STANDARDISED INDICATORS AND CATEGORIES FOR BETTER CMAM REPORTING

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Save the Children

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Content

Acronyms

BMI	Body Mass Index
BSFP	Blanket Supplementary Feeding Programme
CDC	Centers for Disease Control and Prevention (USA)
CMAM	Community-based Management of Acute Malnutrition (also see CTC)
CTC	Community Therapeutic Care (also see CMAM)
CSAS	Centric Systematic Area Sampling
FANTA	Food and Nutrition Technical Assistance
FSL	Food Security and Livelihoods
GAM	Global Acute Malnutrition
GFD	General Food Distribution
HIV	Human Immunodeficiency Virus
IYCF	Infant and Young Child Feeding
MAM	Moderate Acute Malnutrition
M&E	Monitoring and Evaluation
MRP	Minimum Reporting Package
MUAC	Mid-Upper Arm Circumference
NCHS	National Centre for Health Statistics (USA)
NGO	Non-Governmental Organisation
SC	Stabilisation Centre (term for inpatient management of acute malnutrition)
SFP	Supplementary Feeding Programme (see TSFP)
OTP	Outpatient Therapeutic Programme
PLW	Pregnant and Lactating Women
SAM	Severe Acute Malnutrition
sd	Standard deviation (score)
SQUEAC	Semi-Quantitative Evaluation of Access and Coverage
TSFP	Targeted Supplementary Feeding Programme (see SFP)
RUSF	Ready-to-use Supplementary Food
RUTF	Ready-to-use Therapeutic Food
WASH	Water, Sanitation and Hygiene
WFH	Weight-for-height
WHO	World Health Organisation
UNHCR	United Nations High Commissioner for Refugees

INTRODUCTION

This paper outlines standardised reporting categories and definitions as well as indicators for monitoring and reporting on all CMAM components, namely Stabilisation Centres (SCs), Outpatient Therapeutic Programmes (OTPs) and targeted Supplementary Feeding Programmes (TSFPs).
Reporting categories and indicators have been developed through a consensus building process with a large number of humanitarian agencies and can be seen as best practice in CMAM reporting to date. These guidelines can be used by nutrition programme and M&E staff of NGOs as well as government staff to set up comprehensive monitoring and reporting systems for their CMAM programming or adapt their current systems to fit best practice.

CMAM reporting standards presented in this paper have been developed to meet latest Sphere standards and additionally to:

- Calculate unbiased performance for all CMAM components : OTP discharges are reported separately from regular SFP entries[2]; movements between CMAM components are not included in the denominator for calculation of performance
- Avoid double or multiple counting of beneficiaries when they move from one to the next CMAM component or backtrack and start the treatment process again
- Account for any beneficiaries that have been admitted by mistake through an "Other" reporting category in entries and exits

1.1 History

A retrospective analysis of the performance of emergency SFPs published in 2008[3] uncovered inadequate reporting standards, raising concerns over the quality of the interventions as well as the capacity of agencies to learn from experience. Based on the study's recommendations, the Emergency Nutrition Network (ENN) together with Save the Children UK and guided by a steering group of interested agencies led the development of a standardised monitoring and reporting package. This comprised of these overarching guidelines and informed an optional MS Access based software. The software has since been developed into a comprehensive online software. The process of developing this software involved reviewing the indicators and categories used and these guidelines have been updated to reflect this process.

1.2 Programmes and treatment groups

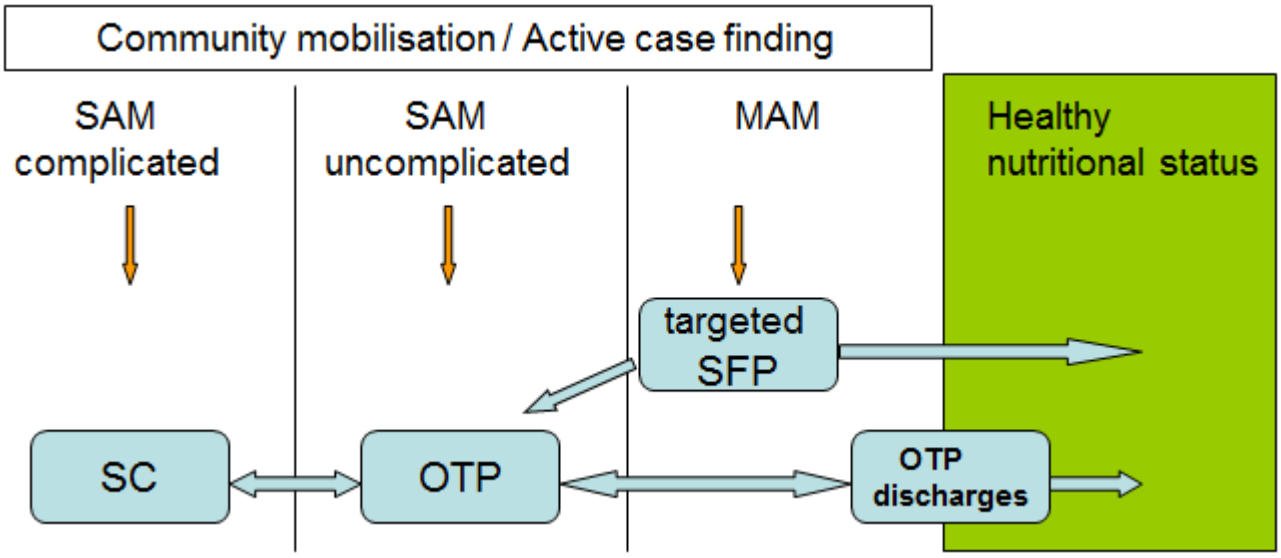
This paper presents monitoring and reporting standards for SC, OTP and targeted SFP given that these programmes are often delivered together as a single Community Management of Acute Malnutrition (CMAM) programme that facilitates movement of beneficiaries between programmes as their nutritional needs and status changes (see **Figure 1**). These standards can be used to report for one programme or for all programmes in CMAM, according to the interest and needs of the MoH and the NGO implementing agency.

It should be noted that beneficiaries that have been discharged from OTP and are admitted to targeted SFP for treatment consolidation (OTP discharges) are separately reported from regular TSFP entries. OTP discharges receiving the same nutritional care as MAM case admitted, however, reporting on these beneficiaries separately prevents distortion of TSFP recovery rate (by excluding beneficiaries leaving the programme and meeting the 'recovered' criteria if they were not necessarily malnourished when admitted to

[2] a recommendation by Sphere which is hardly recognised by implementers to date
[3] *Measuring the Effectiveness of Supplementary Feeding Programmes in Emergencies*, Carlos Navarro-Colorado, Frances Mason and Jeremy Shoham, Humanitarian Practice Network Paper 63, September 2008. ODI

the programme). These guidelines will refer to such beneficiaries as “OTP discharges” throughout.

Figure 1: *Beneficiary flow between programmes*



Each programme has treatment groups that are monitored and reported on. Typically for targeted SFPs there are two treatment groups: 6-59 months and Pregnant and lactating women (PLW). However other treatment groups might include: <6 months, 6-23 months, 24-59 months, older children (5-10 years), adolescents (11-17 years), adults (+18 years) and elderly (+60 years).

PROGRAMME ENTRIES, EXITS AND PERFORMANCE INDICATORS

2.1 Overview

The following section outlines the procedure for reporting entries and exits for each programme: SC, OTP, TSFP/OTP discharges. Each programme has slightly different entry and exit categories and programme performance indicators and each is explained in detail in the following sections. Calculation of performance indicators is also explained.

Annexes provide information on tools necessary for data collection and reporting (Annex 1), Monthly site report templates for each programme (Annexes 3-6), registration books (Annex 7-10) and tally sheets based on the these guidelines (Annex 11-13).

Entries

Entries include new admissions, re-admissions (***optional***), beneficiaries moved in from another programme and 'other', a category required to capture small numbers who do not fit in any given category. See an example for targeted SFP in **Table 1**. Cells in **white** and **blue** are completed manually by the user when entering the data. Cells in **blue** are ***optional categories*** and do not have an effect on performance indicator calculations if unused in data entry. The cells in **yellow** are those automatically calculated.

Table 1: *Example of entry categories*

New Admissions			Re- admission	**Total Admissions**	**Other Entries**		**Total In**
WFH/ BMI	MUAC	Relapse			Moved in from other tSFP sites	Other	

Exits

Exits include discharges corresponding to the Sphere minimum standards (recovered, death, defaulter and non-recovery), beneficiaries moved out to another site of the same programme and as for admissions, an 'other' category. Defaulters can be reported as confirmed or unconfirmed (***optional***), and non-recovery can be recorded as medical referral, non-response and transfer to therapeutic programme (***optional***). See an example for targeted SFP in **Table 2**.

Table 2: *Example of exit categories*

Discharges							**Total Discharges**	Moved-out to other tSFP	Other	**Total Out**
Recovered	Death	Defaulter		Non-recovery						
		Unconfirmed	Confirmed	Medical referral	Non-response	Transfer to TFP				

Entry and exit information is found as usual on beneficiary cards and in registration books. These are recorded on site tally sheets at the end of each service day and can be summarised on monthly site reports before entered into a data base, e.g. CMAM Report.

Section 5 of these guidelines provides advice on interpretation of performance indicators.

2.2 Stabilisation Centre entries, exits and performance indicators

2.2.1 Stabilisation Centre entries

Table 3: *SC entries*

New Admissions				Re-admission	Total Admissions	Other Entries		Total In
WFH/BMI	MUAC	Oedema	Relapse			Moved in from OTP	Other	
a	b	c	d	e	W=a+b+c+d+e	f	g	Y=W+f+g

1. New admission (a, b, c): Beneficiary with SAM directly admitted to the programme because s/he meets the admission criteria and has not been under treatment elsewhere for this episode of SAM.

- New admissions are separated by criteria of admission: WFH/BMI, MUAC and nutritional oedema (with cut offs for anthropometric measures according to programme protocol). The user can decide to use some or all of these categories depending on the criteria used in the programme, this will not affect the final calculations.
- Convention dictates that when a beneficiary is admitted fulfilling both WFH and MUAC criteria he/she is reported under WFH. When a beneficiary has nutritional oedema s/he should be recorded only in the oedema category column whether or not s/he fulfils other criteria for admission.

> Users wishing to simplify reporting: For those wishing to report new admissions more generally it is recommended that at least marasmus (identified by WFH and/or MUAC) and kwashiorkor[4] cases (cases with nutritional oedema) should be kept separate. If all new admissions are reported without disaggregation a decision should be made on which column should always be filled in (a, b or c).

2. Relapse (d): Beneficiary re-admitted to the programme after having been successfully discharged as recovered within the last two months (this is a new episode of SAM). Relapse is considered as 'new admission' in calculations. ***Optional category***

3. Re-admission (e): Beneficiary re-admitted to the programme within two months after having left it for a reason that does not include recovery (e.g. after defaulting or non-response or medical referral). ***Optional category***

Total Admissions (W): Total number of cases starting treatment in a SC site (sum of new admissions and relapses and re-admissions).

4. Moved-in from OTP (f): Beneficiary who has been transferred from OTP to SC - due to deterioration of his/her nutritional status and/or medical complications - to continue treatment for SAM.

- These beneficiaries are not counted as admissions to the programme as they were already under treatment in the OTP.

5. Other (g): Beneficiary who is admitted to the SC for reasons unrelated to their nutritional status (not meeting SC admission criteria). Reporting principles are similar to OTP (see section 2.3.1)

Total In (Y): Total number of beneficiaries entering SC: Total admissions + Other entries (Moved in from OTP + Other).

[4] Marasmic kwashiorkor is included under the oedema criteria.

2.2.2 Stabilisation Centre exits

Table 4: *SC exits*

Discharges							Total Discharges	Other	Total Out
Promoted to OTP (moved-out to OTP)	Recovered	Death	Defaulter		Non-recovery				
			Unconfirmed	Confirmed	Medical referral	Non-response			
h	i	j	k	l	m	n	X=h+i+j+k+l+m+n	o	Z=X+o

1. Promoted to OTP[5](h): Beneficiary who has been discharged from the SC and promoted to OTP after having successfully completed the treatment of medical complications in the SC[6].

- This is an internal movement between programmes; however from the point of view of the SC, it also corresponds to a discharge and permits performance of the SC to be monitored.

2. Recovered (i): Beneficiary who has reached the recovered criteria defined for the programme i.e. complete recovery from SAM

- The majority of beneficiaries reaching the discharge criteria in SC are not recovered[7]. The recovered category in SC can be used only for:
  - The very few beneficiaries who remain in SC until full recovery; these cases are exceptional
  - Infants <6 months successfully discharged as recovered (see reference guidelines in Annex 16)

3. Death (j): Beneficiary who died from any cause while registered in the programme.

4. Defaulter (k+l): Beneficiary who is absent for two consecutive weighings, i.e. on day 3.

- As for OTP, active absentee tracing should be organised as soon as the absence of a beneficiary is noticed, not waiting until the beneficiary becomes a defaulter. A home visit should be made to confirm the outcome (and facilitate re-entry into the programme if possible).
- There are two defaulter categories for advanced users: confirmed and unconfirmed (if outcome is unknown).

4.1. Defaulter unconfirmed (k): Beneficiary who is absent for two consecutive weighings, i.e. on day 3, and whose final outcome is not known (since no defaulter tracing was done).

4.2. **Defaulter confirmed** (l): Beneficiary who is absent for two consecutive weighings (i.e. on day 3) for whom a home visit has confirmed that the beneficiary is alive and is a 'true' defaulter.

- **Optional category:** Programmes that do not implement home visits for defaulter tracing should not use this category (and should report defaulters as 'defaulters unconfirmed').

If during the home visit:

- The beneficiary decides to re-enter the programme, s/he is re-admitted and the re-admission classified as above. This beneficiary still counts as a 'true' defaulter in the reporting of the corresponding week/month.
- The beneficiary is found to be dead, to be a 'true' defaulter or to have been transferred; the outcome needs to be corrected in the report.
- The beneficiary is found to be dead, it is important to determine the date of the death: it will be considered a death in the SC if s/he died within the window period until being considered a defaulter (3 days). If the beneficiary died outside of these 3 days s/he is considered a defaulter (confirmed).

[5] This term reflects successful completion of treatment in SC but the requirement for ongoing treatment for SAM in OTP.
[6] Child is clinically well and alert, and has appetite to continue treatment based on RUTF.
[7] Stabilisation centres typically provide only inpatient treatment for 'phase 1' and the 'transition phase', i.e. for metabolic restoration, prevention and treatment of life-threatening conditions and appetite recovery.

Users wishing to simplify reporting: For those wishing to report defaulters more generally the total number of defaulters should be reported under column (i) 'defaulter unconfirmed'.

5. Medical referral (m): Beneficiary who has a serious illness that requires diagnosis and/or treatment beyond the scope of available nutrition programmes (i.e. SC , OTP, targeted SFP) and is therefore referred to a higher level health facility / hospital requiring interruption of nutritional treatment by the programme and continuation by the health facility / hospital. If the nutritional treatment is continued while the beneficiary is in the higher level health facility / hospital, the beneficiary is not discharged from the programme, and should not be included in the exit reporting. ***Optional category***

6. Non-response (n): Beneficiary who has not reached discharge criteria after a pre-defined length of time despite all investigations and transfer options. See chapter 4 and relevant guidelines (see Annex 16) for the appropriate investigations that should be carried out in these situations (e.g. medical problems, sharing of rations, etc.).

Users wishing to simplify reporting: For those wishing to report Non-recovery more generally all cases of Medical referral and Non-response can be added up and filled in the Non-response category (n).

Total Discharges (X): Total number of beneficiaries who were discharged from the SC. This is calculated by adding together the above exit categories of h, i, j, k, l, m and n.

7. Other (o): This category is included in order to allow reporting of beneficiaries for whom the outcome is unclear (e.g. because the card was lost), or when it is discovered that a beneficiary was admitted by mistake.

- The number of beneficiaries in this category should always be kept at a minimum and should ideally equal 0. If 'other'> 0 then a reason should be given; if no reason has been provided, the situation should be further explored by the supervisor and appropriate actions taken.

Total Out (Z): Total number of beneficiaries exiting SC: Total discharges + other.

2.2.3 Stabilisation Centre performance indicators

As for OTP, there are two levels of analysis, depending on user priorities, needs and capacities:

Basic level analysis	Advanced level analysis
• Promoted to OTP rate • Recovery rate • Defaulter rate • Death rate • Non-recovery rate	• Promoted to OTP rate, recovery rate, defaulter rate, death rate **AND** • Medical referral rate • Non-response rate • % defaulters for which actual outcome is unconfirmed • % relapse, % re-admission • Average length of stay

Basic level analysis indicators:

The following indicators correspond to recommended Sphere Minimum Standards:

Performance Indicator	Calculation	Formula
Promoted to OTP rate[8]	Number of beneficiaries promoted to OTP[9]+ number of recovered, divided by total discharges multiplied by 100	[h+i] / X *100
Recovery rate	Number of successfully discharged as recovered, divided by total discharges multiplied by 100	i /X *100
Death rate	Number of beneficiaries who died whilst registered in programme, divided by total discharges multiplied by 100	j / X *100
Defaulter rate	Number of defaulters unconfirmed + number of defaulters confirmed, divided by total discharges multiplied by 100	[k+l] / X *100
Non-recovery rate[10]	Number of medical referrals + number of non-response, divided by total discharges multiplied by 100	[m+n] / X *100
The sum of the five above rates should always be 100% (thus, the denominator 'total discharges'(X) for the calculation is the number of promoted to OTP + recovered + death + defaulter unconfirmed + defaulter confirmed + non-response + medical referral).		

Advance level analysis indicators:

Permits analysis of non-recovery in more detail as follows:

Performance indicator	Calculation	Formula
Medical referral rate	Number of SC beneficiaries who are referred outside of the nutrition programme for medical care and cannot continue nutritional treatment, divided by total discharges multiplied by 100	m / X *100
Non-response rate	Number of beneficiaries who that are discharged as non-response, divided by total discharges multiplied by 100	n / X *100
The sum of the two above rates + promoted to OTP, recovered, death and defaulter rate should always be 100% (thus the denominator 'total discharges'(X) for the calculation is the number of promoted to OTP + recovered + death + defaulter unconfirmed + defaulter confirmed + non-response + medical referral).		

And additional indicators:

Indicator	How calculated	Formula
Percentage of Defaulters for which actual outcome is unconfirmed	Number of defaulters unconfirmed, divided by total defaulters (defaulter unconfirmed + defaulters confirmed) multiplied by 100	k / [k+l] *100
Percentage of Relapse	Number of relapses divided by total admissions multiplied by 100	d / W *100
Percentage of Re-admission	Number of re-admissions divided by total admissions multiplied by 100	e / W *100
Average Length of stay (ALS)	ALS should be calculated for all beneficiaries of same age group (e.g. children 6-59 months) who are discharged as 'promoted to OTP'.	See below
Percentage of male (or female) Total admissions	Number of Total admissions male (or female) divided by Total admissions multiplied by 100. This indicator is only calculated for children 6-59 months.	-

Formula of Average Length of Stay (ALS)

[8]Used as a measure of those successfully discharged from SC and moved-in to OTP to continue treatment for SAM

[9] Equivalent to Moved-out to OTP; also known as Transfer-out to OTP

[10] The rate includes beneficiaries in two categories (non-response and medical referrals), both representing beneficiaries that did not have a positive nutritional outcome under the treatment received in SC.

Length of stay is the number of days elapsed between admission and discharge. It is calculated for all beneficiaries 'promoted to OTP'[11] one by one. Subsequently, the average out of these individual length of stay will be calculated:

Average Length of Stay = Sum of Individual Length of stay (promoted to OTP beneficiaries) – in days / Number of promoted to OTP beneficiaries

2.3 Outpatient Therapeutic Programme entries, exits and performance indicators

2.3.1 Outpatient Therapeutic Programme entries

Table 5: *OTP entries*

New Admissions				Re-admission	Total Admissions	Other Entries		Total In
WFH/BMI	MUAC	Oedema	Relapse			Moved in From SC/OTP	Other	
a	b	c	d	e	W=a+b+c+d+e	f	g	Y=W+f+g

1. New admission (a, b, c): Person with Severe Acute Malnutrition (SAM) directly admitted to the programme because s/he meets the admission criteria and has not been under treatment elsewhere for this episode of SAM.

- New admissions are separated by criteria of admission: WFH/BMI, MUAC and nutritional oedema (with cut offs for anthropometric measures according to programme protocol). The user can decide to use some or all of these categories depending on the criteria used in the programme, this will not affect the final calculations.
- Convention dictates that when a beneficiary is admitted fulfilling both WFH and MUAC criteria he/she is reported under WFH. When a beneficiary has nutritional oedema s/he should be recorded only in the oedema category column whether or not s/he fulfils other criteria for admission.

Users wishing to simplify reporting: For those wishing to report new admissions more generally it is recommended that at least marasmus (identified by WFH and/or MUAC) and kwashiorkor[12] cases (cases with nutritional oedema) should be kept separate. If all new admissions are reported without disaggregation a decision should be made on which column should always be filled in (a, b or c).

2. Relapse (d): Beneficiary re-admitted to the programme after having been successfully discharged as recovered within the last two months (this is a new episode of SAM). ***Optional category***

3. Re-admission (e): Beneficiary re-admitted to the programme within two months after having left it for a reason that does not include recovery (e.g. after defaulting or non-response or medical referral). ***Optional category***

Total Admissions (W): Total number of cases starting treatment in an OTP site (sum of new admissions and relapses and re-admissions).

4. Moved-in from SC/OTP (f): Beneficiary who has been transferred from SC or other OTP to continue treatment in OTP.

[11] The average length of stay for other beneficiaries may be useful: thus the average time dead beneficiaries were in the programme before death can give an indication of where efforts need to be focused to lower the rates. Here it is also useful to record the time during the day (night?, early in the morning?).

[12] Marasmic kwashiorkor is included under the oedema criteria.

- These beneficiaries are not counted as admissions to the programme as they were already under treatment (either in SC or other OTP).

5. Other (g): Beneficiary who is admitted to the OTP for reasons unrelated to their nutrition status (not meeting OTP admission criteria).

- The number of beneficiaries in this category should always be kept to a minimum and should ideally equal 0. If 'other'> 0 then a reason should be given; if no reason has been provided, the situation should be explored further by the supervisor and appropriate action taken.
- The 'other' category is not counted in Total admissions (because it is not a SAM admission)

Reminder: The 'other' category does not relate to beneficiaries who fall outside of the specified treatment group. For example: the OTP targets children 6-59 months, but older children with SAM are identified at the OTP and the programme manager permits their entry. In this instance a new treatment group needs to be defined.

Total In (Y): Total number of beneficiaries entering OTP: Total admissions + Other entries (Moved in from SC/OTP + Other).

2.3.2 Outpatient Therapeutic Programme exits

Table 6: *OTP exits*

Discharges						**Total Discharges**	Moved-out		Other	**Total Out**
Recovered	Death	Defaulter		Non-recovery			OTP to SC	OTP to OTP		
		Unconfirmed	Confirmed	Medical referral	Non-response					
h	i	j	k	l	m	X=h+i+j+k+l+m	n	o	p	Z=X+n+o+p

1. Recovered (h): Beneficiary who has reached the discharge criteria of success defined for the programme.

Note that beneficiaries that are discharges from OTP as recovered should be referred to TSFP (if available) for follow up and admitted in "OTP discharges" (<u>not</u> as a new admission in TSFP).

2. Death (i): Beneficiary who died from any cause while registered in the programme.

- Where a beneficiary dies during transit from OTP to SC, the death should be recorded as death within the programme and reported as death in OTP.
- Deaths do not usually occur at the feeding site. Possible sources of information for the death will usually be a relative or neighbour. Death should be confirmed by a home visit. Until the death is confirmed, the beneficiary may be classified as 'defaulter unconfirmed'.

3. Defaulter (j+k): Beneficiary who is absent for two consecutive weighings e.g. absent at service round three.

- As for TSFP, active absentee tracing should be organised as soon as the absence of a beneficiary is noticed, not waiting until the beneficiary becomes a defaulter. A home visit should be made to confirm the outcome (and facilitate re-entry into the programme if possible).
- There are two defaulter categories for advanced users: confirmed and unconfirmed (if outcome is unknown).

3.1. Defaulter unconfirmed (j): Beneficiary who is absent for two consecutive weighings, and whose final outcome is not known (since no defaulter tracing was done).

3.2. **Defaulter confirmed** (k): Beneficiary who is absent for two consecutive weighings, and for whom a home visit has confirmed that the beneficiary is alive and is a 'true' defaulter.

- **Optional category:** Programmes that do not implement home visits for defaulter tracing should not use this category and should report defaulters as 'defaulters unconfirmed'.

If during the home visit:

- The beneficiary decides to re-enter the programme, s/he is re-admitted and the re-admission classified as above. This beneficiary still counts as a 'true' defaulter in the reporting of the corresponding week/month.
- The beneficiary is found to be dead, to be a 'true' defaulter or to have been transferred; the outcome needs to be corrected in the report.
- The beneficiary is found to be dead, it is important to determine the date of the death: it will be considered a death in the OTP if s/he died within the window period until being considered a defaulter (3 service rounds). If the beneficiary died outside of these 3 service rounds s/he is considered a defaulter (confirmed).

Users wishing to simplify reporting: For those wishing to report defaulters more generally the total number of defaulters should be reported under column (i) 'defaulter unconfirmed'.

4. Medical referral (l): Beneficiary who has a serious illness that requires diagnosis and/or treatment beyond the scope of available nutrition programmes (i.e. in targeted SFP or in OTP or SC) and is therefore referred to a health facility / hospital requiring interruption of nutritional treatment by the programme and continuation by the health facility / hospital. If the nutritional treatment is continued while the beneficiary is in the health facility / hospital, the beneficiary is not discharged from the programme, and should not be included in the exit reporting. ***Optional category***

5. Non-response (m): Beneficiary who has not reached discharge criteria after a pre-defined length of time (usually 3 or 4 months) despite all investigations and transfer options. See chapter 4 and relevant guidelines (see Annex 16) for the appropriate investigations that should be carried out in these situations (e.g. medical problems, sharing of rations, etc.).

Users wishing to simplify reporting: For those wishing to report Non-recovery more generally all cases of Medical referral and Non-response can be added up and filled in the Non-response category (m).

Total Discharges (X): Total number of beneficiaries who were discharged from the programme. This is calculated by adding up the above exit categories of h, i, j, k, l and m.

6. Moved-out from OTP to SC (n): Beneficiary who has started treatment in OTP and is moved-out to SC to continue treatment due to deterioration of his/her nutrition status and/or development of medical complications.

7. Moved-out from OTP to other OTP (o): Beneficiary who requests transfer to another OTP site to continue treatment.

Moved-out[13] beneficiaries should not be counted as discharges out of the programme as they will continue treatment in another OTP site or in an SC within the same programme.

8. Other (p): This category is included in order to allow reporting of beneficiaries for whom the outcome is unclear (e.g. because the card was lost), or when it is discovered that a beneficiary was admitted by mistake.

[13]This category is split in two due to the different information they provide and are required in order to improve performance understanding in the OTP site.

- The number of beneficiaries in this category should always be kept at a minimum and should ideally equal 0. If 'other' > 0 then a reason should be given; if no reason has been provided, the situation should be further explored by the supervisor and appropriate actions taken.

Total Out (Z): Total number of beneficiaries exiting OTP: Total discharges + moved out + other.

2.3.3 Outpatient Therapeutic Programme performance indicators

As for targeted SFP, there are two levels of analysis, depending on user priorities, needs and capacities:

Basic level analysis	Advanced level analysis
• Recovery rate • Defaulter rate • Death rate • Non recovery rate	• Recovery rate, defaulter rate, death rate **AND** • Medical referral rate • Non-response rate • % defaulters for which actual outcome is not confirmed. • % relapse, % re-admission • % OTP beneficiaries requiring inpatient care • Average weight gain and Average length of stay

Basic level analysis indicators:

The following indicators correspond to recommended Sphere Minimum Standards:

Performance indicator	Calculation	Formula
Recovery rate	Number of beneficiaries successfully discharged as recovered, divided by total discharges multiplied by 100	h / X *100
Death rate	Number of beneficiaries who died whilst registered in programme, divided by total discharges multiplied by 100	i / X *100
Defaulter rate	Number of defaulters unconfirmed + number of defaulters confirmed divided by total discharges multiplied by 100	[j+k] / X *100
Non-recovery rate[14]	Number of medical referrals + number of non-response, divided by total discharges multiplied by 100	[l+m] / X *100

The sum of the four above rates should always be 100% (thus the denominator 'total discharges'(X) for calculation is the number of recovered + death + defaulter unconfirmed + defaulter confirmed + non-response + medical referral).

Advance level analysis indicators:

Permits analysis of non-recovery in more detail as follows:

Performance indicator	Calculation	Formula
Medical referral rate	Number of OTP beneficiaries who are referred outside of the nutrition programme for medical care and cannot continue nutritional treatment, divided by total discharges multiplied by 100	l / X *100
Non-response rate	Total number of beneficiaries who are discharged as non-response, divided by total discharges multiplied by 100	m / X *100

The sum of the two above rates + recovered, death and defaulter rate should always be 100% (thus the denominator

[14] This rate includes two groups: 'non-response' and 'medical referral'. Together they represent beneficiaries who have not sufficiently responded to treatment to be cured/ recovered.

'total discharges' (X) for calculation is the number of recovered + death + defaulter unconfirmed + defaulter confirmed + non-response + medical referral).

And additional indicators:

Performance indicator	Calculation	Formula
Percentage of Defaulters for which actual outcome is unconfirmed	Number of defaulters unconfirmed divided by total defaulters (defaulter unconfirmed + defaulters confirmed) multiplied by 100	k / [j+k] *100
Percentage of Relapse	Number of relapses, divided by total admissions multiplied by 100	d / W *100
Percentage of Re-admission	Number of re-admissions divided by total admissions multiplied by 100	e / W *100
Percentage OTP beneficiaries requiring inpatient care	Number of children moved-out to SC, divided by total number of discharges, plus all moved-outs, multiplied by 100	n / [X+n+o] *100
Average weight gain (AWG) and Average length of stay (ALS)	These indicators can be calculated for all beneficiaries of the same age group (e.g. children 6-59 months) who are discharged as recovered, although calculations made on a random sample of at least 40 beneficiaries may provide a good estimate. These indicators are calculated for marasmus and kwashiorkor separately.	See below
Percentage of male (or female) Total admissions	Number of Total admissions male (or female) divided by Total admissions multiplied by 100. This indicator is only calculated for children 6-59 months.	-

Formula of Individual and Average Weight Gain (AWG)

Weight gain is calculated as the difference in weight on day of entry to the programme[15] until discharge from the programme for recovered beneficiaries one by one (in gram/kg/day):

Individual weight gain = [W 2 - W1 / W] / T (in gram/kg/day)

W = Weight <u>in kg</u> on the day of entry to the programme (for Kwashiorkor cases day of minimum weight)
W1 = Weight <u>in grams</u> on day of entry to the programme (for Kwashiorkor cases day of minimum weight)
W2 = Weight <u>in grams</u> the day of discharge from the programme
T = Number of days elapsed between W1 and W2

Subsequently, the average out of these individual weight gains will be calculated:

Average weight gain = Sum of individual weight gains (gram/kg/day) / Total number of beneficiaries

Formula of Average Length of Stay (ALS)

Length of stay is the number of days elapsed between admission and discharge. It is calculated for recovered beneficiaries[16] one by one. Subsequently, the average out of these individual length of stay will be calculated:

Average Length of Stay = Sum of Individual Length of stay (recovered beneficiaries) – in days / Number of recovered beneficiaries

[15] For Kwashiorkor cases use the day of minimum weight; that means after oedema has subsided.

[16] The average length of stay for other beneficiaries may be useful: thus the average time dead beneficiaries were in the programme before death can give an indication of where efforts need to be focused to lower the rates. Here it is also useful to record the time during the day (night? early in the morning?).

2.4 Targeted Supplementary Feeding Programme entries, exits and performance indicators

2.4.1 Targeted Supplementary Feeding Programme entries

Table 7: *Targeted SFP entries*

New Admissions			Re- admission	**Total Admissions**	**Other Entries**		**Total In**
WFH/ BMI	MUAC	Relapse			Moved in from other tSFP sites	Other	
a	b	c	d	W=a+b+c+d	e	f	Y=W+e+f

1. New admission (a, b): Beneficiary with Moderate Acute Malnutrition (MAM) directly admitted to the programme because he/she meets the admission criteria and is not under treatment elsewhere for this episode of MAM

- New admissions are separated by criteria of admission: WFH/BMI and MUAC (with cut offs according to programme protocol). The user can decide to use one or all of these categories depending on the criteria used in the programme, this will not affect the final calculations.
- Convention dictates that when a beneficiary is admitted fulfilling both for WFH and MUAC criteria he/she is reported under WFH only.

> WFH/BMI and MUAC categories can also be joint to one category in case the programme does not want to distinguish between WFH/BMI and MUAC admissions.

2. Relapse (c): Beneficiary re-admitted to the programme after having been successfully discharged as recovered within the last two months (this is a new episode of MAM). ***Optional category***

3. Re-admission (d): Beneficiary re-admitted to the programme within two months after having left it for a reason that does not include recovery (e.g. after defaulting, medical referral, non-response, transfer to therapeutic programme). ***Optional category***

Total Admissions (W): Total number of cases starting treatment in a targeted SFP site (sum of new admissions and re-admissions).

4. Moved-in from other targeted SFP sites (e): Beneficiary that has been moved from one targeted SFP site to another to continue treatment.

- These beneficiaries are not counted as admissions to the programme as they were already under treatment in another targeted SFP site. They are counted in order to capture the total programme caseload, which is necessary for ordering rations and for other programme planning purposes.

5. Other (f)*:* Beneficiary that is admitted to the targeted SFP for reasons unrelated to their nutrition status (not meeting targeted SFP admission criteria).

- The number of beneficiaries in this category should always be kept to a minimum and should ideally equal 0. If 'other'> 0 then a reason should be given; if no reason has been provided, the situation should be explored further by the supervisor and appropriate action taken.
- The 'other' category is not counted in Total admissions (because it is not a MAM admission)

> Reminder: The 'other' category does not relate to beneficiaries who fall outside of the specified treatment group. For example: the targeted SFP targets children 6-59 months, but older children with MAM are identified at the SFP and the programme manager permits their entry. In this instance a new treatment group needs to be defined.

Total In (Y): Total number of beneficiaries entering targeted SFP: Total admissions + Other entries (Moved in from other tSFP sites + Other).

2.4.2 Targeted Supplementary Feeding Programme exits

Table 8: *Targeted SFP exits*

Discharges							**Total Discharges**	Moved-out to other tSFP	Other	**Total Out**
Recovered	Death	Defaulter		Non-recovery						
		Unconfirmed	Confirmed	Medical referral	Non-response	Transfer to TFP				
g	h	i	J	k	l	m	X=g+h+i+j+k+l+m	o	p	Z=X+o+p

1. Recovered (g): Beneficiary who has reached the discharge criteria of success defined for the programme[17].

2. Death (h): Beneficiary who died from any cause while registered in the programme.

- Deaths do not usually occur at the feeding site. Possible sources of information for the death will usually be a relative or neighbour. Death should be confirmed by a home visit. Until the death is confirmed, some programmes may classify the beneficiary as 'defaulter unconfirmed'.

3. Defaulter (i+j): Beneficiary who is absent for two consecutive weighings, e.g. absent at service round three.

- Active absentee tracing should be organised as soon as the absence of a beneficiary is noticed, not waiting until the beneficiary becomes a defaulter. A home visit should be made to confirm the outcome (and facilitate re-entry into the programme if possible).
- There are two defaulter categories for advanced users: confirmed and unconfirmed (if outcome is unknown).

3.1. Defaulter unconfirmed (i): Beneficiary who is absent for two consecutive weighings, and whose final outcome is not known (since no defaulter tracing was done).

3.2. **Defaulter confirmed** (j): Beneficiary who is absent for two consecutive weighings, and for whom a home visit has confirmed that the beneficiary is alive and is a 'true' defaulter.

- **Optional category:** Programmes that do not implement home visits for defaulter tracing should not use this category and should report defaulters as 'defaulters unconfirmed'.

If during the home visit:

- The beneficiary decides to re-enter the programme, s/he is re-admitted and the re-admission classified as above. This beneficiary still counts as a 'true' defaulter in the reporting of the corresponding week/month.
- The beneficiary is found to be dead, to be a 'true' defaulter or to have been transferred; the outcome needs to be corrected in the report.
- The beneficiary is found to be dead, it is important to determine the date of the death: it will be considered a death in the targeted SFP if s/he died within the window period until being considered a defaulter (3 service rounds). If the beneficiary died outside of these 3 service rounds s/he is considered a defaulter (confirmed).

Users wishing to simplify reporting: For those wishing to report defaulters more generally the total number of defaulters should be reported under column (i) 'defaulter unconfirmed'.

4. Medical referral (k): Beneficiary who has a serious illness that requires diagnosis and/or treatment beyond the scope of available nutrition programmes (i.e. in targeted SFP or in OTP or SC) and is therefore referred to a health facility / hospital requiring interruption of nutritional treatment by the programme and continuation by the health facility / hospital. If the nutritional treatment is continued while the beneficiary is in the health facility / hospital, the beneficiary is not discharged from the programme, and should not be included in the exit reporting. ***Optional category***

[17] This is referred to as "cured", "nutritionally recovered" or "discharged successfully" in different guidelines.

5. Non-response (l): Beneficiary who has not reached discharge criteria after a pre-defined length of time (usually 3 or 4 months) despite all investigations and transfer options. See chapter 4 and relevant guidelines (see Annex 16) for the appropriate investigations that should be carried out in these situations (e.g. medical problems, sharing of rations, etc.).

6. Transfer to therapeutic programme (m): Beneficiary who is referred to a therapeutic feeding programme (OTP or SC) after deterioration of his/her nutritional status and development of severe acute malnutrition (SAM). ***Optional category***

> Users wishing to simplify reporting: For those wishing to report Non-recovery more generally, all cases of Medical referral, Non-response and Transfer to therapeutic programme can be added up and filled in the Non-response category (l).

Total Discharges (X): Total number of beneficiaries who were discharged from the programme. This is calculated by adding up the above exit categories of g, h, i, j, k, l and m.

7. Moved-out to other tSFP site (o): Beneficiary who requests transfer to another targeted SFP site to continue treatment.

- These beneficiaries are not counted as discharged as they continue treatment in the programme. They are counted to capture the total programme caseload, which is necessary for ordering rations and for other programme planning purposes.

8. Other (p): This category is included in order to allow reporting of beneficiaries for whom the outcome is unclear (e.g. because the card was lost), or when it is discovered that a beneficiary was admitted by mistake.

- The number of beneficiaries in this category should always be kept at a minimum and should ideally equal 0. If 'other'> 0 then a reason should be given; if no reason has been provided, the situation should be further explored by the supervisor and appropriate actions taken.

Total Out (Z): Total number of beneficiaries exiting targeted SFP: Total discharges + moved-out + other.

2.4.3 Targeted Supplementary Feeding Programme performance indicators

There are two levels of analysis, depending on user priorities, needs and capacities:

Basic level analysis	Advanced level analysis
• Recovery rate • Defaulter rate • Death rate • Non-recovery rate	• Recovery rate, defaulter rate, death rate **AND** • Medical referral rate • Non-response rate • Transfer to therapeutic programme rate • % relapse, % re-admissions • % Defaulter for which actual outcome is unconfirmed • % Beneficiaries requiring TFP treatment • Average weight gain and Average length of stay

Basic level analysis indicators:

The following indicators correspond to recommended Sphere Minimum Standards:

Performance indicator	Calculation	Formula
Recovery rate	Number of beneficiaries successfully discharged as recovered, divided by total discharges, multiplied by 100	g / X *100
Death rate	Number of beneficiaries who died whilst registered in programme, divided by total discharges, multiplied by 100	h / X *100
Defaulter rate[18]	Number of defaulters unconfirmed + number of defaulters confirmed divided by total discharges multiplied by 100	[i+j] / X *100
Non-recovery rate[19]	Number of medical referrals + number of non-response + number of transfers to therapeutic programme, divided by total discharges multiplied by 100	[k+l+m] / X *100
The sum of the four above rates should always be 100 % (thus the denominator 'total discharges' (X) for calculation is the number of recovered + death + defaulter unconfirmed + defaulter confirmed + non-response + medical referral + transfer to therapeutic programme).		

Advanced level analysis indicators:

Permits analysis of non-recovery in more detail as follows:

Performance indicator	Calculation	Formula
Medical referral rate	Number of targeted SFP beneficiaries who are referred outside of the nutrition programme for medical care and cannot continue nutritional treatment, divided by total discharges multiplied by 100	k / X *100
Non-response rate	Number of beneficiaries who are discharged for non-response divided by total discharges multiplied by 100	m / X *100
Transfer to therapeutic programme rate	Number of transfers to therapeutic programme (OTP or SC) divided by total discharges multiplied by 100	l / X *100
The sum of the three above rates + recovered, death and defaulter rates should always be 100 % (thus the denominator 'total discharges'(X) for calculation is the number of recovered + death + defaulter unconfirmed + defaulter confirmed + non-response + medical referral + transfer to therapeutic programme.		

And additional indicators:

Performance indicator	Calculation	Formula
Percentage of defaulters for which actual outcome is unconfirmed	Number of defaulters unconfirmed divided by total defaulters (defaulters unconfirmed + defaulters confirmed) multiplied by 100	i / [i+j] *100
Percentage of relapse	Number of relapse divided by total admissions multiplied by 100	c /X *100
Percentage of re-admissions	Number of re-admissions divided by total admissions multiplied by 100	d /X *100
Percentage of beneficiaries requiring TFP treatment	Number of Transfer to TFP divided by total number of discharges multiplied by 100	m / X *100

[18] This rate includes two groups: 'defaulters confirmed' and 'defaulters non-confirmed'. It corresponds to the 'defaulter rate' in the Sphere Minimum Standards. This rate is complemented by the 'percentage of defaulters for which actual outcome is non-confirmed' where this can be calculated.

[19] This rate includes three groups: 'non-response', 'medical referral', 'transfer to therapeutic feeding programme'. Together they represent beneficiaries who did not have sufficiently responded to treatment to be cured/ recovered.

Average Weight Gain (AWG) and Average Length of stay (ALS)	These can be calculated for all beneficiaries of same age group (e.g. children 6-59 months) who are discharged as recovered, though calculations made on a random sample of at least 40 beneficiaries may provide a good estimate.	See below

Formula of Individual and Average Weight Gain (AWG)

Weight gain is calculated as the difference in weight on day of entry to the programme until discharge from the programme for recovered beneficiaries one by one (in gram/kg/day):

Individual weight gain = [W 2 - W1 / W] / T (in gram/kg/day)

W = Weight in kg on the day of entry to the programme
W1 = Weight in grams on day of entry to the programme
W2 = Weight in grams the day of discharge from the programme
T = Number of days elapsed between W1 and W2

Subsequently, the average out of these individual weight gains will be calculated:

Average weight gain = Sum of individual weight gains (gram/kg/day) / Total number of beneficiaries

Formula of Average Length of Stay (ALS)

Length of stay is the number of days elapsed between admission and discharge. It is calculated for recovered beneficiaries [20] one by one. Subsequently, the average out of these individual length of stay will be calculated:

Average Length of Stay = Sum of Individual Length of stay (recovered beneficiaries) – in days / Number of recovered beneficiaries

2.5 OTP discharges in TSFP entries, exits and performance indicators

Beneficiaries that have been discharged from OTP and are admitted to targeted SFP for treatment consolidation (OTP discharges) are separately reported from regular TSFP entries. OTP discharges receiving the same nutritional care as MAM case admitted, however, reporting on these beneficiaries separately prevents distortion of TSFP recovery rate (by excluding beneficiaries leaving the programme and meeting the 'recovered' criteria if they were not necessarily malnourished when admitted to the programme).
The separation of OTP discharges from other TSFP admissions improves the analysis of targeted SFP performance indicators, as recommended by Sphere 2011.

2.5.1 OTP discharges in TSFP entries and exits

Table 9: *OTP discharges in TSFP entries and exits*

New beneficiaries	Completed programme	Dropouts	Referral to TFP	Death	Other	Total Out
a	b	c	d	e	f	X=b+c+d+e+f

[20] The average length of stay for other beneficiaries may be useful: thus the average time dead beneficiaries were in the programme before death can give an indication of where efforts need to be focused to lower the rates. Here it is also useful to record the time during the day (night? early in the morning?).

1. New beneficiaries (a): The number of beneficiaries entering the programme for fulfilling the programme admission criteria.

2. Completed the programme (b): The number of beneficiaries who completed the treatment, as determined in the programme protocol, and that were instructed not to return again.

3. Dropouts (c): The number of beneficiaries who were expected during the reporting period who did not show up to the distribution for 2 consecutive service days.

4. Referrals to TFP (d): The number of beneficiaries who were referred for treatment to OTP or SC[21].

5. Death (e): Beneficiary who died from any cause while registered in the INS.

6. Other (f): This category is included in order to allow reporting of beneficiaries for whom the outcome is unclear (e.g. because the card was lost), or when it is discovered that a beneficiary was admitted by mistake.

- The number of beneficiaries in this category should always be kept at a minimum and should ideally equal 0. If 'other'> 0 then a reason should be given; if no reason has been provided, the situation should be further explored by the supervisor and appropriate actions taken.

Total Out (X): Total number of beneficiaries exiting INS: Completed the programme + drop outs + deaths + other.

2.5.2 OTP discharges in TSFP performance indicators

There are no standard performance indicators as there are for targeted SFP. However, the indicators presented below might help in monitoring the treatment outcomes of the beneficiaries followed up in this part of targeted SFP.

Performance indicator	Calculation	Formula
Completed rate	Number of beneficiaries who completed the programme divided by Total Out multiplied by 100	b / X *100
Drop out rate	Number of drop outs divided by Total Out multiplied by 100	c / X *100
Referral to TFP rate	Number of referrals to TFP divided by Total Out multiplied by 100	d / X *100

[21] **Note** that no referrals from OTP discharges to tSFP are necessary as OTP discharges is a reporting category under tSFP and beneficiaries already receive the same treatment. The use of action protocols is recommended for any case loosing weight in OTP discharges.

SUGGESTIONS ON NARRATIVE REPORTS

Each organisation has its own narrative reporting requirements. The information and level of detail required will also be different depending on the period of the report (e.g. monthly or final report) and its audience and purpose (e.g. for internal programme management, for the donor, etc.).

The following general rules apply when writing reports and quoting statistics from programmes:

- Present the summary site report for the current reporting period in the main text or as an appendix (example below, is from the CMAM Report software).

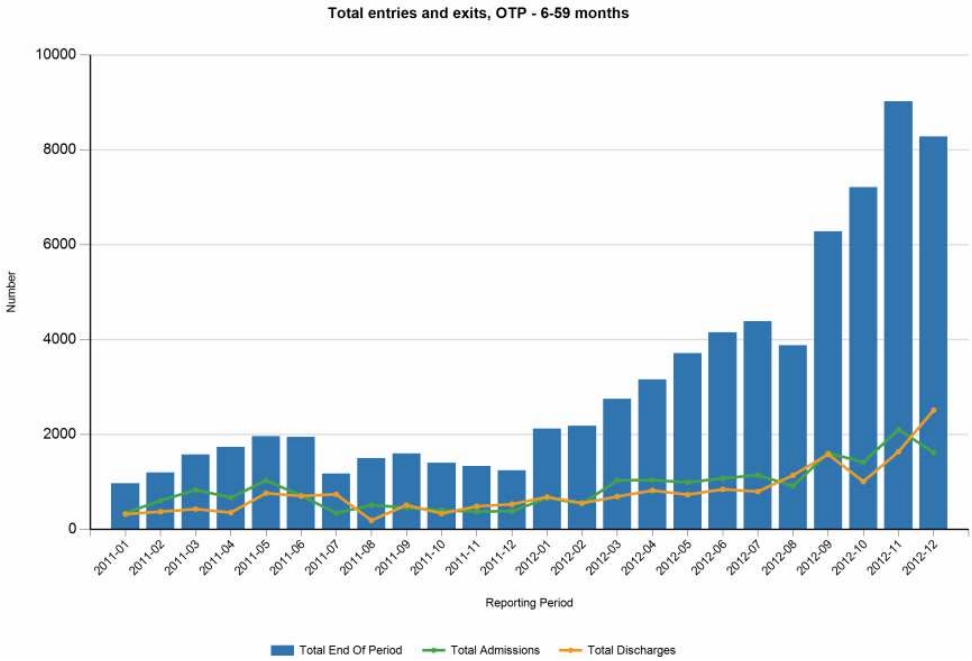
Targeted Supplementary Feeding Programme

		New Admissions								Discharges											
												Defaulter		Non-recovery							
Treatment Groups	Total Beginning of Period	WFH / BMI	MUAC	Relapse	Re-admission	Total Admissions	Moved in from other TSFP sites	Other	Total In	Recovered	Death	Unconfirmed	Confirmed	Medical Referral	Transferred to TFP	Non-response	Total Discharges	Moved out to other TSFP	Other	Total Out	Total in charge at End Of Period
6-59 months	739	0	10	0	0	10	0	2	12	52	0	1	0	0	0	0	53	0	0	53	698
Older children (5-10yrs)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pregnant/Lactating women	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total:	739					10			12								53			53	698

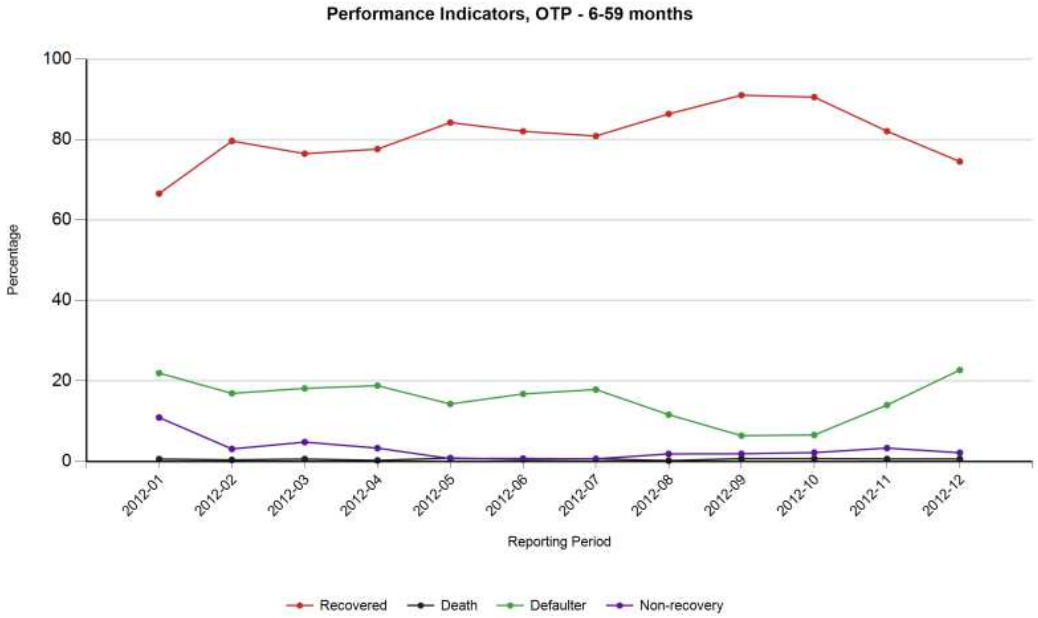
Performance Indicators

	Basic Performance Indicators (%)				Advanced performance indicators (%)						New Admission indicator analysis (%)	
					Non-recovery breakdown							
Treatment Groups	Recovered	Death	Defaulter	Non-recovery	Medical Referral	Non-response	Transferred to TFP	Relapse	Re-admission	Defaulters for which outcome is not confirmed	WFH / BMI	MUAC
6-59 months	98.1%	0.0%	1.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	100.0%
Older children (5-10yrs)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Pregnant/Lactating women	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-	0.0%

- Present a graph showing the monthly evolution of entries/exits over time from the beginning of the intervention (or at least the previous year if it is a long term programme) and current caseload (see example below).



- Present a graph showing the monthly evolution of performance indicators over time from the beginning of the intervention (or at least the previous year if it is a long term programme). This will allow visual representation of statistical trends (see example below).



- State the objectives of the programme for the reporting period (Sphere indicators) and give reasons in case they were not achieved. Describe the activities performed during the period and the main incidents that may have affected programme performance, both positive and negative.
- Define objectives for the subsequent period and define activities to achieve them.
- Always include context information to describe the programme and aid interpretation of the programme performance indicators. Include the summary table showing programme and context characteristics as an appendix. In more comprehensive reports this can be developed in the text.

Additional recommendations:

1. Never mix treatment groups in the calculation of programme performance indicators. When reporting information on any indicator, always specify the treatment group to which it refers.
2. When reporting percentages in the text (e.g. recovery rates), always quote the numerator and the denominator, e.g. recovery rate of 86.4% (133/154).
3. When reporting population based data (e.g. SAM rates from a survey), always quote confidence intervals. The survey/coverage summary table (from the MRP software) can be inserted as an appendix to the report including more details about the survey.
4. When reporting population based malnutrition rates, always explain which measure of malnutrition was used (e.g. weight-for-height against the WHO standards, MUAC, etc.), and if possible, the source (e.g. a survey, a surveillance system, a rapid assessment, etc.).

GUIDANCE ON INTERPRETING PROGRAMME PERFORMANCE INDICATORS

Timely and correct interpretation of indicators is essential to highlight problems and allow appropriate and timely decision making and action. The following are general rules when interpreting indicators:

4.1 General rules when interpreting indicators

- In general, emergency feeding programmes should demonstrate high coverage and recovery rates combined with low default and death rates in order to be called effective.
- Programme performance indicators should always be interpreted in relation to each other and with other programme characteristic and contextual information.
- Trends of performance indicators should be followed through graphs plotting change over time
- In situations where targets are not met an explanation must be sought and reported. When offering a potential 'explanation' it is important that this information has been validated (not just simply based on perceptions of the staff or a single informant). Explanations should always be supported by evidence. If possible, it is important to explain what other potential explanations were considered and why they were rejected.
- The need for special investigations to better understand the programme and how it could be improved should always be considered e.g. surveys, re-analysis of data, focus group discussions with caretakers, special supervision of activities, *adhoc* data collection, etc.

4.2 Sphere Minimum Standards

Sphere Minimum Standards include performance indicator targets for supplementary and therapeutic feeding programmes. These standards specify the "minimum levels to be attained in humanitarian response" for nutrition interventions and act as benchmark for their performance. Apart from the Sphere Minimum Standards indicators (recovered, died, defaulted, non-recovered), other indicators exist that give useful information to judge how well a programme is implemented and whether action should be taken to improve the programme quality. The indicators suggested in Section 2 are labelled as '***optional'*** and 'additional' indicators. Guidance is provided here on how to interpret Sphere Minimum Standards and these extra indicators, along with suggestions for action in cases where indicator targets are not met.

Table 10 below summarises the Sphere Minimum Standard indicators defined in section 2.

Table 10: *Sphere minimum standards for performance indicators*

Indicator	Indicator of…	SC and OTP	Targeted SFP
Performance indicators			
• Recovered %	• Quality of care	> 75%	> 75%
• Death %	• Quality of care	< 10% [22]	< 3%
• Defaulter %	• Accessibility, acceptability	< 15%	< 15%
• Non-recovered %		-	-
• Average length of stay (ALS)	• Quality of care (medical and diet)	45 – 60 days	60 days
Average weight gain (AWG)			
• SC until full recovery	• Quality of care (medical and diet)	8 g/kg/d	≥3g/kg/d
• Outpatient (SC and/or OTP)		≥4 g/kg/d	
Coverage			
• Camp	• Acceptability, accessibility	> 90%	> 90%
• Urban		> 70%	> 70%
• Rural		> 50%	> 50%

[22] Experience has shown that death rate in OTP is much less than then Sphere target of 10%, therefore the MRP software will flag any rate more than 3%.

Entries and exits • Total number of beneficiaries registered • Admissions and exits • Re-admissions • Readmission after recovery	• Nutrition situation evolution • Trends in food security • Workload and size of programme	< 5%	< 5%

4.3 Acting on substandard Sphere Minimum Standards

When indicators do not meet standards and signal a need for action, the following questions might be asked to seek for quality improvement of the programme:

Table 11: *Questions to ask when indicators do not meet standards*

Indicator of… (Refer to Table 11 above)	
Quality of care (medical and nutritional)	• Staff: Is there enough staff, also at night in SC? Well trained? High workload? Sufficiently qualified? Staff attitude with beneficiaries and caregivers? • Nutrition protocols: Are they correct? Do staff follow protocols adequately (phases and timing, recipes and amounts, day/night, food intake monitored, • Environment: Is it overcrowded/poor (exposure to cross infection medical treatment etc.)? • Shortage of food products and/or drugs, accurate measurement/equipment? • Failure to monitor clinical status, to diagnose associated or complicated conditions? • Inappropriate selection of beneficiaries to go directly to OTP? Appetite test carried out?
Access and acceptability	• Active case finding and referral done by MUAC but admission through WFH (caretakers de-motivated when child not admitted)? Inadequate explanations/encouragement given? • Long stay in SC leading to high opportunity cost for the family? • Do caretakers properly understand programme objectives and treatment (duration, number of meals or sachets and amounts per day, no sharing of foods etc.)? • Referral system not adapted/non existing/not enough time devoted for adapted explanations to caregivers? • Long distances to site, long waiting time at the site: programme not decentralized enough? • SC: overcrowding, high cross infection risk? • Weak community mobilization, no outreach programme (active case finding)?
Nutrition situation evolution and related factors affecting nutrition	• Household food insecurity: ration sharing, stealing, selling etc? • Major events affecting the programme e.g. Drought, failure of harvest? • Displacement, movements, security etc.? • Outbreak of diseases?

4.4 Single indicator guidance – Performance indicators

Performance indicators defined by Sphere are the percentages of recovered, death, defaulter and non-recovered.

They:

- Provide information on the proportion of beneficiaries completing the treatment successfully or un-successfully.
- Are interdependent (all four add up to 100%) and should be interpreted in relation to each other and with other information
- Are difficult to interpret during the first 2 months after the opening of the programmes as there are no recovered beneficiaries yet and therefore the percentage of deaths and defaulters are usually high.

The following lists performance indicators and guides on their interpretation:

A. Recovery rate
Any recovery rate below 75% needs to be investigated. As this rate is interlinked with the other performance indicators, reasons for low recovery rate might be found in high defaulter and/or death and/or non-recovery rates. Please refer to sections below for actions to be taken.

B. Death rate
Any high death rate needs to be investigated. It is important to look at the day (after admission) and hour (day or night) of death as well as the causes. Be aware that the proportion of death tends to be under-estimated as death often occurs amongst defaulters, especially in rural areas where defaulter tracing is difficult.

Possible reasons for high death rate (see also Table 12):
- Late identification of malnutrition and/or late presentation at treatment site
- Low quality of care in SC - unqualified staff, inadequate night care, inadequate treatment /action protocols
- Limited capacity of staff – unable to identify medical complications in OTP/targeted SFP
- Lack of referral options, slow referral, refusal of referral to SC

Routine compilation of information on reasons for death can help to identify problems with treatment and protocols and can highlight where training and supervision are needed.

C. Defaulter rate
Defaulters are beneficiaries that leave the programme before they have fully recovered from malnutrition, thus they are still at high risk of mortality. A high defaulter rate shows the inability of the programme to retain beneficiaries, therefore, it is extremely important to assess why beneficiaries leave the programme and if they return, why.

Possible reasons for high defaulter rate:
- Access problems - programme not decentralised enough, poor staff behaviour with caretakers, high household opportunity costs at certain times of the year.
- Misunderstanding of programme goals and the nutritional treatment provided - caretaker does not understand the length and aim of treatment or was not told by staff.
- Absentee tracing is not implemented by the programme – beneficiaries that miss a service day are not followed up and might become a defaulter.
- Perception of inadequate quality of care.
- Displacement/movement to other areas.
- Staff admits beneficiaries from areas beyond the feeding site's catchment area.

<u>Suggested action:</u> Reasons for default should be collected either by outreach workers/volunteers and/or through focus group discussions in the community. This will help to identify trends in defaulting and adjustments to the programme that should be considered (e.g. the need to open new sites to facilitate access[23]) and to promote malnourished beneficiaries to continue nutritional treatment.

Due to the high mortality risk associated with OTP beneficiaries, active absentee tracing should be implemented (it's important not to wait until the beneficiary becomes a defaulter).

C.1 Percentage of Defaulters for which outcome is unconfirmed
This indicator shows how effectively defaulter tracing is implemented by the programme. A high percentage

[23] Sphere Minimum Standard: more than 90% of the target population is within less than one day´s return walk (including time for treatment) of the programme site.

shows that few defaulters are visited at their home, thus, it is an indicator of the quality of home visiting. When this percentage is high, the defaulter rate should be questioned[24], and further investigations are needed. Tracing of defaulters is important in order to understand reasons for defaulting (e.g. family moved/displaced), verify true outcomes (child died, child admitted in other health facility) and possibly convince beneficiaries to return to the programme to continue treatment.

Suggested action: Among other actions, implement active absentee and defaulter tracing and report accordingly: this will enable reporting on defaulter confirmed and defaulter unconfirmed indicators

D. Non-recovery rate

This rate is an indicator of the underlying causes of malnutrition. It could point out problems such as TB/HIV, sharing of food in the household or general household food insecurity. For example, a high rate can indicate the need for advocacy for Food Assistance (GFD, cash or vouchers), referral programme gaps, as well as the need for stronger links with other sectors (TB programmes, Food security and livelihood programmes, WASH initiatives).

However, non-recovery rate is a composite indicator[25] and thus provides limited information on the underlying reasons for high non-recovery rates. It is therefore recommended that each component of the non-recovery rate be analysed separately to understand why beneficiaries do not recover from malnutrition whilst in the programme:

C.1 Non-response rate	C.2 Medical referral rate	C.3 Transfer to TFP rate
When the number of cases in this category is high it may indicate underlying problems related to the beneficiary (e.g. chronic disease, sharing of rations, beneficiary refuses to eat ration) or to the programme (see Table 12 Quality of care), that results in the beneficiary not gaining weight or stagnant weight, e.g. due to the lack of individual monitoring. Non-response should be very low if action protocols are followed[26]	Serious medical illness and/or medical complications that cannot be diagnosed/treated in the programme and need external specialised care outside CMAM. Medical referrals in targeted SFP and OTP are uncommon if there is a referral SC, as usually beneficiaries are first referred to SC.	High rates can point to low quality of care by programme or outbreak of diseases, e.g. malaria.
Suggestion: Staff needs to investigate beneficiary that do not gain body weight or increase in MUAC as expected. Staff should follow the action protocols (for guidance on action protocols see FANTA or Valid manuals in Annex 16)	*Suggestion: Follow the action protocols. Consider stronger link to HIV/ TB programmes and/or improvement of quality of care amongst staff (see Table 12).*	*Suggestion: Consider improvement of quality of care amongst staff (see Table 12).*

[24] If defaulters are not traced and their reason for defaulting is not confirmed it is possible that some defaulters could actually have died, thus the defaulter rate might mask the death rate.

[25] In targeted SFP it summarizes non-response rate, medical referral rate and transfer to TFP rate. In OTP/SC it summarises non-response rate and medical referral rate.

[26] Most cases of non-response should be referred for further diagnosis/treatment outside the programme and hence be classified as medical referrals.

4.5 Single indicator guidance - Additional indicators

A. Coverage

Coverage indicates how many of the beneficiaries in need of treatment are taking part in the programme. Coverage provides information on awareness, acceptability and accessibility of the programme and thus aiding impact assessment. Coverage should be estimated by a population based coverage survey (e.g. SQUEAC or CSAS); nutrition surveys are not particularly good tools for assessing coverage (especially for SAM treatment as the sample is usually too small) but can give useful indirect estimates. Note that coverage information is not collected routinely but can be calculated by indirect means (Annex 16).

Factors affecting coverage include:

- Awareness and perception of malnutrition
- Awareness and perception of the feeding programme (positive/negative feedback from community members who attend the programme)
- Distance of treatment site from home and transportation means/costs to the treatment site
- Time/priority for other work
- Security
- Relationship between staff and beneficiaries
- High opportunity cost for beneficiaries or caregivers
- Social environment
- Availability of food and nutrition products at health facility (pipeline)

Suggested action: Among others factors, consider improvement of community awareness on malnutrition and the programme, decentralise programme as much as possible, build staff/beneficiary relationships (positive feedback)

B. Average weight gain (AWG) and Average length of stay (ALS)

The programme goal is to treat beneficiaries as quickly as possible and with maximal weight gain. AWG and ALS share an inverse relationship (if AWG is low ALS is high).

Factors that negatively influence AWG and ALS:

- Poor quality of medical and/or nutritional care
- Low quantities of food received or consumed (issue of sharing or stealing)
- Low quality/care of preparation of therapeutic foods (dilution, recipes...)
- High levels of food insecurity in the area
- High number of Kwashiorkor cases
- High proportion of chronic diseases
- High absentee rate
- Discharges not given on time

Suggested action: Among other factors, consider improvement of quality of care amongst staff (Table 12), make sure that absentees are traced and return to the programme, and that beneficiaries are discharged on the same day that the exit criteria are reached.

C. Admissions

Trends in the number of admissions provide information on the general food and nutritional situation as well as on the development of the programme over time. If possible, admission numbers should be compared to the same month in the previous year (e.g. March 2012 with March 2011) keeping in mind food security patterns (hunger gaps) [27] and possible changes in the catchment area. Furthermore, disease patterns (malaria

[27] Usually the food security situation changes over the year with higher food insecurity just before harvest time and lower food insecurity in post-harvest months. Malnutrition rates generally rise and fall according to this pattern,

season or ARI season) might have an impact on admission numbers. Admission numbers are used for planning (e.g. number of feeding sites, food quantity, human resources, workload, etc.), lobbying/advocacy and to verify that targets were reached. Additionally, categorising admissions by gender or criteria can identify differences in the types of malnutrition.

Factors that can increase admission rates:

- Increased awareness by the population (especially for a new programme or after home visitor component is implemented) and/or increased confidence in the programme
- Improved security (people are free to move)
- Increased burden of diseases and/or increased food insecurity
- Regular community/mass screening for malnutrition

C.1 Relapse

A record of relapse rates can help programme implementers to understand the general food security situation in the area and can point to other underlying causes of malnutrition e.g. disease, inadequate feeding and child care practices and others.

Reasons for high relapse rate:

- Low food security situation at household level; beneficiaries lose weight again, leading to a new episode of malnutrition soon after recovery
- Beneficiaries may have been discharged from the programme too early.

Suggested action: Among other factors, consider interventions at the household level to increase food security for vulnerable groups e.g. by linking discharged beneficiaries to Food Security and Livelihoods (FSL) programmes directly. Advocate for additional assistance (GFD, cash, vouchers).

C.2 Readmission

Comparing numbers of defaulters and medical referrals will give an insight into how many beneficiaries return to the programme. This is also an indicator of how effectively defaulter tracing is done.

Suggested action: Among other factors, improve defaulter tracing.

D. Percentage of male and female total admissions

This indicator can highlight gender imbalance thus showing if either gender is over- or under-represented in total admissions to the programme. Any percentages that fall outside of the normal range of males and females (44.5% - 55.5%[28]) should be investigated. Questions that should be asked include; Do both sexes have the same access to treatment? Is one gender discouraged to seek treatment? Are males more vulnerable to malnutrition than females (cultural norms), or vice versa?

E. Attendance rate[29]

This is the percentage of beneficiaries admitted to the programme that actually attend the programme on each service day or each month. It gives information on acceptability and accessibility and helps in the interpretation of outcome indicators. Data for attendance can be obtained from registration books.

Suggested action: Due to the high mortality risk associated with OTP beneficiaries, active tracing of absentees should be organised as soon as it is noticed that a beneficiary has not attended a service day (rather than waiting until the beneficiary becomes a defaulter). A list of absentees can be produced by the Programme manager and provided to outreach workers in order to perform absentee tracing activities.

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with subsequent impact on admission rates of feeding programmes.

[28] Approximated from male/female normal ratio of 0.8-1.2

[29] Formula for calculation: Daily/Weekly attendance (in %) = Number of beneficiaries present each distribution / Number of beneficiaries expected x 100 and for Monthly attendance (in %): Sum weekly attendance / Number of weeks

F. Percentage of beneficiaries requiring inpatient care (i.e. moved-in to SC)

This refers to the beneficiaries moved-out from OTP and moved-in to SC due to deterioration of their nutritional situation and/or medical complications. It is worth noting that beneficiaries 'moved-out from OTP to SC' might include two types of beneficiaries[30]; those that were transferred on the day of admission (because they were "complicated-SAM") which is good OTP practice, AND those who developed "complicated-SAM" or lost weight after some time at the OTP, which may reflect poor practice at the OTP site. In order to distinguish between the two types of moved-out, the number of beneficiaries 'moved-out to SC' the day of admission must be known. The significance of this indicator is similar to the 'transfers to TFP' rate in targeted SFP.

[30] This would depend on programme registration procedures and compliance i.e. whether a SAM case with medical complications diagnosed at the OTP on the day of admission is directly given a referral slip to be admitted at the SC or is first admitted and assigned a SAM number at the OTP before being transferred to the SC.

ANNEXES

Annex 1 Tools for data collection and reporting

This section describes the main data collection and reporting tools for SC, OTP and targeted SFP. Where temples already exist these can be adapted to facilitate the improved monitoring and reporting standards presented in this paper.

Beneficiary cards
Beneficiary cards are used in all three programmes. Standard targeted SFP beneficiary cards can also be used for beneficiaries admitted under the OTP discharge section in TSFP as the same information is collected. However, it should be clearly marked on the card that this beneficiary is a OTP discharge beneficiary.

Most organisations and health services use their own beneficiary cards. See Annex 2 for an example of a targeted SFP beneficiary card from FANTA. Examples of OTP and SC beneficiary cards can be found in manuals from both FANTA and the WHO[31].

The minimum information to record on a card is:

- Identification of the beneficiary: unique identification number (for OTP and SC only) (see below), name, address – in case the beneficiary needs to be visited at home
- Age (in months) or date of birth and sex
- Anthropometry on admission (weight, height, MUAC)
- Criteria used for admission (weight-for-height, oedema, MUAC, BMI, other)
- Classification of admission (new admission, relapse, re-admission, etc.)
- MUAC and weight for each service day
- Anthropometry at discharge (weight, height, weight-for-height, MUAC)
- Exit category (Recovered, dead, defaulter, etc.)
- Dates of entry and exit from the programme

Cards usually contain additional information that is important for beneficiary management and follow up. This may include; follow up of height, clinical description of the beneficiary's status, medical treatments received, vaccination status, breastfeeding status, distribution of non-food items, distance to the feeding site, dates for visits between admission and discharge.

For SAM beneficiaries, effective tracking between the OTP and SC can be aided by use of 'unique identification numbers'[32]. The unique identification number (also known as "SAM number") is assigned at the facility where the beneficiary is first diagnosed and enters into the programme, either the OTP or SC; this number then stays with the beneficiary throughout their recovery. For targeted SFP a unique identification number is not recommended.

Registration books
Individual programmes make different decisions about whether or not to maintain a registration book as well as using beneficiary cards. If registration books are used, when more than one treatment group is admitted at the feeding site it is advised record each group in separate sections of the registration book (e.g. children 6-59 months on pages 1-40, PLW on pages 41-80, TFP-follow up on pages 81-120). See Annexes 7-10 for

[31] *Management of the child with a serious infection or severe malnutrition,* WHO (2000) downloadable at: http://whqlibdoc.who.int/hq/2000/WHO_FCH_CAH_00.1.pdf and *Training guide for Community-based Management of Acute Malnutrition,* FANTA (2008) downloadable at: http://www.fantaproject.org/cmam/training.shtml

[32] See FANTA or Valid International CMAM guidelines for examples of unique identification systems.

model registration books for programme reporting.

The information in the registration books can be used to fill in daily tally sheets and to triangulate information from other sources to cross check for discrepancies or correct reporting errors.

Tally sheet
At the end of each service day, the feeding site supervisor should compile the reporting for the day in a standard tally sheet for each treatment group (Annexes 11-13 provide tally sheets). This information can be obtained directly from the registration book or from the beneficiary cards, if these are kept at the feeding site. See Annex 14 for instructions on how to complete a tally sheet.

Monthly Site Report
At the end of the month the reporting for each feeding site can be compiled by transferring the totals of the tally sheet onto a monthly site report sheet, or through direct data entry into a data base, e.g. CMAM Report, if user capacity and resourcing exists.

Annex 2 Beneficiary card targeted SFP, FANTA 2008

SUPPLEMENTARY FEEDING TREATMENT CARD FOR CHILDREN, EXAMPLE

	Registration no.:	
Name of Child:	Age:	Sex: M / F
Caregiver's Name:	Name of Community Leader:	
Community:	Supplementary Feeding Site:	

ENTRY	Direct New Admission	New Admission, Referred from Inpatient care/ Outpatient care	Referred from Other Supplementary Feeding Site	Re-Admission after Defaulting

ADMISSION		DISCHARGE	
Date		Date	
Weight		Weight	
Height		Height	
WFH		WFH	
MUAC (mm)		MUAC (mm)	
		Length of Stay (days)	
		Status	1. Cured 4. Non-recovered 2. Died 5. Referral 3. Defaulted

DRUGS GIVEN ONCE	DATE	OTHER
Vitamin A		
Mebendazole		
Measles Vaccination		
EPI update		

#	DATE	WEIGHT	HEIGHT	MUAC	WFH	IRON	REMARKS
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							

Annex 3 Monthly site report template – SC

SC

	ENTRIES											EXITS											
		New Admissions						Other entries				Discharges											
																	Non-recovery						
Treatment groups	Total beginning of period	WFH/BMI	MUAC	Oedema	Relapse	Re-admission	Total Admissions	Moved in from OTP	Other	Total IN	Promoted to OTP (moved-out to OTP)	Recovered	Death	Defaulter unconfirmed	Defaulter confirmed	Medical Referral	Non-response	Total Discharges	Other	Total OUT	Total end of period

Cells in white and blue are completed manually. Cells in blue are optional categories and do not have an effect on performance indicator calculations if not used. Cells in yellow are calculated.

Annex 4 Monthly site report template – OTP

OTP

	ENTRIES										EXITS											
		New Admissions						Other entries			Discharges							Moved out				
															Non-recovery							
Treatment groups	Total beginning of period	WFH/BMI	MUAC	Oedema	Relapse	Re-admission	Total Admissions	Moved in from SC/OTP	Other	Total IN	Recovered	Death	Defaulter unconfirmed	Defaulter confirmed	Medical Referral	Non-response	Total Discharges	OTP to SC	OTP to OTP	Other	Total OUT	Total end of period

Cells in white and blue are completed manually. Cells in blue are optional categories and do not have an effect on performance indicator calculations if not used. Cells in yellow are calculated.

Annex 5 Monthly site report template – targeted SFP

TSFP

	ENTRIES								EXITS											
		New Admissions					Other entries			Discharges								Other discharges		
Treatment groups	Total beginning of period	WFH/BMI	MUAC	Relapse	Re-admission	Total Admissions	Moved in from other TSFP sites	Other	Total IN	Recovered	Death	Defaulter unconfirmed	Defaulter confirmed	Non-recovery: Medical Referral	Non-recovery: Transfer to therapeutic programme	Non-recovery: Non-response	Total Discharges	Moved out to other TSFP site	Other	Total OUT	Total end of period

Cells in white and blue are completed manually. Cells in blue are optional categories and do not have an effect on performance indicator calculations if not used. Cells in yellow are calculated.

Annex 6 Monthly site report template – OTP discharges in TSFP

OTP discharges

	ENTRIES & EXITS								
Treatment groups	Total beginning of period	New beneficiaries	Completed programme	Dropouts	Referral to TFP	Death	Other	Total OUT	Total end of period

Annex 7 Registration book - Inpatient Management of Acute malnutrition (SC)

Serial Nb.	Unique ID Nb.	Date of Entry	Name	Address	Sex	Age	Entry information						Exit information					Remarks
							W	H	WFH *(sd)*	Oedema *(Y/N)*	MUAC *(mm)*	Type of Entry *	Date of exit	Type of Exit **	WFH (zs)	MUAC (mm)	Days in SC	
1																		
2																		

*Type of Entry: N = new admission; Rl, = relapse; Rad = re-admission; MiO = moved-in from OTP; O = other

**Type of Exit: POTP= promoted to OTP; R = recovered; D= defaulter; X= death; MR = medical referral; NR= non-response; O = other

Days in SC (length of stay): This is to be filled only for beneficiaries that are promoted to OTP to continue SAM treatment AND for those remaining in SC until recovered from SAM. It is the number of days from Date of Entry until Date of Exit (date when beneficiaries is promoted to OTP or recovered in SC).

Annex 8 Registration book - Outpatient Management of Acute malnutrition (OTP)

Serial Nb.	Unique ID Nb.	Date of Entry	Name	Address	Sex	Age	Entry information: Visit 1						Exit Information						Attendance (weekly visits)		Remarks
																	If recovered				
							W	H	WFH *(sd)*	Oedema *(Y/N)*	MUAC *(mm)*	Type of Entry *	Date of exit	Type of Exit **	WFH *(sd)*	MUAC *(mm)*	Days in OTP	Weight on Exit	Visit 2 Date	..up to Visit 12	
1																					
2																					
Total for attendance																					

*Type of Entry: N = new admission; Rl, = relapse; Rad = readmission; MiSC = moved-in from SC; O = Other

**Type of Exit: R = recovered; D= defaulter; X= death; MR= Medical referral; NR = non-response; MoSC = moved-out to SC; MoOTP = moved-out to other OTP; O = Other

Days in OTP (length of stay): For recovered beneficiaries only. It is the number of days from Date of Entry until Date of Exit.

Weight on exit: This is the weight on the date of exit for those discharged as recovered.

Attendance/weekly visits: On each service day either 1) you will mark the attendance (X = present; O = absent) or 2) you may want to write down the weight on the day of the visit (then absent children would be those without the follow up weight in)

Total for attendance: At the end of each page the total of children present should be noted as total: Present / Absent, e.g. 5 / 2

Annex 9 Registration book - Targeted Supplementary Feeding Programme (TSFP)

Serial Nb.	Unique ID Nb.	Date of Entry	Name	Address	Sex	Age	Entry information: Visit 1					Exit Information						Attendance (weekly visits)		Remarks
																If recovered				
							W	H	WFH *(sd)*	MUAC *(mm)*	Type of Entry *	Date of Exit	Type of Exit **	WFH *(sd)*	MUAC *(mm)*	Days in tSFP	Weight on Exit	Visit 2 Date	..up to Visit 12	
1																				
2																				
																	Total for attendance			

*Type of Entry: N = new admission; Rad = re-admission; Rl = relapse; MiSFP = moved-in from other tSFP; O = other

**Type of Exit: R = recovered; D= defaulter; X = death; NR= non-response; MR = medical referral, TTFP = transfer to TFP, MoSFP = move-out to other tSFP; O= other

Days in tSFP (length of stay): For recovered beneficiaries only. It is the number of days from Date of Entry until Date of Exit.

Weight on exit: This is the weight on the date of exit for those discharged as recovered.

Attendance/weekly visits: On each service day either 1) you will mark the attendance (X = present; O = absent) or 2) you may want to write down the weight on the day of the visit (then absent children would be those without the follow up weight in)

Total for attendance: At the end of each page the total of children present should be noted as total: Present / Absent, e.g. 5 / 2

Annex 10 Registration book – OTP discharges in TSFP

Serial Nb.	Unique ID Nb.	Date of Entry	Name	Address	Sex	Age	Entry information: Visit 1					Exit information					Attendance (weekly visits)		Remarks
							Type of Entry *	W	H	WFH *(sd)*	MUAC *(mm)*	Date of Exit	Type of Exit **	W	WFH *(sd)*	MUAC *(mm)*	Visit 2 Date	..up to Visit 12	
1																			
2																			
																Total for attendance			

*Type of Entry: Tfol = TFP follow up; Chr =Chronic disease; PLW = Pregnant lactating women

**Type of exit: C = Completed; D = Dropped out; Ref= Referral; X = Death; O = other

Attendance/visits: On each service day either 1) you will mark the attendance (X = present; O = absent) or 2) you may want to write down the weight on the day of the visit (then absent children would be those without the follow up weight in)

Total for attendance: At the end of each page the total of children present should be noted as total: Present / Absent, e.g. 5 / 2.

Annex 11 Tally sheet – OTP

Feeding site		**Month**		**Responsible person**	
Location		**Year**		**Organisation/Agency**	

Treatment group	

	Date of Service day	1	2	3	4	5	
	Total beginning of period (V)						**TOTAL**
ENTRIES	WFH/BMI (a)						
	MUAC (b)						
	Oedema (c)						
	Relapse (d)						
	Re-admission (e)						
	Total Admissions (W=a+b+c+d+e)						
	Moved in from SC/OTP (f)						
	Other (g)						
	Total In (Y=W+f+g)						
EXITS	Recovered (h)						
	Death (i)						
	Defaulter unconfirmed (j)						
	Defaulter confirmed (k)						
	Medical Referral (l)						
	Non-response (m)						
	Total Discharges (X=h+i+j+k+l+m)						
	Moved out OTP to SC (n)						
	Moved out OTP to OTP (o)						
	Other (p)						
	Total Out (Z=X+n+o+p)						
	Total end of period (V+Y-Z)	1	2	3	4	5	

Annex 12 Tally sheet – targeted SFP

Feeding site		**Month**		**Responsible person**	
Location		**Year**		**Organisation/Agency**	

Treatment group	

	Date of Service day	1	2	3	4	5	
	Total beginning of period (V)						**TOTAL**
ENTRIES	WFH/BMI (a)						
	MUAC (b)						
	Relapse (c)						
	Re-admission (d)						
	Total Admissions (W=a+b+c+d)						
	Moved in from other tSFP sites (e)						
	Other (f)						
	Total In (Y=W+e+f)						
EXITS	Recovered (g)						
	Death (h)						
	Defaulter unconfirmed (i)						
	Defaulter confirmed (j)						
	Medical Referral (k)						
	Non-response (l)						
	Transfer to therapeutic programme (m)						
	Total Discharges (X=g+h+i+j+k+l+m)						
	Moved out to other tSFP sites (o)						
	Other (p)						
	Total Out (Z=X+o+p)						
	Total end of period (V+Y-Z)	1	2	3	4	5	

Annex 13 Tally sheet – OTP discharges in TSFP

Feeding site		**Month**		**Responsible person**	
Location		**Year**		**Organisation/Agency**	

Treatment group	

Date of Service day	1	2	3	4	5	
Total beginning of period (V)						**TOTAL**
New beneficiaries (a)						
EXITS: No. completed programme (b)						
EXITS: Referrals to TFP (c)						
EXITS: No. of dropouts (d)						
EXITS: Death (e)						
EXITS: Other (f)						
Total Out (Z=b+c+d+e+f)						
Total end of period (V+a-Z)	1	2	3	4	5	

Annex 14 Instructions for completing a Tally Sheet

Annex 12 Tally sheet –targeted SFP

Feeding site	Moringa HF	Month	March	Responsible person	Mrs Mutinta
Location	Moringa town	Year	2012	Organisation/Agency	Hope NGO

Treatment group: 6-59 months

	Date of Service day	12/03	26/03				
	Total beginning of period (V)	30	29				TOTAL
ENTRIES	WFH/BMI (a)	4	12				16
	MUAC (b)	2	5				7
	Relapse (c)	0	2				2
	Re-admission (d)	0	1				1
	Total Admissions (W=a+b+c+d)	6	20				26
	Moved in from other SFP sites (e)	1	0				1
	Other (f)	0	0				0
	Total In (Y=W+e+f)	7	20				27
EXITS	Recovered (g)	4	9				13
	Death (h)	0	1				1
	Defaulter non-confirmed (i)	1	0				1
	Defaulter confirmed (j)	0	0				0
	Medical Referral (k)	0	0				0
	Non-response (l)	1	0				1
	Transfer to therapeutic programme (m)	1	0				1
	Total Discharges (X=g+h+i+j+k+l+m)	7	10				17
	Moved out to other tSFP sites (o)	0	1				1
	Other (p)	1	0				1
	Total Out (Z=X+o+p)	8	11				19
	Total end of period (V+Y-Z)	29	38				

Note: Most OTPs have weekly service rounds. Therefore there will be 4-5 service days to be filled and added together for the reporting month. Sites with many beneficiaries may need more than one service day to complete a service round. In this case one tally sheet per service round can be used, and then added up for the reporting month.

Example: Completing a tSFP tally sheet for March 2012

(use one tally sheet per treatment group)

A. This example is for a tSFP programme for children aged 6-59 months old that is run biweekly.

B. The reporting month of March has two service days (i.e. two service rounds); 12th March and 26th March 2012.

C. At the end of each of these service days (columns 1 and 2) the number of cases in each reporting category (rows related to ENTRIES and EXITS) are entered with the help of beneficiary cards and/or registration books.

D. Total Admissions, Total discharges, Total In, Total Out and Total end of period have to be calculated manually using the formulas provided in the tally sheet (e.g. for Total Admissions add rows a + b + c + d)

E. For calculation of all totals for the reporting month of March 2012, figures for both service days (i.e. columns 12/03 and 26/03) should be added (e.g. for Total In: 7 + 20 = 27) and the result entered in the TOTAL column on the right hand side. These totals will be entered into the monthly site report form or directly into the MRP software.

Annex 15 Calculation and reporting of overall programme outcomes for SC and OTP together

Note: Rows highlighted in grey correspond to the basic analysis level (minimum reporting of *performance indicators*). The letters in capitals only refer to this table and are not connected to any of the tables in the other parts of these guidelines.

		OTP		**SC**		**OTP + SC**	
		Number	%	Number	%	Number	%
EXITS	Promoted to OTP [a]			I	I/Q x 100		
	Discharged recovered (to INS)	A	A/V x 100	J	J/Q x 100	A+J	[A+J]/Y x 100
	Death	B	B/V x 100	K	K/Q x 100	B+K	[B+K]/Y x 100
	Defaulter confirmed	C		L		C+L	
	Defaulter unconfirmed	D		M		D+M	
	Defaulter (confirmed+ unconfirmed)	C + D	[C+D]/V x 100	L + M	[L+M]/Q x 100	C+D+L+M	[C+D+L+M]/Y x 100
	Medical referral	E	E/V x 100	N	N/Q x 100	E+N	[E+N]/Y x 100
	Non-response	F	F/V x 100	O	O/Q x 100	F+O	[F+O]/Y x 100
	Non-recovery	E+F	[E+F]/V x 100	N+O	[N+O]/Q x 100	E+F+N+O	[E+F+N+O]/Y x 100
	Total discharges	V = A+B+C+D+E+F		Q = I+J+K+L+M+N+O		Y= A+B+C+D+E+F+J+K+L+M+N+O	
	Moved-out from OTP to SC [b]	G					
ENTRIES	Moved-in from OTP to SC [b]			P			
	Moved-in from SC to OTP [c]	H					
	% OTP beneficiaries requiring inpatient care [c]		G/[V+G] x 100				
	Defaulter for which the outcome is not confirmed		D/[C+D] x 100		M/[L+M] x 100		D+M/[C+D+L+M] x 100
	Missing beneficiary rate from SC to OTP [d]						[I–H]/I x 100
	Missing beneficiary rate from OTP to SC [d]						[G–P]/G x 100

Table adapted from VALID Manual

[a] These are movements within the programme, not exits. They are therefore not counted when calculating performance for the therapeutic programme as a whole, but they are included to allow monitoring performance in the SC (successfully stabilised in SC and moved-out to OTP to continue SAM nutritional treatment).

[b] These are movements within therapeutic programme and therefore are not included when calculating overall outcomes. They are included here to calculate missing beneficiary rate within programme components and the % of OTP beneficiaries requiring inpatient care.

[c] This is included in order to monitor the percentage of beneficiaries requiring inpatient care (see chapter 8 for details on interpretation)

[d] % of beneficiaries moved from one facility to another facility and that fail to attend the receiving facility within a reasonable period of time. These can only be calculated when there is complete reporting from all the OTPs in the geographical area under review (and excluding OTPs that transfer beneficiaries to SC in another district)

Annex 16 Resources

A. Community Management of Acute Malnutrition (CMAM)

Management of severe malnutrition: a manual for physicians and other senior health workers, WHO (1999) http://whqlibdoc.who.int/hq/1999/a57361.pdf

Community-based Therapeutic Care. A Field Manual, Valid International (2006) http://www.fantaproject.org/ctc/manual2006.shtml

Assessment and Treatment of Malnutrition in Emergency Situations. Manual of Therapeutic Care and Planning for a Nutritional Programme. Action Contre La Faim/Prudhon, Claudine (2002)

Guidelines for the management of the severely malnourished, ACF, Michael Golden and Yvonne Grellety, 2007

The care of Acute, Moderate Malnutrition, Prevention of severe wasting, Targeted Supplementary Feeding Programme. Yvonne Grellety, 2006

MSF nutrition guidelines, MSF 2006

Harmonised Training Package Version 2 update 2011, ENN and Nutrition Works, Module 11 and 12 http://www.ennonline.net/htpversion2/modules

Training guide for Community-based Management of Acute Malnutrition, FANTA (2008) – Module 8 Monitoring and Reporting on CMAM http://www.fantaproject.org/cmam/training.shtml

B. Treatment of severely acute malnourished children < 6 months

Guidelines for the management of the severely malnourished, ACF, Michael Golden and Yvonne Grellety, 2007

MSF nutrition guidelines, 2006 http://medmissio.de/proxy/alfresco-system/api/node/content/workspace/SpacesStore/87c2cbe3-8663-4afb-a56d-33a07d9c0557/test

Infant Feeding in Emergencies, Module 2, Version 1.0, Part 8, ENN, IBFAN, Terre des hommes, UNHCR, UNICEF, WFP, WHO; (2004) http://helid.digicollection.org/en/d/Js8230e/3.html

Infant Feeding in Emergencies. Module 2, Version 1.1. Part 8, ENN, IBFAN-GIFA, Terre des hommes, CARE USA, Action Contre la Faim, UNICEF, UNHCR, WHO, WFP, Linkages (2007) http://www.ennonline.net/resources/4

Management of Acute Malnutrition in Infants, (MAMI Project), ACF, UCL, ENN (2010). http://www.ennonline.net/research/mami

Management of Severe Acute Malnutrition. Module 13: Harmonized Training Package (HTP) Version 2, ENN (2011) http://www.ennonline.net/pool/files/ife/m13-management-of-severe-acute-malnutrition-entire-modeule.pdf

C. Monitoring and Evaluation of CMAM programmes

Training guide for Community-based Management of Acute Malnutrition, FANTA (2008) – Module 8 Monitoring and Reporting on CMAM http://www.fantaproject.org/cmam/training.shtml

Monitoring Feeding Programmes, In: Nutrition Guidelines, MSF, 2006

Community-based Therapeutic Care. A Field Manual, Valid International (2006) http://www.fantaproject.org/ctc/manual2006.shtml

Guidelines for the management of the severely malnourished, ACF, Michael Golden and Yvonne Grellety, 2007

D. MRP/CMAM Report related

Measuring the effectiveness of Supplementary Feeding Programmes in Emergencies. Navarro-Colorado, Carlos, Frances Mason and Jeremy Shoham (2008) Humanitarian Practice Network. Network Paper 63. http://www.ennonline.net/pool/files/ife/measuring-the-effectiveness-of-sfp-odi-networkpaper063.pdf

Development of a Minimum Reporting Package for Emergency Supplementary Feeding Programmes Project. ENN, Save the Children UK (2011) http://www.ennonline.net/pool/files/research/mrp-report-final.pdf