Operational Protocol

Integrated Management of Acute Malnutrition

2017

Department of Public Health
Ministry of Health and Sports

COMMUNITY MOBILIZATION

OUTPATIENT TREATMENT PROGRAMME

SUPPLEMENTARY FEEDING PROGRAMME

INPATIENT TREATMENT PROGRAMME

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Operational Protocol
for
Integrated Management of Acute Malnutrition
2017

Department of Public Health
Ministry of Health and Sport

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PART 2

IMAM
Operation Protocol

Content

Part 2 : IMAM Operational Protocol

Content

Operational Guidelines for Integrated Management of Acute Malnutrition

Implementation of IMAM will be based on the existing health service delivery system instead of developing independent special therapeutic centers for acute malnutrition because the prevalence of acute malnutrition in Myanmar is not that high (<-3SD - 2.1% and <-2SD – 7.9% in MICS 2009 – 2010; <-3SD – 1.3% and <-2SD – 7.0% in DHS 2016). Rolling out of IMAM in Myanmar will be carried out according to the outline mentioned in this Operational Guideline. This operation guideline is prepared based on the current context of Myanmar and will be updated in order to meet the changing situation in the country.

1.1. Rolling out of IMAM and its components to be delivered

IMAM is implemented in Myanmar after Central Level Training of Trainers, State and Region Level Training of Trainers and finally Township Level Training for Basic Health Staff and Community Volunteers. When IMAM is implemented, all four components of IMAM_ (1) Community Mobilization, (2) Supplementary Feeding Programme for Moderate Acute Malnutrition (SFP), (3) Outpatient Therapeutic Programme for Severe Acute Malnutrition without complications (OTP) and (4) Inpatient Therapeutic Programme for Severe Acute Malnutrition with complications (ITP), will be implemented region by region throughout the country.

1.2. Entry point of IMAM

IMAM services are delivered to community by Basic Health Staff, Community Volunteers, Nutrition Implementation Partners which may be International Non-Government Organizations or Local Non-Government Organizations and government hospitals ranging from Station Hospital to Tertiary hospital. Starting point or entry point of IMAM services delivery can betaken place in two settings: (a) rolling out in the community setting and (b) rolling out in hospital setting.

(a) In community setting:

After township level training for BHS and volunteers, Community mobilization is carried out through 4 main activities. These activities have to be performed by community volunteers (CHW and AMW) supervised by BHS. Where volunteers are not available, BHS has to carry out these activities by themselves. The 4 main activities are:

- Community awareness raising on malnutrition and its consequences
- Active Case Finding by MUAC measurement and triage.
- Referral of children with acute malnutrition to the relevant health facilities (SFP & OTP in RHC/SRHC and ITP in hospitals). In community setting, the children with Moderate Acute Malnutrition (MAM) or Severe Acute Malnutrition (SAM) without complication found out during community mobilization are provided SFP or OTP services accordingly together with IYCF Counselling. Severe Acute Malnutrition (SAM) with complications are referred to hospital for ITP.
- Regular home visits to children with acute malnutrition according to the criteria mentioned in the national protocol.

This approach is a new approach which is developed together with introduction of IMAM services in the country. This approach can be implemented anywhere throughout the country especially where human resources is not an issue.

Another entry point for the community setting is based on the existing system of Growth Monitoring and Promotion (GMP) activity performed by BHS. After the Community mobilization, GMP is done. The children whose Weight for Age fall in the Yellow or Red areas during GMP are referred to RHC and SRHC to undergo a comprehensive nutritional assessment based on MUAC, weight and height and oedema detection to confirm if they suffer from MAM or SAM. They are referred to IMAM Services for IYCF Counselling and simultaneous ambulatory treatment with SFP or OTP, or referred to hospital for ITP if they show medical complications.

Appropriate entry point or both can be applied according to the situation.

Mothers or caretakers of malnourished children will also be provided with cIYCF counselling with 3 As (Assess, Analyze and Act) by Basic Health Staff, Community Volunteers, and staff from other Nutrition Implementation Partners at the time of diagnosis, throughout the treatment with IMAM service and at the time of discharge from IMAM service. 3As cIYCF Counselling has to be done according to the National Guidelines for cIYCF counselling.

Community volunteers, midwives and PHS-II are key players in the implementation of IMAM in community setting. They will deliver the IMAM services at health center in RHC/SRHC villages.

(b) In hospital setting:

In hospitals, passive case finding by MUAC measurement to all attending children patients, in both Outpatient Department and Inpatient Department, can be done by clinical staff (Paediatricians, Civil Assistant Surgeon, Preregistration House Physician, and Nurses). The patients who are identified as malnourished based on the MUAC are referred to the Stabilisation Centre

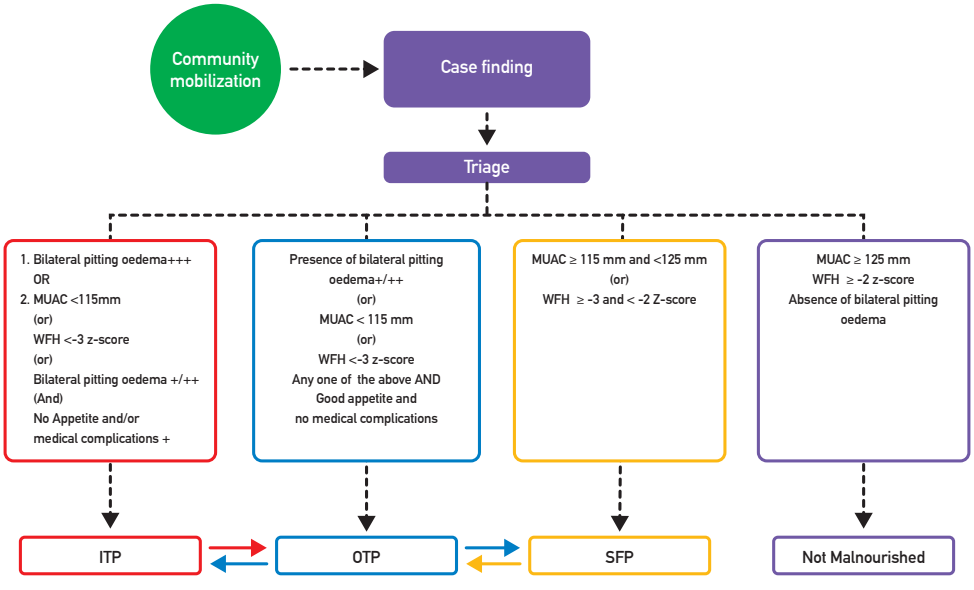
within the hospital to undergo a comprehensive nutritional assessment, including MUAC, weight, height and oedema detection. If they are confirmed SAM and show medical complications, they are then admitted to the SC and started treatment with F-75 If they are confirmed SAM but do not show any medical complications, they are referred to the closest OTP and start treatment with RUTF.

Mothers or caretakers of all children identified as malnourished are also provided with 3As cIYCF counselling at the point of first contact, during admission period in hospital and before being discharge from the hospital. It is important then to refer these "treated with success" children to OTP services (RHC and SRHC) for ambulatory follow-up treatment with RUTF and further cIYCF counselling services.

1.3. Linking the components of IMAM

Although components of IMAM are categorized into four, they are not separate entities and they link to each other, as illustrated in Figure (1).

Figure 1 Linkage between SF, OT and IP



After screening with MUAC measurements and triage, children with MUAC <125 mm and ⩾115 mm are diagnosed as suffering of Moderate Acute Malnutrition and referred to SFP. When they reach all discharge criteria (MUAC ⩾125 mm and W/H >= -2 ZS for 2 consecutive visits -visits are made at every two week), they are discharged from the SFP. However, if their MUAC deteriorates below 115 mm or develop bilateral pitting oedema of "+" or "++", they are referred to OTP. If they develop the oedema of "+++" or get other diseases, refer them to ITP.

At the time of screening, if MUAC is below 115 mm or the oedema is present", refer them to OTP, where they will undergo a full nutritional and medical assessment. When all discharge criteria are met (MUAC is ⩾115 mm and W/H>= -2 ZS and no oedema for 2 consecutive weeks), they are discharged from the OTP and referred to SFP for further follow up nutritional support for another 3 months. They are discharged from SFP after the 3 month ration (provided they don't suffer from another episode of acute malnutrition).

In any programme, if the child does not respond to the treatment, follow the steps for failure to respond the respective programme.

1.4. Roles and responsibilities of persons involving at different levels of IMAM services

The specificity of Integrated Management of Acute Malnutrition is that it is integrated in the health system, and therefore, health key players have all their specific roles and responsibilities in delivering IMAM services. The essential key players are

(a) Community Volunteer,

(b) Midwife and Public Health Supervisor – Grade II (PHS-II) at the SRHC/field level,

(c) Health Assistant (HA)/ Lady Health Visitor (LHV) at RHC level,

(d) Township Health Nurse (THN) and Township Medical Officer (TMO) at Township level,

(e) clinical staff at different level hospitals,

(f) State/Region Nutrition Teams (SRNT) at State and Region level,

(g) IMAM Technical Working Group and

(h) National Nutrition Center (NNC) at central level. Other potential players in the field may be INGOs or Local NGOs who are working in Acute Malnutrition. UN agencies such as UNICEF and WFP may provide technical, financial and supply assistance to support the IMAM programme.

(a) Community Volunteer

After receiving the IMAM Training, the community volunteers' roles and responsibilities will be:

1) Performing Community mobilization
2) Assist BHS in Active Case Finding by MUAC measurement (during community screening and GMP sessions)
3) Assist BHS in filling records, ration cards and assigning AM number
4) Assist BHS in distributing the rations such as RUSF/FBF or RUTF to mothers/caretakers of malnourished children
5) Explaining mothers/caretakers about proper feeding with RUSF/FBF or RUTF.
6) Assist BHS to do cIYCF Counselling to mothers/caretakers of malnourished children or mothers/caretakers with feeding problems
7) Assist BHS in performing home visits for SAM children according to the criteria defined in the protocol

(b) Midwife and Public Health Supervisor – Grade II at SRHC level

After receiving the IMAM Training, Midwifes and PHS-II will be mainly responsible for community mobilization with active case finding, as well as for the running of the SFP and OTP sites. Their specific roles and responsibilities will be:

1) Community mobilization
2) Supervising Active Case Finding and triage for children with Acute Malnutrition performed by volunteers and referral of the malnourished children to the respective programme
3) Performing passive screening among the sick children who visit them
4) Performing Appetite test for children with SAM at the time of diagnosis and at follow up visits. Referral of the child with poor appetite test to ITP.
5) Conducting medical consultation to detect any potential complication on admission and at each follow up visit
6) Filling records and ration cards and assigning AM number for each malnourished child
7) Distribution of ration (RUSF/FBF or RUTF) to the mothers/caretakers
8) Explaining causes and consequences of malnutrition, proper feeding with RUSF/FBF or RUTF and importance of regular follow up visits to the mothers/caretakers

9) Performing cIYCF Counselling to mothers/caretakers of malnourished children at the time of diagnosis, during treatment or before discharge from the programme, or to mothers/caretakers with feeding problems

10) Performing regular (weekly for SAM and bi-weekly for MAM) follow up visits for the malnourished children

11) Referral of malnourished children, who fail to respond to/are deteriorating from, the current treatment programme to the appropriate level of programme

12) Receiving the referral from another treatment center and continuing the respective treatment

13) Supervision of Community Volunteers in Community mobilization, cIYCF counselling and follow-up visits by community volunteers to mothers and caretakers and/or children who are receiving SFP or OTP; and providing technical support to the volunteer depend on the child's situation/response to the respective programme

14) Estimation of supplies (RUSF/FBF and RUTF) requirement on a monthly basis

15) Complete the monthly statistics report (number of admissions and exits of the OTP and SFP programme) and send it to the RHC

16) Reporting the IMAM implementation status to HA/LHV at RHC

(c) HA and LHV at RHC level

After receiving the IMAM Training, HA and LHV, their main responsibility will be related to community mobilization with active case finding, SFP and OTP. Their specific roles and responsibilities will be:

1) Supportive supervision and technical assistance to Midwives, PHS-II and Community Volunteers

2) Compilation of supplies (RUSF/FBF and RUTF) requirements estimated by midwives and PHS-II Sub-RHC level)

3) Compilation of the monthly statistics reports sent by the midwives

4) Compilation ofthe IMAM implementation reports from midwife and PHS-II

5) Monitoring & Evaluation of the IMAM implementation based on the reports from midwife and PHS-II

6) Reporting of monthly IMAM implementation status in their catchment area to TMO/LHV at township level

7) Request of monthly supplies (RUSF/FBF and RUTF) requirements to Township

(d) TMO and THN at Township level

After receiving the IMAM Training, TMO's roles and responsibilities will be:

1) Supportive supervision and technical assistance to Midwives, PHS-II, and Community volunteers at the field level, to HA and LHV at RHC level and to medical staff at IP services at Township Hospital and Station Hospital
2) Supply chain and stock management, including compilation of supplies (RUSF/FBB, RUTF, drugs for systematic treatment) requirements submitted from HA (RHC level) and SRNT, storage of RUSF/FBF and RUTF at Township level and transport from township to RHC and SRHC (TMO may need to co-ordinate with local authority, International and Local NGOs, and other social groups for mobilization of resources for the transport of RUSF/FBF and RUTF)
3) Monitoring & Evaluation of the IMAM implementation based on the reports from Sub-RHC and RHC
4) IMAM data compilation of the monthly reports, based on the reports submitted from Sub-RHC and RHC, to submit to SRNT
5) TPHN is responsible to assist TMO for the above mentioned roles.

(e) Clinical Staffs (Medical Officers, Paediatricians and Nurses) from Station Hospital, Township Hospital, General Hospital with Paediatric Ward and Paediatric Hospital

Clinical staff from hospitals are responsible for:

1) Passive case finding followed by triage
2) Provision of IP with F-75/F-100 and treatment of associated diseases
3) Referral of treatment unresponsive cases to next level of referral center for further investigation and treatment
4) Referral of malnourished children "treated with success" at IP to OTP for further follow up ambulatory treatment with RUTF
5) Performing cIYCF Counselling to mothers/caretakers of malnourished children at the time of diagnosis, during treatment or before discharge from hospital
6) Estimation of monthly supplies requirements (F-75/F-100/RUTF/essential drugs for systematic and specific treatment), request of supplies to SRNT, supplies Stock management and storage
7) Record filling, Preparation of monthly report and submission to the respective next level of management

(f) State/Region Nutrition Team

SRNT is responsible for:

1) Supportive supervision and technical assistance to Township level IMAM implementation staff
2) Monitoring & Evaluation of the IMAM implementation through the collection of Township monthly IMAM data
3) Preparation of monthly State/Region IMAM data after compilation and analysis of the monthly reports
4) Implementation reports to be submitted to NNC
5) Estimation of quarterly supplies requirement (RUSF/FBF, RUTF, therapeutic milk, essential drugs) for the state/region based on the requirements sent by the Townships
6) Supplies Stock management and storage

(g) IMAM Technical Working Group

IMAM Technical Working Group is responsible for:

1) Providing technical inputs to NNC in the development of National Guidelines for both technical and operational aspects related to the IMAM programme
2) Provide technical inputs for the development of training materials for IMAM at various levels
3) Ensuring quality trainings on IMAM
4) Monitoring of IMAM quality implementation at various levels.

(h) National Nutrition Center (NNC)

NNC is responsible for:

1) Preparation of National IMAM Guidelines with the assistance of NTWG and UNICEF
2) Supportive supervision and technical assistance to SRNT and Township level IMAM implementation staff
3) Monitoring & Evaluation of the nation-wide IMAM implementation status
4) Estimation of annual requirements of supplies (RUSF/FBF, RUTF, essential drugs) for the respective states/regions

5) Declare Nutrition Emergency Situations according to the prevalence of Acute malnutrition

6) Development of National IMAM data on the detection and treatment of Acute malnutrition (admissions, cure rate, death rate, defaulter rate, non-respondent rate) by townships, region, disaggregated by age.

(i) International/Local Non-Government Organization as Implementing Partners

Their responsibility is the same as that of Midwife and PHS-II except No.13, 15 and 16 according to MoU with MoHS. Instead of reporting to RHC, sharing of IMAM data to the TMO is mandatory in order to avoid overlapping of service delivery and underreporting of incidence of acute malnutrition in the particular area.

2. Supply, Storage and Distribution

Supplies for IMAM are bulky and heavy as well as need a lot of storage space. Moreover, they are attractive to rodents and insects. Therefore, systematic estimation of required supplies, proper storage and well planned transport/ logistics arrangement are vital to avoid shortage as well as damage during storage at different level of treatment facilities.

2.1 Forecast of Supplies

This chapter will focus only on estimation of nutrition supplies requirements and essential drugs for systematic treatment. IMMCI guidelines are referred to for estimation of other medicines and supplies.

Important nutrition supplies for the treatment of acute malnutrition are:

1) Ready to Use Therapeutic Supply (RUTF)
2) Ready to Use Supplementary Food (RUSF)
3) Fortified Blended Food (FBF)
4) F-75
5) F-100
6) Amoxycillin
7) Albendazole

2.1.1 Estimation of RUTF requirements

RUTF requirement at township level is calculated through the following steps:

❑ **Step 1 – Calculate the township SAM case load by using formula below:**

Case load = N x P x K x C

Where_

N = Size of target population in the area (6-59 months) which can be calculated by (Total population X Proportion of 6-59 months old children)

P = Prevalence of SAM/MAM (usually estimated from any available nutritional survey or from the officially announced source)

K = Correction factor to account for new (incident cases) over a given time period which can be calculated by (K = 1 +t/7.5 ; here t is time period in months)

C = Expected mean programme coverage over a given time period

Example: Apple Town has Total population of 121,400 and proportion of 6 – 59 months old children is 17.3% of total population. Prevalence of SAM in this town is 1.34%. Township Health Department of that town is estimating RUTF requirement for 1 year with expected programme coverage of 56%.

N = Total population X Proportion of 6-59 months old children

= 121,400 x 17.3% = 21,002

P = 1.34%

K = 1 +12/7.5 (t = 1 year = 12 months) = 2.6

C = 56%

Case load = N x P x K x C =21,002 x 1.34% x 2.6 x 56% = 410

❑ **Step 2 – Calculate the supply requirement by using formula below:**

Annual requirement	=	Annual case load	x	Daily requirement	x	Minimum treatment duration

Example:

(a) Calculation of RUTF requirement

The average requirement per child will be based on a child of 10 kg, who needs 3 sachets of RUTF per day.

Therefore, annual requirement of RUTF for Apple Town is:

Annual requirement	=	Annual case load	x	Daily requirement	x	Minimum treatment duration

= 410 x 3 x 45 days = 55,350 Sachets = 369 cartons (55,350 sachets/150 sachets)

Therefore, monthly requirement at a health facility can also be calculated by:

A	**Number of patients/admissions per month**	**34**
B	Daily requirement (child 10 kg)	3 sachets
C	Average treatment duration	45 days
D	Quantity of RUTF per months (sachet) A x B x C	34 x 3 x 45 = 4,590 sachets
E	Number of cartons RUTF per month (150 sachets per carton)	4,590 ÷ 150 ≈ 31 cartons

2.1.2 Estimation of RUSF/FBF requirement

FBF requirement is calculated through the following steps:

❑ **Step 1 – Calculate case load for the MAM by using formula below:**

Case load = N x P x K x C

The estimation of the caseload for the MAM programme should include MAM children 6-59 months, acutely malnourished pregnant women and lactating mothers of acutely malnourished infants under 6 months. These numbers can be obtained by following the equation provided above.

Once the programme has already started, the caseload could be also calculated with the support of previous admission reports and supply orders. As far as pregnant and lactating mothers of infants <6 months of age, it is important to add these figures into the planning process (once the service is already running and figures can be obtained from previous admissions.

The nutritional supply requirements can be calculated assuming a minimum length of stay of 90 days per child.

❑ **Step 2 – Calculate the supply requirement by using formula below:**

The estimation of the supply requirement for the MAM programme will depend on the type of nutritional supplies available in country (Wheat Soya Blend - WSB+ or RTSF).

Annual requirement	=	Annual case load	x	Daily requirement	x	Minimum treatment duration 90 days

Example:

Let's suppose the annual case load of MAM children 6-59 months is 410.

Annual requirement for WSB+ : 410 x 200gr x 90 days = 7,380,000gr = 7,380 kg

OR

Annual requirement for RUSF: = 410 x 1 sachet x 90 = 36,900 sachets
= 246 cartons (36,900 sachets/150)

Monthly requirement of FBF/RUSF can be calculated as follow:

A	**Number of MAM children admissions per month**	**45**
B	Number of MAM PLW admissions per month	40
C	Daily requirement of Super Cereal plus (g)	200 g
D	Average treatment duration (Days)	90 days
E	Quantity of of Super Cereal plus per months (g) (A + B) x C x D	(45+40) x 200 x 90 = 1,530,000 g
F	Packets of Super Cereal plus per months (1400 g per packet) E ÷ 1400	1,530,000 ÷ 1400 ≈ 1,093 packets

A	**Number of MAM children admissions per month**	**45**
B	Number of MAM PLW admissions per month	40
C	Daily requirement of Lipid Based Nutrient Supplement (RUSF) (sachet)	1
D	Average treatment duration (Days)	90 days
E	Quantity of Lipid Based Nutrient Supplement (RUSF) (sachets) (A + B) x C x D	(45+40) x 1 x 90 = 7,650 sachets
F	Carton of Lipid Based Nutrient Supplement (RUSF) E ÷ 150 Sachets	7,650 ÷ 150 = 51 cartons

2.1.3 Estimation of F 75 requirement

F 75 requirement is calculated through the following steps:

❑ **Step 1**

Estimate the number of admissions of SAM with complications to IP based on the previous year admissions. At the start of the programme, if no data is available, consider that 15% of all the admissions in the IMAM programme should be inpatients.

❑ Step 2

Calculate F 75 requirement by following the formula in the table below:

Table 1. Calculation of F 75 requirement per child

A	Number of patients/admissions per month	6
B	Average consumption per day (child 10 kg)	110 ml x 12 meals/day = 1320 ml ≈ 3 sachets
C	Average treatment duration in phase 1	3 days
D	Quantity F75 per months (ml) A x B x C	6*(110 ml * 12 meals) * 3 days = 23,760 ml
E	Number of sachets F 75 per month D ÷ 600 ml	≈ 40 sachets
F	Number of cartons F75 per month E ÷ 120 sachets	40/120 = 0.3 carton ≈ 1 carton

*When 102.5 g of F 75 packet (Small packet) is mixed with 500 ml of water, 600 ml of F 75 solution is obtained. Calculation is assumed that children does not have Oedema +++ and small and frequent meal is providing.

2.1.4 Estimation of F 100 requirement

Calculation of F 100 requirement can be done by following the formula in the table below:

Table 2. Calculation of F100 requirement per child

A	Number of patients/admissions per month	6
B	Average consumption per day (child 10 kg)	250 ml x 6 meals/day = 1,500 ml = 2.5 sachets
C	Average treatment duration in Transition Phase	3 days
D	Quantity F 100 per months (ml) A x B x C	6 x (250 ml x 6 meals) x 3 days = 27,000 ml
E	Number of sachets of F 100 per month D ÷ 600 ml	27,000/600 = 45 sachets++
F	Number of cartons F 100 per month E ÷ 90 sachets	45/90 = 0.5 carton ≈ 1 carton

++ When 114 g of F 100 sachet is mixed with 500 ml of water, 600 ml of F 100 solution is obtained

2.1.5 Estimation of RUTF requirement for transition phase

Table 3. Calculation of RUTF requirement per child

A	**Number of patients/admissions per month**	**6**
B	Average consumption per day (child 10 kg)	3 sachets per patient (10 kg)
C	Average treatment duration with RUTF	7 days
D	Quantity RUTF per months (sachet) A x B x C	6 x 3 x 7 days =126 sachets
E	Number of cartons per month D ÷ 150 sachets	126/150 = 0.84 carton ≈ 1 carton
F	Number of cartons RUTF per month E ÷ 150 sachets	45/150 = 0.5 carton ≈ 1 carton

2.1.6 Estimation of Amoxicillin for OTP

Amoxicillin requirement is calculated by;

$$\text{Amount of 250 mg capsules} = \left[\frac{\text{250 mg (25 mg per Kg per dose x average body weight of 10 Kg)} \times \text{2 times a day} \times \text{5 days}}{\text{250 mg}} \right] \times \text{SAM Case load}$$

Cotrimoxazole can be used alternatively and estimated by;

24 mg per Kg per dose x 2 times a day x 5 days x SAM Case load

A	**Number of patients/admissions per month**	**6**
B	Average consumption per day (child 10 kg)	2 tabs per day (10 kg)
C	Average treatment duration	5 days
D	Amoxycilline requirement per month A x B x C	6 x 2 x 5 = 60
E	Number of Pac per month (Pac-100 tabs) D ÷ 100 Tabs	60/100 = 0.6 ≈ 1 PAC

2.2 Inventory management

Inventory management consists of estimating storage capacity at the respective level of health department, determining frequency of shipment, reordering level, and buffer stock level based on the available storage capacity and estimated caseload. From National level through State/Region to Township level, health departments have to deal with this inventory management.

2.2.1 Storage capacity for nutrition supplies & frequency of shipment for the supplies

Storage capacity and frequency of shipment for the supplies are estimated through the following steps:

(A) Storage capacity or storage space is estimated based on the store space available for nutrition supplies which is calculated by following formula:

- Store space = length (L) x width (W) x height up to the eaves (H)
- Storage space (storage capacity) = Remaining space of store space (L x W x H) after taking into consideration of the space between stacks and walls and the space between the stack and the eaves

As a general rule, approximately half of the space in small stores can be used as actual storage space and up to three-quarters (75%) of the space in large store can be used as actual storage space.

For example, Apple Town has a store of 100 meters x 50 meters x 8 meter. Therefore, its Store space is 100 x 50 x 8 = 40,000 Cubic meter. Actual storage space is 40,000 cubic meter x 75% = 30,000 cubic meter.

(B) The following step is to estimate the quantities of supplies that can be stored in the available storage space. By dividing the Storage space by the respective dimensions of the packaging unit for each type of supply, the quantity of supplies which can be kept in that store is estimated (see Table 5 below).

For example, if 30,000 cubic meter is divided by 39 x 28.5 x 19.7 cm, about 1,370,079 cartoons (150 sachets of RUTF per carton) or 205,511,827 sachets of RUTF can be stored in Apple Town's Store.

Table 4. Dimension and Weight of Nutrition Supplies

Item	Unit	No of packet/sachet per carton	Dimension per carton	Weight in Kgs for each carton
Therapeutic spread	sachet	150	39 x 28.5 x 19.7 cm	14.7
F-75	sachet	120	38.5x29x32 cm	13.38
F-100	sachet	90	38.5x29x26 cm	11.16
ReSoMal	sachet	100	57x27x16 cm	5.9

2.2.2 Buffer stock

Buffer stock is a level of extra stock that is kept reserved for stockouts due to uncertainties in supply and demand.

In general, Buffer stock should be round about 25%-30% of actual needs for a period of time. For example, if township sends quarterly requests (3 months quantities of supplies), the buffer stock should amount to the quantities needed for one month.

For example, if 20,551 sachets of RUTF is the quantities to cover the needs for a quarter in Apple Township, the buffer stock for Apple Township Town should be about 20,551 sachets/3 = 6,850 sachets or 45 cartons. This quantity could be adjusted to the township storage capacity.

However, for special situation such as area with difficult transportation, Buffer stock and Re-ordering level should be calculated by:

$$\text{Buffer stock} = \left[\text{Maximum Daily Usage} \times \text{Maximum Lead Time in Days}\right] - \left[\text{Average Daily Usage} \times \text{Average Lead Time in Days}\right]$$

Re-ordering level is a level of inventory at which replenishment is to be done and when stock is falls to this amount, then respective item must be reordered. Re-ordering level is calculated by:

$$\text{Re-ordering level} = \text{Buffer stock} + \text{Lead Time Demands}$$

Where_

$$\text{Lead Time Demands} = \text{Daily usage} \times \text{Lead Time in Days}$$

Lead Time is the time it takes the suppliers or manufacturing process to provide the requested amount.

2.2.4 Supply and Procurement of IMAM supplies

2.2.4.1 Monthly indent of IMAM supplies From SRHC to State/Region

The responsible BHS at SRHC level and RHC - Main, after estimating the monthly forecast for IMAM supplies, fills the Supply Indent Form – 1 (SRHC Level) Annex.1, signs and submit to RHC. The estimation is done based on number of cases in the previous month or prevalence of acute malnutrition (By MUAC) in the township or prevalence of acute malnutrition according to DHS survey 2015 – 2016.

Health Assistant at RHC compiles Indent Forms from SRHC and RHC – Main monthly into Indent Form – 2 (RHC Level) Annex.2, signs and submits to Township Health Department.

At the township level, Nutrition Focal person checks the quantities requested against the prevalence of the township acute malnutrition, and compiles into the Supply Indent Form – 3 (Township Level) Annex.3, signs and submits to State/Region Nutrition Team Focal person monthly.

2.2.4.2 Monthly indent of IMAM supplies by Hospital Nutrition Unit

After estimation of monthly requirement of IMAM supplies for HNU, based on the case load at the end of previous month, the focal person fills the Supply Indent Form (HNU), signs and submit to the next level.

For the Station Hospital, the focal person submits the HNU indent form to the township focal person. The township focal person compiles the indents from Station Hospitals within the township and together with indent from the Township Hospital HNU, township focal person fills the Supply Indent Form (HNU) Annex.4, signs and submits to State/Region Medical Service Department. Frequency of indent may be monthly or quarterly depends on the case load.

For the State/Region Hospitals, the focal person of HNU forecasts monthly requirement, based on the case load at the end of previous month, and prepares the Supply Indent Form (HNU), signs and submits to State/Region Medical Service Department. Frequency of indent may be monthly or quarterly depends on the case load.

Focal point from State/Region Medical Service Department compiles the requests from Township Hospitals and State/Regional Hospitals, signs the State/Region Supply Indent Form (HNU) and submit to Department of Medical Service, Ministry of Health and Sport with a copy to State/Region Nutrition Team.

HNU Focal Persons from Central Level Hospitals prepared the Supply Indent Form (HNU), signs and submits to Department of Medical Service, Ministry of Health and Sport. Frequency of indent may be monthly or quarterly depends on the case load.

The Focal Person for Department of Medical Service, Ministry of Health and Sport compiles the requests from states/regions and send the information to National Nutrition Center.

2.2.4.3 Procurement of IMAM Supplies

At the beginning of every year, State/Region Nutrition Team Focal person estimates the annual requirement of IMAM supplies based on the prevalence of acute malnutrition at state/region level or case load of acute malnutrition based on the previous year Supply Indent Form – 3 (Township Level) and the Supply Indent Form (HNU). The information of acute malnutrition prevalence at state/region, number of children between 6 – 59 months together with number of PLW and the amount required of each supply should be submitted to National Nutrition Center.

Focal person at National Nutrition Center compiles the number of children between 6 – 59 months together with number of PLW and the amount required of each supply from every state/region and compiles them as annual requirement of IMAM supplies at national level and share it with Supply and Procurement Division of DoPH.

Supply and Procurement Division of DoPH facilitates the international procurement of IMAM supplies for the respective year.

2.2.4.4 Issue of IMAM Supplies for SFP and OTP

When the IMAM supplies from international supplier arrives at Country, NNC co-ordinates with Supply and Procurement Division to send the quarterly requirements of SRHC, RHC and Township level IMAM activities (SFP and OTP) to state/region (State/Region Nutrition Team), and co-ordinates with CMSD to send the requirements of Hospital Nutrition Units (ITP). IMAM supplies are issued with properly filled and signed Central Level Issue Form.

State/Region Nutrition Team issues township's request with properly filled and signed State/Region Level Issue Form Annex.5. Focal person at SRNT also have to sign in Supply Indent Form – 3 (Township Level).

The Focal Person from Township Health Department issues RHC's request with properly filled and signed Township Level Issue Form Annex.6. The Focal Person also have to sign the Indent Form – 2 (RHC Level).

2.2.4.5 Issue of IMAM Supplies for HNU

Respective CMSD issues requirements of HNUs from Central Level Hospitals, State/Region Hospitals and Township Hospitals, with properly filled and signed Issues Forms, on their request and also have to sign the Supply Indent Form (HNU).

Similarly, Township Hospital issues Station Hospital's request with properly filled and signed Issues Forms, and also signs the Supply Indent Form (HNU).

2.3 Storage of the supplies

Generally, nutrition supplies should be stored in clean, dry and cool warehouses and stored away from direct sunlight. Temperature and humidity in the warehouse should be regularly checked and recorded. Products should be stored in a way that ensures the circulation of air is not prevented and regular stock turnover can be assured.

Store should be sufficiently big to store enough (3 months at township level) stock and well ventilated and sheltered from the rain. It must be regularly cleaned/disinfected as well as protected from rodents, and insects. Store must always be secured and kept under lock and key. Food commodities should be separated from the non-food items. Food products are put on wood-pallets and kept 30cm from the wall. Height of supplies piles should be limited (avoid piling up until the ceiling).

Goods received and distributed are recorded on stock cards.

For

the specific storage conditions for RUTF, F-75 and F-100, store manager needs to check the specific instructions from the respective manufacturers.

2.4 Stock Management

A supply stock book for received, used and balance of supplies (Annex.7) should be kept to record supply stock movement and to complete the stock balance in the monthly report.

When receiving deliveries:

- Check the commodities on delivery: conditions of the goods, packaging and labelling, quantities.
- Verify on the waybill the content of the delivery and certify the reception of the delivery
- Indicate (in writing) any problems or inconsistencies between the actual delivery and the waybill. Retain one copy of the waybill and return one copy to the driver.

2.5 Logistics and transport

Head and focal persons for nutrition at each level of health department are responsible for the development of IMAM supplies distribution plans. Transportation of supplies to States and Regions will be done by NNC in cooperation with Procurement and Supply Section, Department of Public Health Central Medical Store and Depot (CMSD).

3. Capacity building and training

Based on the most recent Treatment Protocol of IMAM, NNC/TWG has to prepare training curriculums for BHS for all components of IMAM i.e. Community Mobilization, Supplementary Feeding, Outpatient Treatment, and Inpatient Treatment for health staff. Central level ToT followed by State and Regional Level ToT will be implemented first. Then, multiplier training will be done at township level. After the township level, BHS has to train Community Volunteers and Auxiliary Midwives. After these initial trainings, continued hands-on training, and coaching in CME programme are also required regularly.

If major changes are introduced to the IMAM Technical Protocol and Operational Guidelines, another series of initial trainings will be provided to health staff and volunteers.

4. Supervision, Monitoring and Evaluation

Supervision, Monitoring and Evaluation are essential and integral parts of the IMAM programme.

4.1 Supervision

Supportive supervision is carried out at IMAM implementation in the field. Key players in the community portion is Community Volunteer and Midwife/PHS-II, and Clinical staffs in ITP.

Community Volunteer

Community Volunteers are directly supervised by Midwife or PHS-II. Supportive supervision at this level focuses on having MUAC Tapes, IMAM related IEC materials and Flip Chart, correct MUAC measurement, correct use of IMAM Flip Chart, IYCF Counselling in IMAM context, performance at home visit and their role in community mobilization. Midwife and PHS-II have to fulfil and improve the requirements of the volunteers in these area in terms of technical or material (MUAC tape) support. At this level, supportive supervision is done at every contact during the service delivery.

Midwife and PHS-II

Supportive supervision to Midwife/PHS-II is done by HA or LHV at every quarter of a year, and at least once a year it should also be accompanied by TMO/Focal from State/Region Health Department & NNC from central level.

Supervision visit focus on Equipment, Capacity building, Organization of

space or building for IMAM Service delivery, Active and Passive Case finding, Correct performance of Appetite Test, applications of admission criteria and procedure, application of discharge criteria and procedure, IYCF counselling in IMAM context, Community mobilization and Stock management. Supportive supervision checklist described in Annex 6 is used for this purpose.

Clinical staff in ITP

IMAM activities at hospital are supported and supervised by Focal from State/ Region Health Department/NNC at least once a year. Supportive supervision tools for ITP is described in Annex 7. Supportive supervision at tertiary hospitals may require a separate procedure and it is devised accordingly.

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4.2 Monitoring and Evaluation

Data are critical for planning services, ordering supplies, monitoring the quality of services at the level of each RHC/SRHC and in the whole township and for identifying facilities where additional training or supervision is required. Monthly data also form part of the surveillance system to assess the nutritional status of the population, to identify the magnitude of acute malnutrition at township level and identify pockets of malnutrition within a particular township.

Monthly reporting is to be made by Hospital or Hospital Nutrition Units, Health Centers with GAM prevalence ≥15% and during Emergency/Disaster period. For the rest of health centers, quarterly reporting is required.

Reports from each facility (RHC/SRHC/SH/TH) are sent to the Township and collated in the Township database where they are analysed to assess the quality of services in the township. Indicators used in Monitoring and Evaluation should be graphed to help in interpreting trends as the programme proceeds.

Reports from Hospitals or Hospital Nutrition Units are also to be sent to State/ Region Nutrition Team.

In Monitoring and Evaluation of the IMAM programme, the following indicators will be monitored on a regular basis. The IMAM data are to be reported by SRHC through RHC to Township Health Department quarterly. Then from the Township Health Department to the State and Regional Health Department and finally to the national level (NNC) on a regular basis (Also see in Reporting Chapter)

4.2.1 Numbers of patients by types of entry and exit to health center

Information for this purpose can be obtained from the Registration Book for Acute malnutrition (Annex 8). The columns "Category of Admissions" and "Reasons of Exits" column provide these information.

Types of entry: According to the admission criteria for respective SFP, OTP and ITP, there are 4 possible types of entries to each programme in a health center depending on the type of IMAM services delivered.

New admissions:

a) Relapses: This indicates social problems at individual child's home
b) Readmissions (After defaulting): This indicates good defaulter tracking mechanism (but also presence of defaulting)
c) Internal transfers (Within the same programme)

Types of exit: There are 6 types of exits for each SFP, OTP and ITP, which mostly reflect the programme performance

a) **Cured**
b) **Defaulter**
c) **Dead**
d) **Non respondent**
e) **Transfer to another programme**
f) **Internal transfer** (Within the same programme)

4.2.2 Mean length of stay for cured children:

Shorter the Mean length of stay, the better the quality of care of a particular programme. The recommended average length of stay should not be > 45 days. Information to calculate this indicator can be obtained from Date of Admission Column and Date of Exit Column of the Registration Book for Acute malnutrition. This indicator is used in OTP.

This indicator is calculated through the following steps:

❑ Step [1] First, calculate each individual's length of stay:

An individual length of stay	=	Date the patient reached discharge criteria	-	Date of admission

❑ **Step [2] Then calculate Mean length of stay for cured children:**

$$\text{Mean length of stay for cured children} = \frac{\text{Total of each individual length of stay}}{\text{Number of recovered patients}}$$

4.2.3 Mean rate of weight gain for wasted cured children (g/kg/d)

This indicator is particularly useful to show the quality of feeding. Information to calculate this indicator can be obtained from Minimum Weight column, Weight at discharge column, Date of Exit Column and date of minimum weight of the Registration Book for Acute malnutrition. This indicator is also used in OTP.

This indicator is calculated through the following steps:

❑ **Step [1] First, calculate the rate of weight gain for an individual**

$$\text{Rate of weight gain for an individual} = \frac{\left[\text{Weight at discharge in Kg} - \text{Minimum weight in Kg}\right] \times 1000}{\left[\text{Date of discharge} - \text{Date of minimum weight}\right] \times \text{Minimum weight in Kg}}$$

❑ **Step [2] Then, The Mean rate of weight gain is calculated as follow**

$$\text{The Mean rate of weight gain (g/kg/d)} = \frac{\text{Sum of individual Rates of weight gain}}{\text{Total Number of individuals}}$$

4.2.4 Performance indicators to assess the effectiveness of feeding programme

There are performance indicators to determine the effectiveness of SFP, OTP and ITP.

(a) The performance indicators to assess the effectiveness of Therapeutic Care (OTP and ITP) are the following:

- <10% mortality
- <15% default
- >75% recovery

Coverage >50% for rural areas, >70% for urban areas >90% for camp populations

(b) The performance indicators to assess the effectiveness of Supplementary Feeding Programme are the following:

- <3% mortality
- <15% default
- >75% recovery

Coverage >50% for rural areas, >70% for urban areas, >90% for camp populations

5. Reporting

Due to workload on BHS and current prevalence of acute malnutrition, it is recommended to report community portion of IMAM activities quarterly. However, in the health centers with GAM prevalence ⩾15% and during emergency or disaster period, monthly reporting is required until situation is controlled/stable. On the other hand, because of nature of severity in SAM with complications, it is essential to report ITP activities monthly to monitor the performance of the ITP.

For the community component of IMAM, Midwife/PHS-II will prepare the SFP and OTP reports, based on the Nutrition Screening Tally Sheet, the Register Book for Acute malnutrition and the individual patient records and submit them to RHC.

The HA of RHC will compile the SRHC and RHC reports, and submit them to the TMO.

On behalf of TMO, the THN/THA will compile the RHC reports as Township level and send the Township Reports to SRNT.

SRNT will prepare and submit their state/region reports to NNC.

For IP, clinical staff from HNU//Station Hospital or Township Hospital will prepare the report and also submit to the State/Region Nutrition Team. SRNT will forward the reports to NNC.

Records and Reporting formats to be used in IMAM are:

(a) **Nutrition Screening Tally Sheet,**

(b) **Individual patient record (OTP card),**

(c) **Individual patient record (ITP Multi Chart),**

(d) **Register Book for Acute malnutrition,**

(e) **Quarterly Report for SFP,**

(f) **Quarterly Report for OTP** and

(g **Monthly Report for ITP.**

(a) Using Nutrition Screening Tally Sheet by MUAC

1. Fill the information such as Name of Township and Village, dates of screening.at the top of the Nutrition Screening Tally Sheet by MUAC Annex.9.
2. Fill the circle in the column "MUAC <115 mm" if a child with a MUAC <115 mm is found. Total the number of filled circles (i.e. number of children with MUAC <115 mm) and write the number down at the bottom of the Tally Sheet. (Figure 4)
3. Fill the circle in the column "MUAC ⩾115 mm &<125 mm", if a child with a MUAC ⩾115 mm &<125 mm is found. Total the number of filled circles and write the number down at the bottom of the Tally Sheet.
4. Similarly, fill the circle in the column "⩾125 mm" if MUAC of a child with a MUAC >= is found 125 mm and write the total number at the bottom.
6. Fill the circle in column "oedema" if a child with bilateral pitting oedema is detected. Total the number of filled circles and write the number down at the bottom of the Tally Sheet.
5. Sum the number of children with MUAC < 115 m, the number of children with MUAC ⩾115 mm &<125 mm, the number of children with MUAC ⩾125 mm and the number of children with oedema to obtain the total number of children screened for the reported period
6. Sum the total number of children with MUAC < 115 and with oedema and divide this number by the total number of children screened to obtain the percentage of children screened with SAM. Sum the total number of children with MUAC ⩾115 and < 125 and divide this number by the total number of children screened to obtain the percentage of children screened with MAM. Sum the total number of children with MUAC ⩾ 125 mm and divide this number by the total number of children screened to obtain the percentage of children screened who are in good nutritional status.

Figure 2 Nutrition Screening Tally Sheet

Township........................ HC................................ Village...............................

From ___ / ___ / _____ to ___ / ___ / _____

Put a cross to the "o" within the different categories, according to the MUAC

	MUAC < 115mm	MUAC ≥ 115mm & < 125mm	MUAC ≥ 125mm	Oedema
6 months and more	ϕϕϕoo	ϕϕϕϕϕ ϕϕϕϕϕ	ϕϕϕϕϕ ϕϕϕϕϕ ϕϕϕϕϕ	ϕϕϕoo
	ooooo	ooooo ooooo	ϕϕϕϕϕ ϕϕϕϕϕ ϕϕϕϕϕ	ooooo
	ooooo	ooooo ooooo	ϕϕϕϕϕ ϕϕϕϕϕ ϕϕϕϕϕ	ooooo
	ooooo	ooooo ooooo	ϕϕϕϕϕ ϕϕϕϕϕ ϕϕϕϕϕ	ooooo
	ooooo	ooooo ooooo	ϕϕϕϕϕ ϕϕϕϕϕ ϕϕϕϕϕ	ooooo
	ooooo	ooooo ooooo	ϕϕϕϕϕ ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
Total				

Example: MUAC measurement in Shwepyithar Viilage was done in 6 – 59 months children and among the 93 children, found 3 children with MUAC <115 mm, 10 children were ≥115 and < 125 and 80 children were ≥ 125 mm. 2 children have bilateral pitting oedema. See Figure 2 Nutrition Screening Tally Sheet.

Percentage of 6-59 months children with MUAC <115 mm	= 3/93	= 3.23%
Percentage of 6-59 months children with MUAC ≥115 and <125 mm	= 10/93	= 10.75%
Percentage of 6-59 months children with MUAC ≥ 125mm	= 80/93	= 86.02%
Percentage of 6-59 months children with oedema	= 2/93	= 2.15%

(b) Individual patient record (OTP card)

If a child meets the OTP admission criteria, fill an OTP card after assigning an AM number to the child and then register the child in the Register Book for Acute Malnutrition. Annex (8).

The first page is to be used at the time of admission to and discharge from OTP. It provides the information on (i) Personal information, (ii) Type of admission, (iii) Admission anthropometry, (iv) History of illness and Physical Examination findings, and (v) Medication provided at the time of admission. Lower section of the first page is to be used at the discharge from OTP and provides information about Discharge Category.

The second page is to be used during the follow up visits in OTP and to record dates of each weekly follow up visits, anthropometry findings at each follow up visit, history of diarrhoea, vomiting, fever and cough, physical examination and appetite test findings, actions required, and outcome of each visit:(Present (child present at the time of visit), Absent at the time of visit, Defaulter after 2 Consecutives absences (absence at 3rd visit), Discharged, Cured, Died, Non-respondent, Referral to IPF, Transfer to Other OT, etc. Cells shaded in grey colour are not to fill.

(c) Register Book for Acute malnutrition

Once the child is identified as having MAM or SAM, give the child an Acute Malnutrition Number and fill the requested information under the Identification heading of the register book. Also fill the information under the Admission label of the register book according to the Individual patient record (OTP admission chart) at admission. At the time of discharge/transfer/referral, also provide the requested information under Exit label and Reason of Exit. Reason of Exit may be Cured, Defaulter, Dead, Transfer to another programme, or Internal Transfer (to OTP or IP).

Find the minimum weight and the date for the minimum weight from the OTP card and also fill it in the Minimum label column of the Register Book at the time of exit.

(d) Monthly / Quarterly report for SFP

See Annex 10

(e) Monthly/Quarterly report for OTP

See Annex 11

(f) Monthly report for ITP

See Annex 12

6. Nutrition in Emergency or Disaster

During an emergency situation, Management of Acute Malnutrition is one of the services to be delivered under the cluster coordination approach. As soon as an emergency state is declared by the government, the Nutrition Cluster is activated to support the government's response.

The objectives of the Nutrition Sector in an emergency aims to improve the nutritional status of boys, girls, and women affected by conflict and disaster by ensuring:

1. **Identification and treatment of acute malnutrition,**
2. **Equitable access to key preventive nutrition-specific services,**
3. **Timely situation monitoring and coordination,**
4. **Resilience strengthening.**

The use of standard MOHS approved guidelines, protocols and monitoring should be prioritised to ensure that short term emergency approaches do not hinder long term IMAM roll out strategy and that the Government health facilities are supported and strengthened in delivering IMAM services, without parallel systems being implemented.

Coordination of the nutrition cluster is be co-chaired by National Nutrition Center and UNICEF, with UNICEF acting as a cluster lead agency. Nutrition implementation partners are members of the cluster. The Nutrition Cluster is formed at national and State/Regional level. In order to understand the broad context of the emergency and the key issues related to the direct and underlying causes of malnutrition and mortality, the Nutrition Cluster performs assessments and gap analysis with the subsequent development of an emergency response plan and mobilization of resources.

6.1 Criteria for decision of a Nutrition Emergency

Based on the assessments and gap analysis results, Nutrition Emergency is defined by the presence of following criteria:

(1) GAM Prevalence ≥15% or 10-14% with presence of aggravating factors, and that GAM Prevalence is higher than the usual GAM Prevalence for that particular area.

Aggravating circumstances are defined as*:

a. Nutrition situation not improving

b. General food ration is below the mean energy, protein and fat requirements

c. Crude mortality rate >1 per 10,000/day

d. Epidemic of measles or whooping cough

e. High prevalence of respiratory or diarrhoeal diseases

(2) Number of acute malnutrition cases (case load) higher than the number of cases that the township health department can manage by itself,

(3) Increased morbidity and mortality induced by the severity of the nutritional situation

*Management of Moderate Acute Malnutrition (MAM): Current Knowledge and Practice, published by CMAM Forum 2014.

6.2 IMAM and other nutrition services to be delivered in emergency

All four components of IMAM: Community mobilization, SFP, OTP and ITP will be continued if an emergency is declared. However some activities might need to be strengthened depending on availability of human and other resources resources to deliver the services.

During an emergency, active Case Finding and Referral of detected cases should be increased. VHW and BHS can carry out active case finding and referrals through

- Mass screening campaign
- Monthly Screening during delivering other essential health care services
- Health Campaigns

Treatment services (OTP, SFP, IP) will be continued by the respective medical staff (BHS and Volunteer together at OTP and SFP level and paedetricians/ nurses at hospital level). The capacity of health services might be supported if the increased caseload exceed their capacity. Nutrition implementing partners (INGO and NGOs) can also be requested to support the process if a gap is identified.

During emergency situations, additional activities might be implemented by Government services or partner organisations to prevent malnutrition and a worsening situation. The main additional activities that should be considered are:

- IYCF in Emergencies to support, promote and protect exclusive and continued breastfeeding and optimal complementary feeding in children aged 6-23months. IYCF activities should feature during regular IMAM activities and at key contact points however during emergency situations additional efforts should be made to promote and protect IYCF practices

during times when they are at greater risk.

- Micronutrient Supplementation, to support distribution of specific supplements or in the form of home fortification and micronutrient powders/sprinkles
- Nutrition Education and Awareness promoting available services, raising awareness of food access, availability and diversity, promoting optimal nutrition behaviour and practices. Addressing issues of health, hygiene, water and sanitation in attempts to address the multifaceted causes of common childhood illness and the impact this would have on a worsening malnutrition situation.
- Blanket supplementary feeding to prevent acute malnutrition in areas of high risk where food insecurity is high and a high prevalence of chronic undernutrition and micronutrient deficiencies exists prior to the emergency. See below.
- Food Security and Livelihood Intervention's should be in place to address the underlying causes of malnutrition where this has been identified as an issue

6.3 Blanket Supplementary Feeding

Blanket Supplementary Feeding Programmes are aimed primarily to prevent a deterioration in the nutritional status of the population, and to reduce the prevalence of acute malnutrition in children under 5 years, thereby reducing the mortality and morbidity risk.

In Blanket Supplementary Feeding Programme, take-home rations with FBF/ RUSF are provided to high risk populations to acute malnutrition (children under 5 years, pregnant women and lactating mothers).

6.3.1 Circumstances to consider Blanket Supplementary Feeding Programmes

Blanket SFPs may be set up under one or a combination of the following circumstances:

- At the onset of an emergency when general food distribution systems are not adequately in place.
- Problems in delivering/distributing the general ration.
- Prevalence of acute malnutrition equal or greater than 15%.
- Prevalence of 10-14% acute malnutrition in presence of aggravating factors.
- Anticipated increase in rates of malnutrition due to seasonally induced epidemics.

- In case of micronutrient deficiency outbreaks, to provide micronutrient-rich food to the target population.
- When food insecurity is high and a high prevalence of chronic undernutrition and micronutrient deficiencies exists prior to the emergency

6.3.2 Admission Criteria for Blanket Supplementary Feeding Programmes

The primary target groups for Blanket SFPs are:

- All children younger than 5
- All Pregnant women from the time of confirmed pregnancy or visible pregnancy, and all lactating mothers until maximum 6 months after delivery.

Other at-risk groups (for instance sick and elderly persons).

6.3.3 Circumstances to close Blanket Supplementary Feeding Programmes

Blanket SFPs can be closed when all following conditions are met:

- General food distribution is adequate and is meeting planned minimum nutritional requirements.
- Prevalence of acute malnutrition is below 15% without aggravating factors.
- Prevalence of acute malnutrition is below 10% in presence of aggravating factors.
- Disease control measures are effective.

6.4 Nutrition Information System during an emergency

The sector/cluster lead manages the Nutrition Information System (NIS). The NIS amalgamates nutrition related information on a monthly basis to be able to monitor the effectiveness of the nutrition sector in addressing the problems in high burden settings.

The NIS is currently managed within UNICEF and collects data from development partners and government services on key indicators relating to IMAM including; admissions, discharge, cure rate etc. The NIS report is shared on a monthly basis with the Nutrition Sector and feeds into the Humanitarian Response Plan.

ANNEXES

IMAM
Operation Guideline

Operational Protocol

Annex.1 Supply Indent Form-1 (SRHC Level)

Month: _____ Name of midwife: _____ Sub-Rural Health Center: _____

Total number of childern (6-59 months): _____ Number of children with SAM (6-59 months): _____

Total number of childern with MAM (6-59 months): _____ Number of PLW with Acute Malnutrition: _____

Sr. No.	Name of Village	Required supplies for targeted children						
		RUTF	RUTF / FBF	Amoxicillin	Albendazole	Metronidazole	.....	.....
Total requirement:								

Requested by _____ Designation _____ Signature _____ Requested Date _____

Supplied by _____ Designation _____ Signature _____

Annex.2 Supply Indent Form-2 (RHC Level)

Month: _____ Name of Health Assistant: _____ Rural Health Center: _____

Total number of childern (6-59 months): _____ Number of children with SAM (6-59 months): _____

Total number of childern with MAM (6-59 months): _____ Number of PLW with Acute Malnutrition: _____

Sr. No.	Name of Health Center	Required supplies for targeted children						
		RUTF	RUTF / FBF	Amoxicillin	Albendazole	Metronidazole	.....	.....
	Total requirement:							

Requested by _____ Designation _____ Signature _____ Requested Date _____

Supplied by _____ Designation _____ Signature _____

Annex.3 Supply Indent Form-3 (Township Level)

Month: _____ Name of Head of Department: _____ Township Health Department: _____

Total number of childern (6-59 months): _____ Number of children with SAM (6-59 months): _____

Total number of childern with MAM (6-59 months): _____ Number of PLW with Acute Malnutrition: _____

Sr. No.	Name of Health Center	Required supplies for targeted children						
		RUTF	RUTF / FBF	Amoxicillin	Albendazole	Metronidazole	.....	.....
Total requirement:								

Requested by _____ Designation _____ Signature _____ Requested Date _____

Supplied by _____ Designation _____ Signature _____

Annex.4 Supply Indent Form (Hospital Nutrition Unit)

MINISTRY OF HEALTH AND SPORT

SUPPLY INDENT FORM
HOSPITAL NUTRITION UNIT

Month: _____

Name of HNU Focal Person: _____

Hospital: _____

Total number of childern with Acute Malnutrition (less than 6 months) : _____

Total number of childern with SAM (6-59 months) : _____

Sr. No.	Items	Requested Amount
1.	F75	
2.	F100	
3.	Resomal	
4.	RUTF	
5.	.....	
6.	.....	
7.	.....	
8.	.....	
9.	.....	
10.	.....	

Requested by _____ Supplied by _____

Designation _____ Designation _____

Signature _____ Signature _____

Requested Date _____

Annex.5 Stage/Region Level Issue Form

အမျိုသားအာဟာရဖွံ့ဖြိုးရေးနှင့်သုသေသနဌာန
ပြည်သူ့ကျန်းမာရေးဦးစီးဌာန
ကျန်းမာရေးနှင့်အားကစားဝန်ကြီးဌာန

_____ ပြည်နယ် / တိုင်းဒေသကြီး

ကုန်ပို့လွှာအမှတ် _____
နေ့စွဲ _____

လတ်တလောအာဟာရချို့တဲ့ခြင်း ဘက်စုံကုသစောင့်ရှောက်ခြင်းဆိုင်ရာဆေးဝါးပစ္စည်းများထုတ်ပေးခြင်း

_____ မြို့နယ်ကျန်းမာရေးဌာနအတွက် လတ်တလောအာဟာရချို့တဲ့ခြင်း ဘက်စုံကုသစောင့်ရှောက်ခြင်းဆိုင်ရာ ဆေးဝါးပစ္စည်းများကို အောက်တွင်လက်မှတ်ရေးထိုးထားသောကိုယ်စားလှယ်အား ကောင်းမွန်စွာ ထုတ်ပေးလိုက်ပါသည်။

Sr. No.	Items	Lot No. / Batch No.	Expiry Date (DD/MM/YY)	Quantity
1.	RUTF			
2.	RUTF / FBF			
3.	Amoxil			
4.	Albendazole			
5.	Metronidazole			

ခွင့်ပြုသူလက်မှတ် _____ အမည် _____ ရာထူး _____

ထုတ်ပေးသူလက်မှတ် _____ အမည် _____ ရာထူး _____

လက်ခံသူလက်မှတ် _____ အမည် _____ ရာထူး _____

Annex.6 Township Level Issue Form

အမျိုသားအာဟာရဖွံ့ဖြိုးရေးနှင့်သုသေသနဌာန
ပြည်သူ့ကျန်းမာရေးဦးစီးဌာန
ကျန်းမာရေးနှင့်အားကစားဝန်ကြီးဌာန

_____ မြို့နယ်

ကုန်ပို့လွှာအမှတ် _____
နေ့စွဲ _____

လတ်တလောအာဟာရချို့တဲ့မှု ဘက်စုံကုသစောင့်ရှောက်ခြင်းဆိုင်ရာဆေးဝါးပစ္စည်းများထုတ်ပေးခြင်း

_____ ကျန်းမာရေးဌာနအတွက် လတ်တလောအာဟာရချို့တဲ့ခြင်း ဘက်စုံကုသစောင့်ရှောက်ခြင်းဆိုင်ရာ ဆေးဝါးပစ္စည်းများကို အောက်တွင်လက်မှတ်ရေးထိုးထားသောကိုယ်စားလှယ်အား ကောင်းမွန်စွာ ထုတ်ပေးလိုက်ပါသည်။

Sr. No.	Items	Lot No. / Batch No.	Expiry Date (DD/MM/YY)	Quantity
1.	RUTF			
2.	RUTF / FBF			
3.	Amoxil			
4.	Albendazole			
5.	Metronidazole			

ခွင့်ပြုသူလက်မှတ် _____ အမည် _____ ရာထူး _____

ထုတ်ပေးသူလက်မှတ် _____ အမည် _____ ရာထူး _____

လက်ခံသူလက်မှတ် _____ အမည် _____ ရာထူး _____

Annex.7 Stock Control Form

Stock control form for: ....

IV#	Date (DD/MM/YY)	Manufacturer	Lot Number	Expiry Date (DD/MM/YY)	Distributed to	Quentity Distributed	Balance	Comment	Signature
						Physical Stock Check			
						Balance Carried Forward			

Annex 8. Registration Book

Region : ..... District : ..... Health Facility : .....

Order No.	AM Number	IDENTIFICATION							ADMISSION								EXIT						MINIMUM WEIGHT		Reason of exit***
		Patient's Name	Address Village / Ward	Age	Sex		Women		Date	Catagory of Admission*	Weight (kg)	Height (cm)	WH / WL (z-score)	MUAC (cm)	Oedema (0,1,2,3)	Diagnosis (MAM or SAM)	Date	Weight (kg)	Height (cm)	WH / WL (z-score)	MUAC (mm)	Oedema (0,1,2,3)	kg	Date	
					M	F	LW	PW																	

M = Male, F = Female, LW = Lactating Women, PW = Pregnant Womwen

*Catagory of A dmission: new, transfer, referral, follow-up SAM, non-respondent SAM

***Reason of exit: Cured, Defaulter, Died, Non-respondent, Transfer, Referral

Annex.9 Nutrition Screening Tally Sheet

Township........................ HC................................ Village..............................

From ___ / ___ / _______ to ___ / ___ / _______

Put a cross to the "o" within the different categories, according to the MUAC

	MUAC < 115mm	MUAC ≥ 115mm & < 125mm	MUAC ≥ 125mm	Oedema
6 months and more	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
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	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
	ooooo	ooooo ooooo	ooooo ooooo ooooo	ooooo
Total				

Name: ______________________________

Position: ______________________________

Signature: ______________________________

Annex 10. MONTHLY / QUARTERLY REPORT – SFP

Health Facility	
Township	
State / Region	
QUARTER / YEAR	

Age group	Total beginning of the month	New admissions	Relapse	Re-admissions (after defaulting < 2 months)	Transfer in (from OTP / other SFP)	Total admissions	Discharges (H)				Transfer out (to other SFP or OTP / hospital)	Total Exits	Total end of the month
							Cured	Dead	Defaulter	Non respondent			
A	B	C	D	E	F	G = C+D+E+F	H1	H2	H3	H4	I	J = H1+H2+ H3+H4+I	K = B+G-J
6-59 months													
>59 months													
Pregnant W													
Lactating W													
TOTAL													
PERFORMANCE INDICATORS							%	%	%	%			
SPHERE STANDARDS							> 75%	< 3%	< 15%				

Definitions

Relapse: Cured MAM child readmitted for a new episode of MAM after more than 2 months of absence
Cured: MAM children and PLW reaching the criteria of discharge
Defaulter: After 2 consecutive absences
Dead: While the child/PLW is registered in the program or within 24 hours of transfer to another health facility
Non respondent: Does not reach the cured criteria after 3 months (12 weeks) in the program.
Child whose MUAC falls below 115 mm during treatment with SFP or is developing medical complication are referred to OTP/hospital and registered in column "I".
%of Cured = (H1÷H) X 100; %of Dead = (H2÷H) X 100; %of Defaulter = (H3÷H) X 100

Annex 10B. SUPPLY MONTHLY REPORT – SFP AND OTP (BACK)

Supplies	Packaging unit	STOCK beginning of the month	STOCK IN (stock received during the month)	STOCK OUT (consumption during the month)	STOCK WASTE (rodents, etc)	STOCK end of the month	Expiry date	Monthly requirements
Plumpy nut	Car-150							
WSB+	Bag-25 kg							
WSB++	Bag – 1.5 kg							
Plumpy Sup	Car – 90							
Sugar	Kg							
Oil	Liter							
Amoxicillin 125 mg.	Bottle							
Amoxicillin 250 mg	Pac-100							
Albendazole	Pac-100							
Vit A 100.000 UI	Pac-500							
Vit A 200.000 UI	Pac-500							
Iron/ Folic acid 60mg + 400ug	Pac-100							

Annex 11. MONTHLY / QUARTERLY REPORT – OTP

Health Facility	
Township	
State / Region	
QUARTER / YEAR	

Age group	Total beginning of the month	New admissions (C)		Relapse	Re-admissions (after defaulting < 2 months)	Transfer in (from ITP or other OTP or SFP)	Total admissions	Discharges (H)				Transfer out (to other SFP or OTP / hospital)	Total Exits	Total end of the month
		W/H<-3ZS **OR** MUAC < 115 mm	Oedema					Cured	Dead	Defaulter	Non respondent			
A	B	C1	C2	D	E	F	G = C1+C2+D +E+F	H1	H2	H3	H4	I	J = H1+H2+ H3+H4+I	K = B+G-J
6-59 months														
>59 months														
TOTAL														
PERFORMANCE INDICATORS								%	%	%	%			
SPHERE STANDARDS								> 75%	< 10%	< 15%				

Definitions

Relapse: Child readmitted after more than 2 months of absence of after previously being discharged as cured
Cured: The patient has reached the criteria for discharge
Defaulter: After 2 consecutive weeks of absences (on the 3rd week)
Dead: If the patient died during treatment in the OT or in transit to the IP or within 24 hours of transfer to another health facility
Non respondent: Does not reach the cured criteria after 3 months (12 weeks) in the program.
Child who is developing medical complication are referred to hospital and registered in column "I".
%of Cured = (H1÷H) X 100; %of Dead = (H2÷H) X 100; %of Defaulter = (H3÷H) X 100

Average Weight Gain – AWG **(only 6-59 months and marasmic)**	g/kg/day

Length of Stay – LoS (only 6-59 months)		6-59 months	>59 months
	Wasting (W/H and MUAC)	days	days
	Oedema	days	days

Annex 11B. SUPPLY MONTHLY REPORT – SFP AND OTP (BACK)

Supplies	Packaging unit	STOCK beginning of the month	STOCK IN (stock received during the month)	STOCK OUT (consumption during the month)	STOCK WASTE (rodents, etc)	STOCK end of the month	Expiry date	Monthly requirements
Plumpy nut	Car-150							
WSB+	Bag-25 kg							
WSB++	Bag – 1.5 kg							
Plumpy Sup	Car – 90							
Sugar	Kg							
Oil	Liter							
Amoxicillin 125 mg.	Bottle							
Amoxicillin 250 mg	Pac-100							
Albendazole	Pac-100							
Vit A 100.000 UI	Pac-500							
Vit A 200.000 UI	Pac-500							
Iron/ Folic acid 60mg + 400ug	Pac-100							

Annex12. MONTHLY REPORT - ITP

Health Facility	
Township	
State / Region	
QUARTER / YEAR	

Age group	Total beginning of the month	New admissions		Relapse	Re-admissions (after defaulting < 2 months)	Transfer in (from SFP, OTP or other ITP)	Total admissions	Discharges (H)						Total Exits	Total end of the month
		W/H<-3ZS **OR** MUAC < 115 mm	Oedema					Treated with success	Cured	Dead	Defaulter	Non respondent	Transfer to OTP		
A	B	C1	C2	D	E	F	G = C1 + C2 + D + E + F	H1	H2	H3	H4	H5	H6	I = H1+H2 +H3+H4 +H5+H6	J =B+G -I
< 6 months															
6-59 months															
>59 months															
TOTAL															
PERFORMANCE INDICATORS									%	%	%	%			
SPHERE STANDARDS									> 75%	< 10%	< 15%				

Definitions

Relapse: Child readmitted after more than 2 months of absence of after previously being discharged as cured
Treated with success: Patients in ITP who successfully complete transition phase of treatment and are transferred to OTP to continue their treatment
Cured: The patient has reached the criteria for discharge
Defaulter: Absconded for 2 consecutive days of absence (on the 3rd day)
Dead:If the patient died during treatment in the ITP
Non respondent: Patients that have failed to respond to treatment OR clinical deterioration after admission and have been referred to another service/hospital who will take over management
%of Cured = (H1+H2÷H) X 100; %of Dead = (H3÷H) X 100; %of Defaulter = (H4÷H) X 100

Annex 12B. SUPPLY MONTHLY REPORT - IP (BACK)

Supplies	Packaging unit	STOCK beginning of the month	STOCK IN (stock received during the month)	STOCK OUT (consumption during the month)	STOCK WASTE (rodents, etc)	STOCK end of the month	Expiry date	Monthly requirements
Plumpy nut	Car-150							
F 75	Car-120							
F 100	Car-90							
Resomal 42 g	Car-100							
Amoxicillin 125 mg	Bottle							
Amoxicillin 250 mg	Pac-100							
Albendazole	Pac-100							
Vit A 100.000 UI	Pac-500							
Vit A 200.000 UI	Pac-500							

Annex 13. Supportive Supervision Checklist (SFP/OTP)

(To be used by supervisor)

SFP/OTP SUPPORTIVE SUPERVISION CHECKLIST			
Township: **RHC/SRHC:** **Health staff in charge of the health facility:** **Health staff present during the visit:** **Name of supervisor staff:** **Date of supervision:**			
Score: 0 = not done; 1 = done but needs improvement; 2 = done correctly; **NO = Non observed** (Acute malnourished patients or equipments not in place)			
Supervision Points		**0,1,2,NO**	**Comments**
Tools - Materials – Equipment		(.....)	MAX: 12 points
1	Anthropometric material present & in good condition (MUAC, scale, board)		
2	Medical material present (stéthoscope, tongue depressor, etc)		
3	Register book present		
4	Forms: individual patient record (OTP card) and transfer forms available and used		
5	Tools/protocol: IMAM protocol and job aids available and used		
6	Health and nutrition education materiel available and used		
Human resources		(.....)	MAX: 2 points
7	Staff has received IMAM training		
Structure and space organization		(.....)	MAX: 10 points
8	Portable water (hygienic) is available		
9	Latrines present and functioning		
10	Hygiene at the health facility adequate		
11	System for waste disposal present and functioning		
12	Sufficient space for anthropometric measurements and registration, appetite test, consultation, storage/pharmacy		

Passive screening		(.....)	MAX: 2 points
13	Passive screening systematically carried out on every child (check in the patient register/ observation if opportunity is given)		
Patients' flux		(.....)	MAX: 4 points
14	Patients' triage conducted (according to danger signs)		
15	Sugar water available and provided to patients		
Admission		(.....)	MAX: 12 points
16	Anthropometric measurements (MUAC, weight, height, oedema) correctly taken (observation on random patients)		
17	W/H calculation correctly performed (verification on random patients cards)		
18	Admission criteria known, applied and noted on the patient's card (verification of random patients cards)		
19	Individual patient's card correctly filled in with all admission data (verification of random patients' cards		
20	Register Book of Acute malnutrition correctly filled in, including AM number (verification of random patients on register)		
21	Explanations given to the mother at admission correct and sufficient		
Appetite test (To observe if there is opportunity)		(.....)	MAX: 10 points
22	Washing of patient's and caregiver's hands before handling RUTF		
23	Appropriate space (quiet, sufficient space, clean)		
24	Explanations given to the mother/caregiver before test correct and sufficient		
25	Staff knows correct quantities for passing/ failing the test		
26	Surveillance of quantities taken and result noted on the patient's card		
Treatment		(.....)	MAX: 14 points
27	Quality of medical consultation (medical history, vital parameters taken, recognition of danger signs) (observation of random patients)		

28	Prompt detection of medical complications and correct application of reference criteria to ITP (observation of random patients)		
29	Systematic medical treatment applied and noted on patient's card (product, dosage and duration correct) (verification of random patient's cards)		
30	Nutritionnal treatment (nb sachets FBF/ RUTF) respected and noted on patient's card (verification of random patient's cards)		
31	Ensuring completion of respective immunization schedule		
32	Failure to response diagnosed and action taken (HV, etc)		
33	Explanations given to the child's mother/ caretaker on the child nutritional status		
Discharge/Referral		(.....)	MAX: 6 points
34	Staff knows discharge criteria, applied the discharge procedure and noted on the patient's card		
35	Adequately explained to the mother		
36	Children needing referral are promptly referred to the closes OTP/ITP facilities and the record is made		
IYCF activities at RHC/SRHC		(.....)	MAX: 4 points
37	IYCF counselling is given by BHS to the mother/caregiver of any child < 2 during curative consultations		
38	IYCF counselling is performed by BHS for any PLW at each ANC and PN visit		
Health and nutrition education awareness		(.....)	MAX: 2 points
39	Health and nutrition awareness sessions performed (witness or from record)		
Regular reports (monthly or quarterly depend on situation)		(.....)	MAX: 6 points
40	IMAM reports correctly filled in (complete and reliable)		
41	IMAM reports sent on time		
42	IMAM reports filed at RHC/SRHC		

Stock/Pharmacy		(.....)	MAX: 8 points
43	Storage conditions adequate (shelves, tags, use of pallets, control of rodents, etc)		
44	Stock books/cards for FBF/RUTF and systematic medical treatment present and correctly filled in		
45	No supplies shortage and sufficient quantities of FBF/RUTF and drugs for systematic treatment		
46	Regular physical inventory performed (at township level)		
Community mobilization		(.....)	MAX: 10 points
47	Criteria for home visits known and applied by BHS, CHW and AMV		
48	Home visits performed by CHW and AMV (nber HV performed during last month)		
49	Active screening assisted by volunteers last month		
50	Monthly meetings organised by BHS with volunteers on IMAM		
51	Regular (monthly/quarterly depend on situation) screening reports correctly filled in and sent on time (at the latest by 5th of the following month)		
	TOTAL MAXIMUM	102	(To deduct scores for Non Observed from Total Maximum)
	TOTAL NON OBSERVED	(.....)	
	TOTAL ACHIEVED	(.....)	
	(Total achieved ÷ Total Maximum) x 100%		

STRENGTHS

01.

02.

03.

04.

05.

WEAKNESS

01.

02.

03.

04.

05.

RECOMMENDATIONS

01.

02.

03.

04.

05.

Annex 14. Supportive Supervision Checklist (ITP)

(To be used by supervisor)

ITP SUPPORTIVE SUPERVISION CHECKLIST			
Township:			
ITP/Hospital:			
Health staff in charge of the health facility:			
Health staff present during the visit:			
Name of supervisor staff:			
Date of supervision:			
Score: 0 = not done; 1 = done but needs improvement; 2 = done correctly; **NO = Non observed** (Acute malnourished patients or equipments not in place)			
		0,1,2,NO	**Comments**
Tools - Materials – Equipment		(.....)	MAX: 14 points
1	Anthropometric material present & in good condition (MUAC, scale, board)		
2	Medical material present (stéthoscope, othoscope, tongue depressor, etc)		
3	Register book present		
4	Forms: individual patient record (ITP card) and transfer forms available and used		
5	Tools/protocol: IMAM protocol and job aids available and used		
6	Material for therapeutic milk preparation available & in good condition		
7	Health and nutrition education materiel available and used		
Human resources		(.....)	MAX: 2 points
8	Staff has received IMAM training		
Structure and space organization		(.....)	MAX: 10 points
9	Portable water (hygienic) is available		
10	Latrines present and functioning		
11	Hygiene at the health facility adequate		
12	System for waste disposal and water discharge system present and functioning		

13	Sufficient space for anthropometric measurements and registration, appetite test, consultation, patient's hospitalization, therapeutic milk preparation, storage/ pharmacy and for patients' stimulation		
Passive screening		(.....)	MAX: 2 points
14	Passive screening systematically carried out on every child at the external consultation and emergency ward (check in the patient register/ observation if opportunity is given)		
Patients' flux		(.....)	MAX: 6 points
15	Patients' triage conducted (according to danger signs)		
16	Sugar water available and provided to patients		
17	Patient's flux clearly organized from external consultation to ITP		
Admission		(.....)	MAX: 12 points
18	Anthropometric measurements (MUAC, weight, height, oedema) correctly taken (observation on random patients)		
19	W/H calculation correctly performed (verification on random patients cards)		
20	Admission criteria known, applied and noted on the patient's card (verification of random patients cards)		
21	Individual patient's card correctly filled in with all admission data (verification of random patients' cards		
22	Register Book of Acute malnutrition correctly filled in, including AM number (verification of random patients on register)		
23	Explanations given to the mother at admission correct and sufficient		
Appetite test		(.....)	MAX: 10 points
24	Washing of patient's and caregiver's hands before handling RUTF		
25	Appropriate space (quiet, sufficient space, clean)		
26	Explanations given to the mother/caregiver before test correct and sufficient		

27	Staff knows correct quantities for passing/ failing the test		
28	Surveillance of quantities taken and result noted on the patient's card		
Treatment		(.....)	MAX: 22 points
29	Quality of medical consultation at admission and during hospitalization (medical history, vital parameters taken, recognition of danger signs) and appropriate actions taken according to the patient's conditino (observation of random patients)		
30	Breastfeeding performed by mothers before feeds		
31	Washing of patient's and caregiver's hands before feeds		
32	Correct preparation of therapeutic milk (F75, F100, F100 diluted) (dosage, hygiene, quantities, etc)		
33	Surveillance of feeds (quantities, position) performed and result noted on the patient's card		
34	Nutritionnal treatment in each phase respected and noted on patient's card (verification of random patient's cards)		
35	Systematic and specific medical treatment applied and noted on patient's card (product, dosage and duration correct) (verification of random patient's cards)		
36	Ensuring completion of respective immunization schedule		
37	Criteria for transfer between phases known and applied		
38	Failure to response diagnosed and action taken (HV, etc)		
39	Explanations given to the child's mother/ caretaker on the child nutritional and health status		
Discharge/Transfer		(.....)	MAX: 4 points
40	Staff knows criteria for transfer to OTP or for discharge, applied the discharge procedure and noted on the patient's card		

41	Transfer/discharge procedure adequately explained to the mother		
Health and nutrition education awareness		(.....)	MAX: 4 points
42	Health and nutrition awareness sessions performed (witness of from record)		
43	Patients stimulation sessions performed		
Monthly reports		(.....)	MAX: 6 points
44	IMAM monthly reports correctly filled in (complete and reliable)		
45	IMAM monthly reports sent on time		
46	IMAM reports filed at IPT		
Stock/Pharmacy		(.....)	MAX: 8 points
47	Storage conditions adequate (shelves, tags, use of pallets, control of rodents, etc)		
48	Stock books/cards for F75, F100, resomal, RUTF and drugs for systematic and specific treatment present and correctly filled in		
49	No supplies shortage and sufficient quantities of F75, F100, resomal, RUTF and drugs for systematic and specific treatment		
50	Regular physical inventory performed		
IYCF activities at Hospital (external consultation, maternity ward, etc)		(.....)	MAX: 8 points
51	IYCF counselling is given by health staff to the mother/caregiver of any child < 2 during external consultations		
52	IYCF counselling is performed by health staff for any PLW at each ANC and PN visit		
53	IYCF counselling is given by health staff to any mother who has just delivered at maternity ward		
54	Any mother who has just delivered is referred to a commmunity IYCF group in her village when existing		
	TOTAL MAXIMUM	102	(To deduct scores for Non Observed from Total Maximum)
	TOTAL NON OBSERVED	(.....)	
	TOTAL ACHIEVED	(.....)	
	(Total achieved ÷ Total Maximum) x 100%		

STRENGTHS

01.

02.

03.

04.

05.

STRENGTHS

01.

02.

03.

04.

05.

RECOMMENDATIONS

01.

02.

03.

04.

05.


MINISTRY OF HEALTH AND SPORTS

unicef