	When	Age	Prescription	Dose
Vitamin A	At admission	6 months to 11 months	100000IU	Single dose on admission
		12 to 59 months	200000IU	Single dose every 4 to 6 months
Note: • Do not give Vitamin A if it had been given over the past 3 months • Give children weighing less than 8 kg or 6-11 months old 3 drops of 200,000 IU Vitamin A (retinol) red capsules (OR one blue capsule containing 100,000IU retinol). • Give children weighing more than 8 kg or 12 – 59 months old 1red capsule of 200,000 IU Vitamin A • **EXCLUDE:** Those referred from Therapeutic feeding centres (TFC) and re-admissions				
Abendazole*	At admission	<12 months	**Do not give**	
		12-59 months	400mgs	1 tab on admission
Note: • Give anti-helminthes again after last 3 months if signs of re-infection appear • Or other anti-helminth according to national guideline: e.g. Mebendazole: Not recommended for < 12 months; give 500mg single dose on admission to children aged 12-59 months • Give children weighing more than 9 kg, a single dose of 500mg tablet on admission				
Iron /folate	At admission	6 to 24 months (with low birth weight)	12.5mg iron/50µg folic acid	Daily dose for one month
		24 to 59months	20-30mg	Daily dose for one month
		6 to 11 years	30-60mg	Daily dose for one month
		Adolescents and adults	60mg	Daily dose for one month
Note: • Provide a fortnight or weekly dose depending on the rounds of distributions for ease of administration, counsel patient/caregiver accordingly. • For children weighing less than 10 kg, half tablet (100mg iron and 20mg folate) every week. • For children >10kg, one tablet (200mg iron and 40mg folate) every week. • In malaria prone areas WHO recommends that Iron and supplementation be targeted to those who are anaemic and are at risk of Iron deficiency. They should receive concurrent protection from Malaria and other infections through prevention and effective case management as outlined in the Somalia guideline on Malaria.				
Measles vaccination	At admission	≥9 months	-	Once
Note: • International guidelines on Integrated Management of Childhood Illnesses (IMCI) recommend that during emergencies measles vaccine should be given to children starting from 6 months because their immunity is likely to be compromised as a result of inappropriate dietary intake and/or increased levels of infections. • It is also important to check each child's immunization card for measles vaccination status and give measles vaccine if the child has not been vaccinated for measles. If child has no card or proof of vaccination against measles, assume that the child has not been vaccinated.				

Annex 4: Systematic treatment for pregnant and lactating mothers

Name of Product	***When***	***Physiological status***	***Prescription***	***Dose***
Vitamin A	Within first 8 weeks	Lactating	200000IU	Single dose on admission
Note: Avoid high dose of vitamin A (200000IU) to pregnant women because it can cause risk of birth defects				
*Albendazole***	At admission	Second trimester	400mg Albendazole	Single dose
Note: In Malaria endemic areas and transmission of infection is high give curative anti-malarial on admission, all women should be advised on prevention measures and clinical cases of Malaria treated promptly according to the national guidelines. ** Or other antihelminth according to national guideline: e.g. Mebendazole: Not recommended during the first trimester of the pregnancy and lactation; At 2nd trimester give 500mg mebendazole (single dose) or 100mg mebendazole twice daily for 3 days. [Studies have shown that slightly higher rates of foetal abnormalities have been seen in mothers taking Mebendazole during early pregnancy (Roundworm, clinical knowledge summaries, 2007)].				

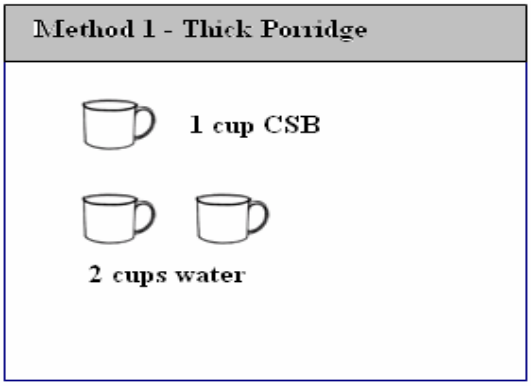
Annex 5: Multiple Micronutrient Supplement Protocol

Target groups	Fortified food rations NOT being used	Fortified food rations ARE being used
Pregnant and lactating women	1 RNI each day	1 RNI each day
Children (6-59 months)	1 RNI each day	2 RNI each week

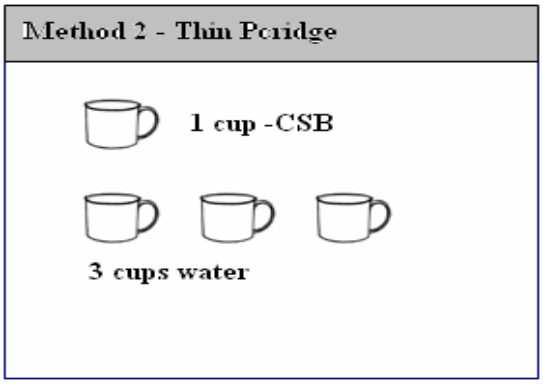
Note:

- In the absence of the multiple micronutrient, provide a daily dose of 60mg+400µg iron + folic acid for a period of 6 months during pregnancy and 3 months postpartum, giving a total duration of 9 months starting from time pregnancy is detected
- Continue Iron and folic acid supplements, if already provided/started to the women, in addition to the RNI.
- Continue Vitamin A supplements to young children and post partum mothers according to existing recommendations.
- Advice mother to continue breastfeeding and complementary feeding.

Annex 6: How to prepare CSB[3]



1. Ensure that the water being used for cooking is safe before starting to cook
2. Wash your hands with soap before you start to prepare the porridge.
3. Mix CSB (or UNIMIX) with part of the cold water to make a paste
4. Add the rest of the water and bring to boil for no longer than 10 minutes
5. Add (if available), oil, sugar, seasonal fruits and or local nuts to increase the energy density and taste
6. Serve on a clean plate or bowl



Nutrition value of 100g of CSB /UNIMIX

Energy-380 Kcal Fat -6g. Carbohydrates-60g Vitamin A – 1700 I.U, Riboflavin – 0.5mg, Pantothenic acid --3mg Phosphorous – 600mg, Sodium – 300mg, Protein-18g, Vitamin D – 200, Niacin – 8mg Folate – 0.2mg Magnesium- 100mg Potassium -700mg Vitamin E -8 I.U

Storage: *How should you store CSB?*

- Keep CSB covered to prevent flies and other dirt getting into it
- Keep CSB in the coolest part of the house
- Use the CSB within 2 weeks to prevent it from spoiling

[3] Kenya National guidelines on IMAM

Annex 7: Nutrition educational messages

	Target audience	Key messages/ action points
Vitamin A supplementation	1.Caretakers of children 6-59 months	**Children** ❖ All children aged 6 to 59 months need a vitamin A capsule every 6 months. ❖ Vitamin A supplementation is safe for children and protects them from diseases such as diarrhoea, acute respiratory infections and also reduces deaths. ❖ Children should be fed as often as possible with vitamin A rich foods (mangoes, green leafy vegetables, wild red and orange fruits, egg York, liver, milk etc). ❖ Children sick with measles, certain eye problems, severe diarrhoea or severe malnutrition should visit health centers because they may need additional Vitamin A according to the treatment schedule.
	1.Breastfeeding women 2. Lactating mothers 2. Pregnant mothers in the 3rd trimester	❖ Timely initiation of BF (within 1 hr of delivery) and giving of colostrums ❖ Importance of continuing to breastfeed for at least 2 years ❖ Importance of ensuring proper hygiene in food preparation and feeding ❖ Give appropriate information to mothers to support exclusive and continued breastfeeding. ❖ Children 0-6 months should be exclusively breastfed: No feeds (including water) other than breast milk only. ❖ Breastfeeding should be on demand (as long as the infant wants). ❖ Encourage breastfeeding during illness. If child is not able to breast feed, encourage expression of breast milk and feed by cup. **Mothers**
	Mothers with children 6 months and above	❖ Encourage continued breastfeeding beyond 6 months together with appropriate complementary feeding. ❖ Give mothers a dose of 200,000 IU of vitamin A if baby is 8 weeks old or less. ❖ Ensure that the capsule is swallowed on site. ❖ Explain body building, energy giving, and protective foods. Body building foods responsible for building and repairing our body (e.g. Meat, beans, milk eggs). ❖ Encourage the mother to consume a balanced diet using locally available foods and a variety of foods rich in vitamin A such as liver, eggs, oranges, yellow sweet potatoes, pumpkins, dark green leafy vegetables. ❖ Explain energy giving foods provide energy to our body to enable us to carry out daily activities like, working, thinking, running, playing etc (sorghum, maize, oil,). ❖ Record in register mother who have received high dose vitamin A supplementation. Also indicate in Child Card that mother has been supplemented with vitamin A. ❖ Explain protective foods enable the body to protect against infection and fight diseases (e.g. Green vegetables, Mangoes, Carrots).
Iron and folate	1.Caretakers of children 6-59 months 2. Pregnant and Lactating Caretakers/mothers	**Children** ❖ Encourage increased fluid intake, including breastfeeding, day and night for children with diarrhoea or vomiting. ❖ Give one dose at 6 mg/kg of iron daily for 14 days. ❖ Discourage withholding of feeds during illness and instead encourage intake of small frequent enriched feeds daily or give an extra meal above child ' s usual daily feeds. ❖ Avoid iron in a child known to suffer from sickle cell anaemia. ❖ Avoid folate until 2 weeks after child has completed the dose of sulpha based drugs. ❖ Encourage mothers to bring all their children below 5 years old to the nearest health facility for growth monitoring monthly as well as for vitamin A supplementation every 6 months. **Mothers** ❖ Give all pregnant women a standard dose of 200mg iron (Feso4) tablets three times a day + 5 mg folate once daily. ❖ If the child is still breastfeeding, encouraged mother to continue.
	Caretakers/mothers with sick children that are malnourished	❖ The child at this stage requires: 1. High energy intake (150 -200 kcal/kg body weight) 2. Sufficient protein 4-5g/kg body weight/day 3. Micronutrients especially potassium, iron, zinc and vitamins ❖ Promote use of anti-malarial interventions such as bed nets for preventing anaemia because malaria is often a major underlying factor. ❖ Provide advice on food items and medicines that should not be taken together with iron supplements since they may inhibit absorption such as milk, antacids, tea, and coffee. ❖ The feeds must be easy to eat and digest. – ❖ To achieve high energy intakes: 1. feed the child frequently, at least six times a day 2. Add oil, honey, margarine, butter, sugar 3. Use fat rich foods like groundnuts, avocado, , sheep ' s milk – ❖ Treat anaemia with treatment doses of iron for 3 months. ❖ Refer severe cases of anaemia to the nearest higher level of care if they are in the last month of pregnancy, have signs of respiratory distress or cardiac abnormalities such as oedema. ❖ To achieve high protein intakes: Use milk, or locally available staple mixed with legumes, meat or fish
	1.Pregnant and lactating mothers	❖ Take the weight (in kg) of all pregnant women and record it on the maternal clinic card. ❖ Provide advice on a balanced diet and emphasize on consumption of iron rich foods such as liver, red meats, eggs, fish, whole-grain bread, legumes and iron fortified foods. ❖ Counsel mothers on appropriate diet for pregnant women using locally available foods. ❖ Promote consumption of vitamin C rich foods such as oranges, green vegetables, as they enhance the absorption of iron. ❖ Encourage consumption of a balanced diet rich in vitamins and minerals. ❖ Emphasize on use of iodized salt.
Hygiene and sanitation	1. Caretakers of children under five years.	❖ Store uncooked food in a safe dry place. ❖ Encourage mother to ensure that all children aged five years and below and pregnant women sleep under insecticide treated mosquito nets, for preventing anaemia because malaria is often a major underlying factor. ❖ Protect food from insects, rodents and other animals ❖ Avoid contact between raw food stuffs and cooked food ❖ Keep areas where children are fed or play free from human and animal faeces ❖ Counsel mothers on diet during lactation as well as consuming enough water (2L per day). Emphasize the importance of extra food while lactating using the list of locally affordable foods. ❖ Keep all food preparation premises clean ❖ Wash hands before preparing food for feeding children

	2. general Community members 3. Household members	❖ Wash cooking utensils Wash fruits and vegetables ❖ Use clean water Cook food thoroughly ❖ Cook food thoroughly ❖ Avoid storing cooked food, instead, prepare food often If cooked food is saved, keep it as cool as possible If previously food is to be eaten reheat it thoroughly before eating ❖ Wash the child's hands before feeding ❖ Use open feeding cups ❖ Feed actively, that is supervise the child and continue offering food until the child has enough
De-worming	Caretakers of children	❖ Outline the hygiene and sanitation above to patients with worm infestation ❖ Give 500mg mebendazole or 400mg albendazole as a single dose in clinic if the child is 2 years of age or older and if the child has not had any in the previous 6 months
Growth monitoring	Caretakers of children under five years	❖ Children aged 0-2 years need to be weighed every month. ❖ Children 0-59 months need to be weighed often enough to determine if they are growing adequately. ❖ When children come for weighing , also check for their immunization and vitamin A supplementation status ❖ Children whose growths are faltering are at high risk and should be monitored closely by health facility staff.
Diarrhoea	Caretakers of children under five years	❖ Replace lost water by giving the child extra fluids. Give small amounts, after each loose stool, as much as the child will drink, in a clean cup till the diarrhoea has passed. ❖ Give fluid after every loose stool (children <2yr – ¼ to ½ cup, children >2yr ½ to 1 cup) ❖ Give breast milk as often as possible- it is the best food and liquid for a child with diarrhoea – it is clean and can reduce the frequency and severity of diarrhoea. ❖ Give extra fluid in between breast feeds ❖ Continue to give frequent meals to the child (CSB or RUSF) ❖ The child needs extra food once the diarrhoea has finished (one extra meal/day for 2 weeks) to recover properly ❖ If diarrhoea is very frequent – several loose stools in an hour, continues without improvement for more than 1 week, or contains blood the child is in danger and needs medical help
Vomiting	Caretakers of children under five years	❖ Replace lost water by giving the child extra fluids slowly. Give small amounts after each episode of vomiting, in a clean cup till the vomiting has passed. ❖ Continue breast feeding ❖ If the child vomits after taking fluids, wait and then try and give very small amounts slowly ❖ Stop giving food for ½ day but continue with fluids ❖ If the child hasn't vomited for ½ day try giving small amounts of food and increase the quantities of both ORS and food slowly. ❖ Continue giving extra fluids till child has recovered ❖ If vomiting continues without improvement, is accompanied by other symptoms, or is very severe the child may become dehydrated and needs to be taken to the clinic.
Dehydration	Caretakers of children under five years	*What causes dehydration?* ❖ Dehydration may be as a result of excessive vomiting and/or diarrhoea *How is dehydration diagnosed?* ❖ Child becomes lethargic (tired), thirsty, miserable, refuses to eat, eyes may

		become sunken *What are appropriate drinks for children with diarrhoea or vomiting?* ❖ Breast milk – the best fluid for the treatment of diarrhoea ❖ Clean water (or boiled) ❖ Oral Rehydration Salts from the clinic (made up with clean water) – helps to replace lost salts ❖ Homemade ORS (4 tsp sugar, ½ tsp salt, squeeze of lemon – in 1 liter of water) *How to prepare and give ORS?* ❖ Add 1 sachet to 1litre clean (boiled and cooled) water (do not add to milk or other fluids) ❖ prepare in a clean bottle ❖ give with a clean cup ❖ children <2yr – ¼ to ½ cup, children >2yr ½ to 1 cup after each loose stool ❖ continue until diarrhoea stops ❖ Keep ORS cool and covered and use within 24hrs.
Community Sensitization	Community members Community health workers, Community Volunteers	❖ What are the different terms used to describe malnutrition? ❖ Is there a perceived difference between malnutrition and general sickness? ❖ What are the perceived signs of malnutrition? These may include skinny legs/ar and loose skin. Remember to include swollen children as oedema is not always associated with malnutrition ❖ What are the perceived causes of malnutrition? Is it food related? ❖ How has the community traditionally dealt with malnutrition? Is knowledge of treatment available to all? Are there specific people in charge of it? ❖ Are there many cases of malnutrition in the community? How can these be identified? **Services and Other outreach activities** ❖ Explain what services are available for malnutrition (Outpatient Therapeutic Program/OTP) for uncomplicated severe cases and inpatient hospital care for complicated cases of severe malnutrition and supplementary feeding for moderate cases ❖ Talk about the other outreach activities that are being carried out – immunisation, preventative services, health education, curative services as sickness can lead to weight loss and weight loss/malnutrition makes it more likely for the child to get an infection and to link with services for malnutrition
Utilization of Supplementary Plumpy	Caretakers of 6-59 months children	❖ Supplementary plumpy® is a food and medicine for very thin children (under 5 years) only. ❖ Supplementary plumpy® should NOT be shared ❖ Supplementary plumpy® is for children 6 – 59 months only that are moderately malnourished ❖ Give the child one sachet of supplementary plumpy® to eat everyday. ❖ Supplementary plumpy® should be eaten in addition to the food the child normally eats at home ❖ Always offer the child plenty of clean water or breast milk to drink while he or she is eating supplementary plumpy® ❖ Wash children's hands and face before feeding

		❖ Use soap for washing children's hands and face ❖ Keep the open sachet of supplementary plumpy® clean and covered and give to the child whenever he/she demands for it. ❖ Breastfeeding the child should continue when they are on supplementary plumpy® ❖ **CHILDREN BELOW SIX MONTHS SHOULD ONLY BE EXCLUSIVELY BREASTFED** and should not be given supplementary plumpy® or any other foods or liquids ❖ Before giving to the child to eat, knead the unopened sachet gently (do not apply too much force) to allow for flow of the content. ❖ Open the sachet using a clean device and then give to the child to eat. ❖ Give only one sachet for the child per day. ❖ Always keep opened sachet in clean place and well covered ❖ Always offer the child plenty of clean water or breast milk to drink while he or she is eating supplementary plumpy® ❖ Supplementary plumpy® should not be shared with other members of the family

Annex 8: Monthly reporting format

Name of Partner:_____ County:_____ District:_____

Name of Facility:_____ Period: From:_____ To:_____

	Categories						
	Children 6-59 months	Pregnant women	Lactating women	Children 6-10 years	Chronically ill (Specify)	Elderly (>60 years)	Total
Total at end of last month (A)							
Total New Admissions (B)							
Z scores (>-3- <-2) MUAC 115-125mm							
MUAC < 21 cm							
Re-admissions (C)							
Transfers from TFC (T)							
Total Admissions D=B+C+T							
Discharged in this period (I):							
Discharged after recovery (E)							
Deaths (F)							
Defaulters (G)							
Referred to Hospital/TFC (R)							
Criteria non respondents(M)							
Total Discharged (I=E+F+G+R+M)							
New Total at end of this month (J=A+D-I)							
Monitoring Indicators							
Proportion recovered = E/I x 100							
Proportion of deaths = F/I x 100							
Proportion of defaulters = G/I x 100							
Proportion referred to Hospital/TFC = R/I x 100							
Average length of stay							

Total number of children absent within the reporting period:_____

Stock Balances	CSB/UNIMIX kg	Ready to Use Food(specify type)	Fe/Folate tin	Vitamin A tin	Mebendazole /Albendazole tin	Multi Micronutrient supplements

Name of Reporting Staff:_____ Signature:_____ Date:_____