MODULE EIGHT

Monitoring and Reporting on CMAM

MODULE OVERVIEW

This module introduces participants to the basic principles of monitoring, reporting on and supervising community-based management of acute malnutrition (CMAM) services, with a focus on outpatient care.

The module describes how individual children are tracked and monitored in CMAM and how monitoring information and data are collected and reported for the service/programme as a whole. The purpose and function of support and supervisory visits are discussed.

The importance of tracking children between outpatient care and inpatient care, using referral slips, filling in the outpatient care treatment cards and using a simple numbering system has been previously covered. This module focuses on bringing it together through a simple monitoring system.

This module includes practical exercises that will provide participants with the opportunity to practice compiling data and information. It also includes a half day field practice at an outpatient care site to observe registration, tracking, monitoring, reporting and supervision procedures.

Monitoring and reporting on CMAM combines outpatient care and inpatient care information, and performance indicators are based on these combined statistics. The monitoring system from each outpatient care and inpatient care site must be well standardized and coordinated to avoid double counting.

Note: This module does not cover monitoring and reporting on the supply system (e.g., management and transportation of equipment, materials, drugs, therapeutic food) or on human resources.

MONITORING AND REPORTING ON CMAM: CLASSROOM

LEARNING OBJECTIVES	HANDOUTS AND EXERCISES
1. Describe the Principles of a Monitoring System for CMAM	
2. Describe How the Individual Child Is Tracked and Monitored in CMAM	Handout 8.1: Monitoring the Individual Child in Outpatient Care Handout 8.2: Registration Numbering System Proposed for CMAM Handout 8.3 Monitoring and Reporting on CMAM Handout 8.4 Filing Outpatient Care Treatment Cards
3. Complete Site Tally Sheets and Site and District Report; Interpret the Findings	Handout 8.3 Monitoring and Reporting on CMAM Handout 8.5 Site Tally Sheet for the Management of SAM Handout 8.6 Site Reporting Sheet for the Management of SAM Handout 8.7 District or National Reporting Sheet for the Management of SAM Exercise 8.1 (a) Outpatient Care Site Tally Sheet and Site Reporting Sheet Exercise 8.2 Completing Site Tally Sheet
4. Calculate and Discuss Service/Programme Performance and Coverage	Handout 1.2 Terminology for CMAM Handout 8.8 CMAM Indicators Handout 8.9 Principles of Coverage Exercise 8.1 (b) Outpatient Care Site Reporting Sheet
5. Monitor and Respond to Barriers to Access	Handout 8.10 Monitoring Barriers to Access Exercise 8.3 Community Meeting Role-Play
6. Explain the Purpose of Support and Supervision Visits and the Role of a Supervisor/Mentor	Handout 8.11 Support and Supervision for CMAM Handout 8.12 Support and Supervision Checklist for Outpatient Care Handout 8.13 Support and Supervision Checklist for Community Outreach Exercise 8.4 Analysis of Site Reports of Three Outpatient Care Sites and One Inpatient Care Site OPTIONAL: Supplemental Reference 8.1 Setting Up a CMAM Monitoring System Using an Electronic Database in Excel
7. Prepare an Outline for CMAM Reporting	Handout 8.14 Guidance on CMAM Reporting
Wrap-Up and Module Evaluation	

MATERIALS

- Handouts
- Calculators
- Flip charts
- Markers, masking tape
- Copies of outpatient care treatment cards
- *Community-Based Therapeutic Care (CTC): A Field Manual*
- Report on *the International Workshop on the Integration of Community-Based Management of Acute Malnutrition* (Washington, D.C., April 28-30, 2008)
- Copies of **Handout 1.2 Terminology for CMAM**, **Handout 4.1 Admission Criteria and Entry Categories** and **Handout 4.17 Discharge Criteria and Exit Categories**

ADVANCE PREPARATION

- Room setup
- Create individual role-play cards for Group Exercise B: Community Meeting Role-Play

MODULE DURATION: FOUR HOURS IN CLASSROOM, HALF-DAY FIELD PRACTICE

Note: Depending on the needs of their audience(s), trainers may skip or spend more or less time on certain learning objectives and activities. The module duration is an estimate of the time it takes to complete all the learning objectives and activities.

LEARNING OBJECTIVE 1:
DESCRIBE THE PRINCIPLES OF A MONITORING AND REPORTING SYSTEM FOR CMAM

Review **Handout 4.1 Admission Criteria and Entry Categories** and **Handout 4.17 Discharge Criteria and Exit Categories.** Note these handouts are to be used for reference throughout the module. Refer Modules 4-6 for additional review of admission and discharge criteria if necessary.

GROUP DISCUSSION: RATIONALE AND PRINCIPLES FOR CMAM MONITORING AND REPORTING SYSTEMS.

Ask participants to brainstorm the following questions:

1. **What are the key aspects of monitoring and reporting on CMAM?**

   Fill in the gaps in the discussion with the following information: To monitor a CMAM service effectively, you will need to:
   - Monitor the individual child
   - Monitor and report on the effectiveness of the service as a whole
   - Supervise and support the health care providers

2. **Why do we monitor CMAM services?**

   Fill in the gaps in the discussion with the following information: Monitoring helps to identify what is working well (strengths), what is not working and where there might be gaps (weaknesses). With this information, weaknesses and gaps can be addressed.

   - In CMAM, the individual child is monitored to ensure that children are treated appropriately and effectively, which helps to continually improve the services the children receive.
   - Health care providers are supervised and supported to maintain their skills and ensure a successful service that treats all children with severe acute malnutrition (SAM) effectively.

3. **What are some characteristics of an effective health management information system (HMIS)?**

   Fill in the gaps in the discussion with the following information: An HMIS must be simple to minimize the demands on health care providers but provide sufficient useful information to ensure service/programme effectiveness and to allow health managers to make decisions and adjustments. An HMIS should complement--not duplicate--existing systems. An HMIS that includes reporting on cases of SAM might already exist, and/or the Ministry of Health (MOH) or UNICEF might have reporting requirements for reporting on acute malnutrition.

4. **Who should be responsible for monitoring and reporting on CMAM? Who should supervise the CMAM service/programme in your districts?**

   Fill in the gaps in the discussion with the following information: This will differ for each district. But for each aspect of monitoring, it is important to determine in advance who specifically is responsible for collecting and documenting the data and who specifically is responsible for reporting.

LEARNING OBJECTIVE 2:

DESCRIBE HOW THE INDIVIDUAL CHILD IS TRACKED AND MONITORED IN CMAM

Become familiar with **Handout 8.1 Monitoring the Individual Child in Outpatient Care, 8.2 Registration Numbering System Proposed for CMAM, Handout 8.3 Monitoring and Reporting on CMAM** and **Handout 8.4 Filing System for Outpatient Care Treatment Cards**.

ELICITATION: INFORMATION AND TOOLS FOR INDIVIDUAL MONITORING.

Ask participants what tools they have encountered in their training that could help track children in CMAM. How do each of these tools help? Fill in the gaps with the tools described below:

- A child's unique registration number
- Outpatient care treatment card: Each child's medical history, physical examination, anthropometry, appetite, medical treatment and nutrition rehabilitation are monitored on an outpatient care treatment card. Progress of individual treatment is recorded through clinical signs, the mother/caregiver's report of illness and anthropometry (mid-upper arm circumference [MUAC] and weight).
- Ready-to-use therapeutic food (RUTF) ration card: The provision of RUTF per session is calculated based on the child's weight of the child and is recorded on an RUTF ration card, along with the session frequency
- Referral slips: These forms, which use the child's unique registration number, are used to refer children from outpatient care to inpatient care and vice versa.

Refer participants to **Handout 8.1 Monitoring the Individual Child in Outpatient Care**. Ask participants what other information is necessary to monitor a child admitted to CMAM. Ask who is responsible for monitoring. Ask them to find the answers in **Handout 8.1**

PARTICIPATORY LECTURE: REGISTRATION NUMBERS.

Note to participants that individual children enrolled in CMAM are tracked within outpatient care and when referred to other services. This ensures that admission, discharge and treatment procedures are followed and documented correctly, which allows health care providers to follow cases of children as necessary.

Children with SAM are registered upon admission to CMAM at the site where they first present and are assigned a unique registration number. This number is noted on their treatment card or health card (or in the registration book if one is used) and is used to track the child while she/he is enrolled in CMAM.

GROUP DISCUSSION: REGISTRATION NUMBERS.

Draw the numbering system in **Handout 8.2 Registration Numbering System Proposed for CMAM, Table 1** on a flip chart. Explain that a standard numbering system for CMAM (**Example 1**) has three parts: the health facility's name or code, the child's individual number and a code representing the service where the child first received treatment. Compare this with the HMIS numbering system for Malawi (**Example 2**). Ask participants if their country uses an HMIS numbering system or another numbering system for other interventions. Discuss how these might differ from the standard numbering system for CMAM. Discuss the bullet points on **Handout 8.2** and answer any questions. Emphasize that numbering systems can vary per country, therefore consultation with the national guideline is essential. Also note that when establishing CMAM, its numbering system should be compatible with the registration numbering system already in place.

LO.2

PARTICIPATORY LECTURE: CLASSIFYING CHILDREN INTO ENTRY AND EXIT CATEGORIEs. Explain to participants that children in CMAM are tracked among services and are not double-counted. Refer participants to **Handout 8.3 Monitoring and Reporting on CMAM, Part A** for more information. This information and the remainder of **Handout 8.3** will be covered further in **Learning Objective 3: Complete Site Tally Sheets and Site and District Reports; Interpret the Findings**.

- **Classifying Entries:** At entry, the child with SAM is classified as a new admission age 6 to 59 months (optional: admission criteria recorded), as a new "other" admission (adults, adolescents, children >5 years, infants < 6 months) or as an old case (when referred from inpatient or outpatient care or when returning after defaulting). A relapse is classified as a new admission, which will be indicated on the outpatient care treatment card.

  Ask participants what tools they have encountered in their training that can help determine which category each child falls into and how to track him/her (e.g., CMAM admission criteria, CMAM entry categories, outpatient care treatment cards). Tell participants that they will shortly learn about other tools to help them with classification and tracking: filing treatment cards in binders and completing site tally sheets and site reporting sheets.

- **Classifying Exits:** On exit from outpatient care, each child is categorized as discharged as cured, died, defaulted or non-recovered; this is also indicated on the outpatient care treatment card and tallied. Ask participants again what tools they have encountered in their training that can help determine which category each child falls into and how to track him/her (e.g., CMAM discharge criteria, CMAM exit categories, outpatient care treatment cards, binders, site tally sheets). Referrals to inpatient care or outpatient care are a separate exit category.

  Note: Children who are referred between outpatient care and inpatient care are considered discharged from the site but NOT from the service/programme. They are registered at the new site using their unique registration number and may return to their original site; their status is "referred." Children who are not recovering are referred for further medical investigation as soon as the condition is diagnosed and exit from CMAM as non-recovered only if they do not reach the discharge criteria after four months of treatment. Children referred to outpatient care from supplementary feeding because their condition has deteriorated are considered new admissions.

REVIEW: OUTPATIENT CARE TREATMENT CARDS.
Distribute copies of outpatient care treatment cards to participants. Review where anthropometry, medical history, physical examination, appetite test, medical treatment and nutrition rehabilitation information for each child are entered. Review the back of the card where information on referrals and discharges (children who were cured, died, defaulted or did not recover) should be entered. Remind participants that health care providers and supervisors should review the outpatient care treatment cards regularly to ensure that current protocols are followed.

PARTICIPATORY LECTURE: FILING OUTPATIENT CARE TREATMENT CARDS.
Explain to participants the importance of having a clear and accessible filing system for outpatient care treatment cards that makes tracking active and exited cases simple and allows for quick reference. Outpatient care treatment cards should be organized in binders or files that remain in the health facility and should be accessible at all times. Active and exited cases should be separated into two binders or sets of files with dividers. The active cases binder or files include cards for all children currently enrolled in CMAM services at that site. Cards in the exited cases binder or files are organized according to exit category. Staff should review the binders or files weekly.

PRACTICE: FILING OUTPATIENT CARE TREATMENT CARDS. Draw a table with two columns on the flip chart. Mark the first column heading as "Active Cases" and the second column as "Exits." In plenary, ask participants which column each of the following classifications belongs in:

- Children currently in outpatient care (Active Cases)
- Cured (Exits)
- Died (Exits)
- Non-recovered – those who have not reached discharge criteria after four months of treatment (after medical investigation) (Exits)
- Absentees – those who have missed one or two outpatient care follow-on visits (Active Cases)
- Defaulted – those who have missed three outpatient care follow-on visits (Exited)
- Referrals awaiting return – those who have been referred from outpatient care to inpatient care (Exited temporarily the site, not the service/programme) or for medical investigation (Active Cases)
  (Note to participants that when the child returns after defaulting or referral, the same outpatient care treatment card is used.)

Distribute copies of **Handout 4.1 Admission Criteria and Entry Categories, Handout 4.17 Discharge Criteria and Exit Categories** and refer participants to **Handout 8.4 Filing Outpatient Care Treatment Cards** for reference. Discuss the active cases or exits categories if questions arise.

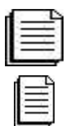
LEARNING OBJECTIVE 3:

COMPLETE SITE TALLY SHEETS AND SITE AND DISTRICT REPORTS; INTERPRET THE FINDINGS

Review **Handout 8.3 Monitoring and Reporting on CMAM** and become familiar with **Handout 8.5 Site Tally Sheet for the Management of SAM**, **Handout 8.6 Site Reporting Sheet for the Management of SAM**, **Handout 8.7 District or National Reporting Sheet for the Management of SAM**, **Exercise 8.1 Outpatient Care Site Tally Sheet and Site Reporting Sheet** and **Exercise 8.2 Completing Outpatient Care Site Tally Sheet**.

PARTICIPATORY LECTURE: ROUTINE DATA COLLECTION. Routine service data are recorded on **site tally sheets** at each site, based on quantitative data recorded after each session. The site tally sheets are compiled in **site and district reporting sheets**. **District reports** combine the information from the different health facilities in the district that provided CMAM services. District reports inform the **national reporting sheets and report system**. The CMAM reporting systems can be a compilation of reporting sheets (hard copies) or entered in an electronic database (excel spreadsheet). . Emphasize to participants the importance of inpatient and outpatient care sites using standardized reporting sheets so that the service's overall effectiveness can be precisely monitored.

Note: At the end of every outpatient care session outpatient care treatment cards for new admissions and new exits are used to fill the site tally sheet for that session. **New admissions** are tallied based on their entry category (per admission criterion and age group or per age group only). **New exits** are tallied based on their exit category (cured, died, defaulted, non-recovered). Depending on the site tally sheet used, referrals from inpatient care to outpatient care could be tallied as an admission (under referral from inpatient care) or separately from new admissions as "moved in."



GROUP DISCUSSION: QUANTITATIVE DATA FROM SITE TALLY SHEETS. Ask participants if they have ever used tally sheets in their work and, if so, what they were using the tally sheets to track. Refer participants to **Handout 8.5 Site Tally Sheet for the Management of SAM** and ask them to examine how the outpatient care site tally sheet considers the quantitative data they record. While referencing the sheet, ask participants where the following categories of children would belong:

- Children under 5 who are referred from supplementary feeding and sent to outpatient care because their condition has deteriorated (**Answer:** classified as "new case' admission 6-59 months)
- Defaulters who exited from the service but returned to outpatient care and had not yet met the discharge criteria
(**Answer:** classified as 'old case' admission: from outpatient/inpatient care or returned defaulters)
- Children who return to outpatient care from inpatient care or vice versa
(**Answer:** classified as 'old case' admission; from outpatient/inpatient care or returned defaulters)

- Children who are moved from one outpatient care site to another to continue their treatment (**Answer:** classified as 'Old case' admission from outpatient/inpatient care or returned defaulters on the outpatient care site tally sheet of new site, and classified as exit as 'referral to outpatient care/inpatient care' on the tally sheet of the old site)
- All children who are admitted to inpatient care after spending some time in outpatient care
(**Answer:** classified as "old case" admission, "to outpatient/inpatient care" on the inpatient care site tally sheet)
- Children with SAM and medical complications who present directly at inpatient care (**Answer:** classified as "new admission 6-59 months" on the inpatient care site tally sheet)
- Children with SAM and medical complications who first present at the outpatient care site, are admitted and classified after registration and start of treatment and then referred to inpatient care
(**Answer:** classified as 'old case' admission from outpatient/inpatient care or returned defaulters" on the inpatient care site tally sheet since they were admitted and exited at the outpatient care site, thus classified twice, once as 'New case' admission and once as 'Referral' exit on the outpatient care site tally sheet), which avoids double-counting)

Ask participants if they can think of additional quantitative data that that might be helpful to capture on these sheets. Ask where they could find the information (e.g., outpatient care treatment cards). Answers could include:

- Gender of new admissions and discharges
- Admission criteria of new admissions
- Average daily weight gain of cured exits
- Average length of stay of cured exits
- Readmission after discharge or relapse

PRACTICE: COMPLETING SITE TALLY SHEET. Refer participants to **Exercise 8.1(a) Outpatient Care Site Tally Sheet**. Ask them to fill in the total number of admissions and exits per week, as well as the number registered in the service/programme at the end of each week and beginning of each subsequent week. As they work, check their responses against the answer key. At the end check answers by asking participants to call out some of the totals. Answer any questions.

EXERCISE 8.1 (A) OUTPATIENT CARE SITE TALLY SHEET (WITH ANSWERS)

SITE					
	WK 32	**WK 33**	**WK 34**	**WK 35**	**TOTAL**
DATE					
TOTAL START OF WEEK (A)					
New Cases 6-59 m bilateral pitting edema **(B1a)**					
New Cases 6-59 m MUAC/WFH **(B1b)**					
Other New Cases (adults, adolescents, children above 5 y, infants <6 months) **(B2)**					
Old cases: Referred from inpatient care; or Returned defaulters **(C)**					
TOTAL ADMISSIONS (D) [D=B+C]					
Cured **(E1)**					
Died **(E2)**					
Defaulted **(E3)**					
Non-recovered **(E4)**					
REFERRALS TO INPATIENT OR OUTPATIENT CARE (F)					
TOTAL DISCHARGES (E)					
TOTAL EXITS (G) [G=E + F]					
TOTAL END OF WEEK (H) [H=A+D-G]					

PARTICIPATORY LECTURE: MONTHLY SITE REPORTS PER HEALTH FACILITY.
Explain to participants that the site reporting sheet is completed monthly using the site tally sheets. It provides performance indicators for the proportion of children discharged as cured, died, defaulted or non-recovered, in addition to the compiled numbers of total admissions, total exits and total number under treatment.

Note: Explain to participants that the monthly reporting system is based on epidemiological weeks that are agreed on at the national level. Every month has a predefined number of weeks (e.g., January has weeks 1-5, February has weeks 6-9, March has weeks 10-13). This is important because the number of weeks vary per month or can be interpreted differently, which can create reporting errors.

Refer participants to **Handout 8.3 Monitoring and Reporting on CMAM** and ask them to read the information in preparation for the following exercise. Briefly answer any questions.

PRACTICE: COMPLETING SITE REPORTING SHEET. Explain to participants that

they will now enter the information from the site tally sheet onto the site reporting sheet **Exercise 8.1 (b) Outpatient Care Site Reporting Sheet**. Ask them to form pairs. Answer any questions. While they are working, circulate among them and check on their progress using the answers below.

EXERCISE 8.1 (B) OUTPATIENT CARE SITE REPORTING SHEET (WITH ANSWERS)

MONTHLY SITE REPORT FOR MANAGEMENT OF SAM

SITE		**IMPLEMENTED BY**	
TALUKA		**MONTH / YEAR**	
		TYPE OF MANAGEMENT (CIRCLE)	Inpatient Outpatient
DISTRICT		**ESTIMATED MAXIMUM CAPACITY**	
		ESTIMATED TARGET malnourished <5s (based on latest survey data and admission criteria)	
		RUTF CONSUMPTION	**Packets/pots** | **kg equivalent**

TOTAL BEGINNING OF THE MONTH (A)	**NEW CASES (B)**		**OLD CASES (C)** Referral from outpatient or inpatient care, or Returned defaulters	**TOTAL ADMISSION (D)** (B+C=D)	**DISCHARGES (E)**				**REFERRAL (F)** to inpatient or outpatient care	**TOTAL EXITS (G)** (E+F=G)	**TOTAL END OF THE MONTH (H)** (A+D-G=H)
	6-59 m (according to admission criteria) **(B1)**	Other (adults, adolescents, children > 5 y, infants < 6 m) **(B2)**			CURED **(E1)**	DIED **(E2)**	DEFAULTED **(E3)**	NON-RECOVERED **(E4)**			
50	42	1	4	47	30	1	4	3	7	45	52
					78.9%	2.6%	10.5%	7.9%			
				TARGET (Sphere Standards)	**>75%**	**<10%**	**<15%**				

E1: Cured = reaches discharge criteria
E3: Defaulted = absent for 3 consecutive sessions
E4: Non-recovered = does not reach the discharge criteria after investigation)

PRACTICE: COMPLETING SITE TALLY SHEET STARTING FROM OUTPATIENT

CARE TREATMENT CARDS. Explain to participants that they are going to practice compiling information for site tally sheets from outpatient care treatment cards, and for a site report from the site tally sheet. Refer participants to **Exercise 8.2 Completing Site Tally Sheet**. Ask them to form pairs and read the instructions. Answer any questions and, while they are completing the site tally sheet and site report, circulate among the groups to check on their progress.

Check answers against the answer key below, and answer any questions. Emphasize to participants that these reports can take many forms and that it is essential to determine and coordinate with reporting systems used in the country and district they are working in.

EXERCISE 8.2 COMPLETING OUTPATIENT CARE SITE TALLY SHEET (ANSWER KEY)

WEEK 1

Ensure that the "total start of week" section is 0 for Week 1. The participants should add the three cases (information on outpatient care treatment cards) to the RHC row. In the admission section, outpatient care cases 1, 2 and 3 should be added to the "New 6-59 months SAM" box.

The tally sheet for Week 1 should read: three MUAC admissions, three total new admissions. There are no exits for Week 1.

WEEK 2

In Week 2, the "total in outpatient care at the start of the week" box is updated with the information from Week 1 (three cases). In the admissions section, outpatient care case 4 should be added to the bilateral pitting edema box and to the "referred to inpatient care" section under exits because the child has bilateral pitting edema +++ and requires inpatient care. The child has been entered and exited from the RHC and is now being treated in inpatient care. Outpatient care case 5 should be added to the "weight-for-height [WFH] < 70% of the median" new admission box.

The tally for Week 2 should read: three in outpatient care at start of week, one bilateral pitting edema admission, one WFH admission, one exit as referral to inpatient care, two total admissions, one exit as a referral and four totals in outpatient care at end of week.

WEEK 3

In the Week 3 tally sheet, the total in outpatient care at the start of the week should be four. In the admission section, outpatient care case 6 should be added to the bilateral pitting edema box. This case does not require inpatient care because the child has bilateral pitting edema ++, which can be treated in outpatient care. There is also one MUAC admission (no card available).

The tally for Week 3 should read: Four total in outpatient care at start of week, one bilateral pitting edema admission, one MUAC admission,

two total admissions, no discharges, no total discharges, six totals in outpatient care at end of week.

WEEK 4
In the Week 4 tally sheet, the total in outpatient care at the start of the week should be six. The bilateral pitting edema +++ case that was referred to inpatient care returns to outpatient care this week and should be added to the admission as an old case "from outpatient/inpatient care" box.

The tally for Week 4 should read: Four new admissions: three MUAC cases and one WFH as a percentage of the median case. The total in outpatient care should be 11.

EXERCISE 8.2 NASIRABAD OUTPATIENT CARE SITE TALLY SHEET (WITH ANSWERS)

HEALTH FACILITY NAME	Rural Health Centre
DISTRICT	Qambar/Shehdadkot
SITE	Nasirabad

WEEK	**WK 1**	**WK 2**	**WK 3**	**WK 4**	**TOTAL**
DATE					
TOTAL START OF WEEK (A)	0	3	4	6	
New Cases 6-59 m Bilateral Pitting Edema **(B1a)**		1	1		
New Cases 6-59 m MUAC/WFH **(B1b)**	3		1	3	
Other New Cases (adults, adolescents, children > 5 y, infants <6 months) **(B2)**		1		1	
Old cases: Referred from inpatient care; or Returned defaulters **(C)**				1	
TOTAL ADMISSIONS (D) [D=B+C]	3	2	2	5	12
Cured **(E1)**					
Died **(E2)**					
Defaulted **(E3)**					
Non-recovered **(E4)**					
REFERRALS TO OUTPATIENT OR INPATIENT CARE (F)		1			1
TOTAL DISCHARGES (E)	0	0	0	0	0
TOTAL EXITS (G) [G=E + F]	0	1	0	0	1
TOTAL END OF WEEK (H) [H=A+D-G]	3	4	6	11	11

LEARNING OBJECTIVE 4:

CALCULATE AND DISCUSS SERVICE/PROGRAMME PERFORMANCE AND COVERAGE

Refer back to **Handout 1.2 Terminology for CMAM** and to **Exercise 8.1 (b) Outpatient Care Site Reporting Sheet**. Become familiar with **Handout 8.8 CMAM Indicators** and **Handout 8.9 Principles of Coverage**. **PAIR WORK AND GROUP**

DISCUSSION: MONITORING SERVICE

PERFORMANCE OF CMAM. Explain to participants that site tally sheets and site reports with summarized performance indicators per site are important tools to monitor trends in that particular site. They provide a look at admissions and performance to see if particular areas need investigation or support.

Divide participants into pairs and ask them to refer back to **Exercise 8.1(b) Outpatient Care Site Reporting Sheet.** Have the pairs calculate the percentages that each exit category (**Discharges [E]**) comprises of the total exits (**Total Exits [G]**). Explain that analysis of the site reports provides information about the performance of the CMAM service for the individual health facility and the district as a whole. The admission and summarized performance indicators can point to areas that need investigation and support. For example, they might find that the service has very high default rates. Once known, ways can be found to address the problems and strengthen the service.

Ask the pairs to draw any conclusions they can from the data. Discuss in plenary.

Note to participants that Sphere minimum standards might not apply to (or be realistic for) CMAM services operated by the MOH as part of routine health services. However, in the absence of other comparisons, Sphere minimum standards can be used as benchmarks to determine performance and service quality.

BRAINSTORM: INDICATORS FOR OUTPATIENT CARE. Ask participants, still

working in pairs, to take five minutes to list performance and output indicators for outpatient care. Remind participants of the work they did in developing logical frameworks in **Module Seven**. Ask one pair to share some indicators and ask other groups to share only additional information. Write responses on the flip chart.

READING AND REVIEW: CMAM INDICATORS. Refer participants to **Handout 8.8**

CMAM Indicators and ask them to read quietly. When they have finished, ask them if they have any modifications for the indicators identified in the exercise above.

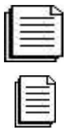
GROUP DISCUSSION: PROGRAMME EFFECTIVENESS. Ask participants how the CMAM service/programme is effective. Follow up by asking participants whether the CMAM service/programme can be considered effective if only half the children who require treatment actually access it. (Service performance plus coverage determines programme effectiveness).

PARTICIPATORY LECTURE: COVERAGE. Explain to participants that it is important to determine coverage levels to see whether the service/programme is reaching children who need treatment. Coverage is one of the most important indicators of how well a service is meeting needs. A service might be of very good quality, with very few deaths, low default rates and high recovery rates. But, if the service is reaching only 30 percent of the children who need treatment, then it cannot be considered successful. The aim is to achieve both good quality and good coverage.

LO.4

Ask participants to read **Handout 8.9 Principles of Coverage**. Pay particular attention to the graph in **Figure 1**, noting the direct correlation between coverage rate, recovery rate and met need. Remind participants that they can use **Handout 8.9** as a reference in their own work. Coverage is expressed as a percentage. If there are 100 children with acute malnutrition living in a service area and 70 of them are in the service, then coverage is 70 percent.

Ask participants to refer to **Handout 1.2 Terminology for CMAM** and read the definition of "coverage ratio." Ask if there are any questions.



PARTICIPATORY LECTURE: COVERAGE SURVEYS. Explain that coverage is usually determined by conducting a coverage survey. A coverage survey methodology called **centric systematic area sampling** (CSAS) has been used in CMAM services. For more information on CSAS, refer participants to *Community-Based Therapeutic Care (CTC): A Field Manual*. Other sampling methods are under development and are discussed in the report on the 2008 *International Workshop on the Integration of Community-Based Management of Acute Malnutrition*; refer participants to that document for further information.

Coverage surveys can provide a lot of information about why children do not attend the service, why some might be excluded and what the possible barriers to access are. However, coverage surveys are costly and require specially trained staff. The need to find simple mechanisms to gauge coverage levels in situations where coverage surveys are not practical or feasible is recognized. Simplified coverage survey methods are being developed and tested.

In the absence of coverage surveys, some services have used simple, somewhat crude, methods to monitor coverage based on targets calculated for the total number of children expected to enroll. Others have used the number of children screened, referred or admitted as proxies. These are not ideal indicators, but they might provide some useful information when a coverage survey is not feasible.

Ask participants to refer to **Handout 1.2** and to read the definition for "coverage," Ask if there are any questions.

LEARNING OBJECTIVE 5:

MONITOR AND RESPOND TO BARRIERS TO ACCESS

Become familiar with **Handout 8.10 Monitoring Barriers to Access** and **Exercise 8.3 Community Meeting Role-Play.**

GROUP DISCUSSION: BARRIERS TO ACCESS. Ask participants to speculate on possible reasons for poor coverage. Discuss how views and perceptions of the service can play a part in poor service uptake. Discuss barriers to access and remind participants of the work they did in the community assessment in Module Three. Review if necessary.

Ask participants to read **Handout 8.10 Monitoring Barriers to Access**; answer any questions.

ROLE-PLAY. INVOLVING THE COMMUNITY. Introduce the exercise to the participants by reading aloud the following introduction:

> The site report from the outpatient care at Health Facility 22 (Badin district) shows a high default rate (20 percent) and a high death rate (12 percent). The health care providers at the outpatient care site are concerned about this. They also know that the mothers/caregivers of many of the children that they referred to inpatient care at the district hospital refuse to go; the health care providers suspect that the high default and mortality rates are linked to this. The nurse asks the community health worker (CHW) to organize a community discussion to get to the bottom of these issues and try to find ways to address them.

Ask for nine volunteers and assign these roles: an outpatient care nurse, a CHW and a community volunteer involved in community outreach for CMAM, two mothers, a father, a grandmother of children under treatment in CMAM, a community elder and a traditional healer. **Exercise 8.3 Community Meeting Role-Play** (on the next page) describes the roles. Give each volunteer a card describing her/his role (prepared in advance) and ask them to start the "community meeting." Tell them that roles can be adapted and they should feel free to improvise.

After 20 minutes, ask participants how they would use what they learned from the community meeting to make changes to the services. Refer to **Exercise 8.3 Answer key** at the end of this learning objective to guide the discussion.

EXERCISE 8.3 COMMUNITY MEETING ROLE-PLAY

Outpatient Care Nurse: You are a nurse at the health facility in charge of outpatient care and ask the LHWs to explore the issues that lead to high default and death rates. You also take an active role in reviewing outpatient care treatment cards and monitoring reports to identify possible causes for poor performance.

CHW: You note that the people in your community refuse to go to the hospital for inpatient care for several reasons: They do not like the hospital; they are afraid they will have to pay for the services; they have no transportation or cannot cover the costs; or they do not want to leave their other children. Refusal to go to the hospital is why several children have died.

Community Volunteer: You are a very active volunteer. There are many defaulters in your area because it is in a part of the district that is farthest from the outpatient care site. You think that either an outpatient care site closer to your community is needed or that people from your area should be able to come to the existing site every two weeks instead of every week. Because there is no other health facility in your area, you wonder if a nurse can use the health facility motorbike and bring the RUTF directly to your area. There also are some issues with referrals using bilateral pitting edema and the MUAC tape. Sometimes you send a child because she/he has bilateral pitting edema or the MUAC reading is red, but the nurse makes a different decision and sends the child home. You think that volunteers need more training to prevent these discrepancies and feel that if a volunteer refers a mother/caregiver and child to CMAM services, the child should be admitted.

Mother 1: You like the CMAM services and know that other people's children got better in the service. Your son had swelling on his feet and legs. You took him to the clinic and got the peanut paste and medicine. You shared the peanut paste with your six other children because it is the hungry season and there is not much food in the house. Your sick son ate maize as well as some of the peanut paste, but the maize was not so good because it had been stored for a long time. After three weeks, your son became very swollen all over his body, and when you went for the outpatient care follow-on session, the nurse wanted to send you to the hospital. It is very far away, and everyone you know who goes there dies. The hospital costs a lot of money, and you have no transportation. You want your son to get better in outpatient care, not in the hospital, and you do not understand why the nurse said your son needs to go there. Last week, you did not take your son to the outpatient care site because you didn't want to be told to go to the hospital again.

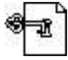
Mother 2: You were referred to CMAM services by community volunteers. They took a measurement of your daughter using a tape and then put their thumbs on her feet. They said that she had swelling on her feet and that you should take her to the outpatient care site. When you got there, the nurse measured your daughter and looked at her feet again. The nurse said she was fine and did not need to be in the service. You were angry and told everyone not to bother with this service. You know nearly every mother in your village.

Father: Your baby twins are in outpatient care. One twin was sick and the other was not, but they both received the special food. The sick one took the medicine given to her in outpatient care and recovered well. You live far from the outpatient care site, and your wife has to carry both children on her back to get them to the site. She had to miss three weeks at the outpatient care site because of the distance. A community volunteer visited you and your wife and told you how important it was to take the children back to the clinic. So, your wife went back the next week, and the children continued to recover. You know other people from your area who are attending the service but do not go every week because it is too far away. One child from your area died because he got suddenly very sick and the family could not get him to the clinic in time. You wonder if it is possible to go to the clinic every two weeks instead of every week. You are very happy with the services and have told the men in your village to send their wives and children to the outpatient care site.

Grandmother: Your daughter died and you were left with four of her children, including the youngest—a four-month-old baby. The baby got very sick and thin. You tried feeding the baby cow's milk mixed with water, but the baby got worse. You took the baby to the health facility and they referred you to outpatient care. The nurse told you that the baby was dehydrated and very malnourished (thin) and needed attention at the hospital. You cannot get to the hospital or stay there because of the other children at home and because you are old and cannot walk far. Two days later, the baby died.

Community Elder: You like the CMAM services. You remember the bad time three years ago when people came and set up tents, and all the swollen and thin children were supposed to go there. Many of them did not go, and many of them died. Now mothers/caregivers can take their children to the outpatient care site at the nearby health facility and get the treatment; everything is good. You have listened to what the others have said about the problems with getting to the hospital. You suggest that the village health committee set up a fund to help provide transportation to the hospital for mothers/caregivers and children who need it.

Traditional Healer: At first, you were very resistant to the idea of the CMAM services and wondered what this strange peanut paste was. Usually mothers and fathers would bring their children to you first and go to the health facility as a last resort. You have your own traditional treatment for thin and swollen children. However, you have seen the children getting better when they go to the health facility. The CHW has taken time to explain to you how CMAM services work, and the community volunteers have shown you a lot of respect. They asked for your help in sending thin or swollen children to CMAM services. You agree with the community elder. You think the village health committee (in which you have a key role) should meet to discuss setting up a transportation fund. You also think that people coming from faraway areas should only have to go to outpatient care sites every two weeks and that the volunteers should send them to the health facility if there is any problem between sessions.



EXERCISE 8.3 ANSWER KEY

Possible service adjustments based on group discussion with community members:

Communications

- Make a better effort to explain that enrolment in outpatient care does not always involve referring the mother/caregiver and child to the hospital (because the fear of outcomes there and of the cost is apparently very strong in the community). Be sure to explain that outpatient care is free.
- Make sure that volunteer case-finders are taking care to explain that after the child's medical condition is evaluated at the outpatient care site, the child might need referral to inpatient care if her/his condition is serious. Most children will be treated as outpatients.
- Reiterate that RUTF is not to be shared. A child who eats all the RUTF gains weight and is less likely to get sick and be referred to the hospital.

Procedures

- To reduce bounced referrals, align both referral and admission around the MUAC entry criterion, if this is not already the case.
- In the short term, allow people from distant villages to return for outpatient care follow-on sessions twice a month and give them two weeks' worth of RUTF.
- In the intermediate term, consider opening more sites to provide weekly outpatient care follow-on sessions within everyone's reach.
- Give volunteers refresher training in bilateral pitting edema and MUAC checks to improve the accuracy of referrals. Consider introducing a referral slip that identifies the referring volunteer to pinpoint the source of inaccurate referrals.
- Institute procedures for case follow-up to ensure that children who miss an outpatient care follow-on session are visited at their homes (follow-up home visit) and that the families are urged to return to the service.
- Give the outpatient care nurse the discretion to keep children with medical complications in outpatient care if, after making the risks clear to the mother/ caregiver, she/he still refuses referral to inpatient care.
- Use the village health committees to establish wider contact with traditional healers to discuss the CMAM service with them, listen to any concerns they have and encourage them to be trained in referring cases of SAM.
- Encourage the village health committees to follow up on the suggestion of establishing a fund to cover costs related to referral between inpatient care and outpatient care (e.g., transportation). Use **Exercise 8.3** as an example of local problem-solving in discussions with other sites and villages.

LEARNING OBJECTIVE 6:

EXPLAIN THE PURPOSE OF SUPPORT AND SUPERVISION VISITS AND THE ROLE OF A SUPERVISOR/MENTOR

Become familiar with **Handout 8.11 Support and Supervision for CMAM**, **Handout 8.12 Support and Supervision Checklist for Outpatient Care**, **Handout 8.13 Support and Supervision Checklist for Community Outreach** and **Exercise 8.4 Analysis of the Site Reports of Three Outpatient Care Sites and One Inpatient Care Site**.

WORKING GROUPS: DEFINING SUPERVISION AND SUPERVISOR RESPONSIBILITIES. Form working groups of five participants. Ask the groups to:

1. To define the term "supervision"
2. List the responsibilities of a supervisor (or supervisory team)
3. Determine who should be responsible for supervision of CMAM in their districts
4. Describe how supervisory visits are usually conducted in their districts and how supervision for CMAM fits into the existing supervision system

Ask one group to share their answers in plenary and other groups to share only additional information. Refer participants to **Handout 8.11 Support and Supervision for CMAM** and ask them to read it quietly and to discuss in their groups any additional information they would add to the previous discussion. Discuss this information in plenary. Note that supervision is not limited to evaluating performance but is a great opportunity to mentor and provide technical support to the staff.

GROUP DISCUSSION: SUPPORT AND SUPERVISION CHECKLISTS. In plenary, ask participants what kind of information they would expect to see on a support and supervision checklist for outpatient care. Remind them, one topic at a time, to think through staffing, admission procedures, medical and nutrition therapeutic care, follow-up for absentees and defaulters, inventory control and discharge procedures. Refer participants to **Handout 8.12 Support and Supervision Checklist for Outpatient Care** and review. Refer them to **Handout 8.13 Support and Supervision Checklist for Community Outreach** for future reference.

WORKING GROUPS: ANALYSIS OF CONSOLIDATED SITE REPORTS. With participants in the same working groups, distribute **Exercise 8.4 Analysis of the Site Reports of Three Outpatient Care Sites and One Inpatient Care Site** and have participants discuss the reports within their groups. Using the site and consolidated reports, ask participants to think through any conclusions that can be drawn about the sites, performance and coverage issues, and what kind of follow-up

information they would need to make appropriate decisions in response. You could suggest that they compare caseloads, common admission criteria, admission and referral patterns, and reasons for and rates of discharge among sites. If appropriate, give an example or two from **Exercise 8.4 Discussion key**, below. Check in with each working group and, if their conversation is lagging, provide them with additional conclusions to determine the key questions to address. When groups have had time to discuss, ask one group to report a conclusion and what additional information is needed, in plenary. Ask another group to provide an additional conclusion, etc.

Note to participants that specific discharge rates from the inpatient care site are not calculated. Children who improve are referred to outpatient care to continue treatment. The specific discharge rates would not reflect poor quality as they include ONLY those children with SAM who had medical complications. This is one reason why the service/ programme must be evaluated as a whole, combining information from both inpatient care and outpatient care as presented in the combined reporting sheet.

EXERCISE 8.4 ANALYSIS OF THE SITE REPORTS OF THREE OUTPATIENT CARE SITES AND ONE INPATIENT CARE SITE (DISCUSSION KEY)

CONCLUSIONS DRAWN FROM REPORTS	QUESTIONS OR POSSIBLE EXPLANATION TO VERIFY
1. Health center B has more patients than the other centers.	1. Is this normal? Does it cover a highly populated area or a very wide area? What are the walking distances to the center? Is this center manageable? Could a second center be opened with existing resources?
2. At health center C, more than half the admissions are from bilateral pitting edema.	2. Is this normal? Are the other health centers neglecting this diagnosis? Or, the opposite—is there an over-diagnosis of bilateral pitting edema here? Is this health center in a different food economy area? Was the same observation made in previous months and in surveys?
3. Out of the overall 246 new admissions, 227 were admitted directly to outpatient care (92.3%) and 19 to inpatient care (7.7%).	3. This could be an indicator of the efficacy of "early detection" and therefore of the quality of community mobilization. It also could indicate that children with serious conditions are hidden at households and are not reached.

CONCLUSIONS DRAWN FROM REPORTS	QUESTIONS OR POSSIBLE EXPLANATION TO VERIFY
4. Health center A is not referring any patients to inpatient care.	4. This could mean that no patients required transfer, but it should be checked through supervision.
5. The death and non-recovered rates in health center A are quite high for outpatient care.	5. This raises questions about the quality of the assessment of patients in this center and the application of and adherence to treatment and action protocols.
6. Health center B's default rate is quite high and warrants follow-up to determine the reasons.	6. Perhaps mothers/caregivers decide not to return because waiting times or walking distances are too long. It will be necessary to visit the center to determine the reasons.
7. Health center C's cured rate is good although there are questions about the non-recovered rate.	7. Is this related to the number of cases with bilateral pitting edema, noted above? Could this be investigated?
8. Overall, 211 children left outpatient care during the month; 200 of these children were discharged. However, 11 were referred back to inpatient care, meaning that the conditions of 5.5% of the children under treatment in outpatient care deteriorated.	8. Why is the condition of children deteriorating when under treatment in outpatient care? Is there compliance to medicine and RUTF protocols? What health and nutrition messages are mothers/caregivers receiving? Are there other underlying health conditions that must be addressed?

9. While 17 children were referred from inpatient care to outpatient care, the outpatient care sites admitted only 14 children referred from inpatient care. Note that 11 patients were referred from outpatient care to inpatient care and 11 admissions are registered in the inpatient care site report as referred from outpatient care.	9. The difference between referrals from inpatient care and admissions to outpatient care could be due to a weak registration system or because some referred children did not go to the outpatient care sites. This observation should trigger closer assessment and supervision of the registration and referral system (e.g., the use of referral slips, the provision of transportation, the messages and explanations given to the mother/caregiver at the time of referral). Note that children who were referred left the site where they were being treated but did not leave the service/programme. The compiled number of cases under treatment in the district is 209, which counts 9 cases less than the sum of the individual report. This difference is due to the 3 missed referrals. Other missed cases may have been in transit while referred across months (Note: this could be a shortcoming in the exercise and if this is repeated at the district level in the field, it should be reported for review of the compilation system).

Note: The specific discharge rates from the inpatient care site are not calculated. Children that improve are referred to outpatient care to continue treatment. The specific discharge rates would not reflect poor quality as they include ONLY those children with SAM that had medical complications. This is one of the reasons why the programme needs to be evaluated as a whole, combining information from both inpatient and outpatient care as presented in the combined reporting sheet, where the performance indicators provide information of the CMAM service in the district for the management of SAM.

LEARNING OBJECTIVE 7:
PREPARE AN OUTLINE FOR CMAM REPORTING

Become familiar with **Handout 8.14 Guidance for CMAM Reporting**

WORKING GROUPS: DISCUSS CMAM REPORTING NEEDS AND DRAFT AN OUTLINE. Form working groups of five participants. Ask the groups to:

1. Discuss needs and use of CMAM reports:

-Who needs and who uses the report for what purposes

-Who prepares the report

2. Draft an outline for minimum reporting on CMAM and discuss the existing monitoring tools and how they feed information into the report

Ask one group to share in plenary and other groups to share only additional information. Refer participants to **Handout 8.14 Guidance for CMAM Reporting**, ask them to read it quietly and to discuss in their groups any information they would add to their outline.

OPTIONAL ACTIVITY

EXTERNAL TRAINING: USING AN ELECTRONIC DATABASE. At the district level, coordinate a special training session on how to set up a CMAM monitoring system using an electronic database in Excel. If possible, ensure that there are sufficient computers available for participants to work in pairs. Become familiar with **Supplemental Reference 8.1 Setting up a CMAM Monitoring System using an Electronic Database in Excel** and have participants review this reference before the activity. Bring copies of completed site tally sheets, site reporting sheets and lists of outpatient and inpatient care sites (with names and locations of health facilities); pass them out to participants. Using **Supplemental Reference 8.1**, go through the setup step by step, making sure that participants understand the content and management of the software.

WRAP-UP AND MODULE EVALUATION

REVIEW LEARNING OBJECTIVES AND COMPLETE EVALUATION FORM.

- Review the module's learning objectives.

In this module you have:

1. Described the principles of monitoring and reporting on CMAM
2. Described how the individual child is tracked and monitored in CMAM
3. Completed site tally sheets and site and district reports, and interpreted the findings
4. Calculated and discussed service/programme performance and coverage
5. Monitored and responded to barriers to access
6. Explained the purpose of support and supervision visits and the role of a supervisor/mentor
7. Prepared an outline for CMAM reporting▪ Ask for any questions and feedback on the module.

- Ask the following review questions:

1. How are individual children tracked in a CMAM service?
2. What information is collected on site tally sheets and site and district reports?
3. What indicators are used to determine service performance?
4. What are the roles and responsibilities of supervisors in outpatient care?

- Discuss and clarify.
- Let participants know that they will have an opportunity to observe procedures and discuss them with staff during the field visit.
- Ask participants to complete the module evaluation form.

COMMUNITY-BASED MANAGEMENT OF ACUTE MALNUTRITION

MONITORING AND REPORTING ON CMAM: OUTPATIENT CARE FIELD PRACTICE FOR HEALTH CARE PROVIDERS

OVERVIEW

- A maximum of five participants should be at each outpatient care site on a given day. Coordinate with as many outpatient care sites as necessary to keep the number of participants at five or fewer.
- This site visit is best conducted on one of the final days of the training, after observing and practicing outpatient care activities at a health facility. Participants must be knowledgeable in all aspects of outpatient care.
- The supervision checklist is long so it can be broken into several sections, allowing different participants to "supervise" different activities during outpatient care.
- Pair participants with someone who speaks the local language.

FIELD PRACTICE LEARNING OBJECTIVES	HANDOUTS TO BRING TO THE OUTPATIENT CARE FIELD PRACTICE
1. Observe and Help the Outpatient Care Site Team Complete Site Tally Sheets from the Individual Outpatient Care Treatment Cards	Handout 8.3 Monitoring and Reporting on CMAM Handout 8.8 CMAM Indicators Handout 8.12 Support and Supervision Checklist for Outpatient Care
2. Review a Site Tally Sheet and the Previous Month's Site Report and Discuss with Staff How to Use and Interpret Data	
3. Review the System for Recording RUTF Distribution and Stock Levels	

PREPARATION FOR THE OUTPATIENT CARE FIELD PRACTICE

- Discuss and review the procedures and steps that participants will undertake at the outpatient care sites:
  - Observe and help the outpatient site team complete site tally sheets from the individual outpatient care treatment cards
  - Calculate the number of clients enrolled in CMAM and double-check it against the number of cards
  - Review a completed site tally sheet and the previous month's site report and discuss what they reveal about the service/programme (e.g., recoveries, defaults, deaths, anything surprising)
- Bring copies of **Handout 8.12 Support and Supervision Checklist for Outpatient Care** in case the outpatient care site does not have any for the participants to complete.

FIELD PRACTICE LEARNING OBJECTIVE 1: OBSERVE AND HELP THE OUTPATIENT CARE SITE TEAM COMPLETE SITE TALLY SHEETS FROM THE INDIVIDUAL OUTPATIENT CARE TREATMENT CARDS

HANDS-ON ACTIVITY AT SITE: Help Outpatient Care site staff Complete site Tally sheets.

OPTIONAL ACTIVITY, IF TIME PERMITS: Review a Sample of Outpatient Care Treatment Cards

- Review samples of outpatient care treatment cards and note the general profiles of the children in the service:
- Are most cases admitted on bilateral pitting edema or low MUAC?
- What are the main ages of children in the service/programme?
- Are there many returned defaulters or relapse cases?
- Do many children come from inpatient care?
- Are many children referred to inpatient care?
- Do many children require follow-up home visits?
- How are follow-up home visits noted on the outpatient care treatment card?

FIELD PRACTICE LEARNING OBJECTIVE 2: REVIEW SITE TALLY SHEET AND LAST MONTH'S SITE REPORT AND DISCUSS WITH STAFF HOW TO USE AND INTERPRET DATA

HANDS-ON REVIEW AT SITE: review SITE tally sheet and discuss recovery and default with staff

- With the outpatient care site staff, review site tally sheet and last month's site report.
- Discuss together recovery and default.
- Discuss with health facility staff:
  - What is the service/program's response to poor recovery, death, and default rates?
  - What is the process for reporting on follow-up home visits in problem cases?
  - What is the system/process for reviewing the cases of children who died that month?
  - What are the challenges with referrals and monitoring of individuals between sites and services?

FIELD PRACTICE LEARNING OBJECTIVE 3: REVIEW SYSTEM FOR RECORDING RUTF DISTRIBUTED AND IN STOCK (AND WHEN/HOW TO PROCURE MORE)

HANDS-ON REVIEW AT SITE: Review with Staff System for Recording RUTF Distributed, In Stock and Procurement

- With staff, review RUTF: distribution, in-stock and procurement.
- Go over a supervision checklist within small groups.
- Fill out (parts of) a supervision checklist based on observed activities linked to supplies at outpatient care.

FEEDBACK ON FIELD PRACTICE SESSIONS

After each field practice, conduct a feedback session in which participants will:

- Provide feedback on strengths observed at each health facility
- Raise issues for clarification by facilitators
- Identify key gaps that need more practice/observation time. Additional classroom time for practice with forms, calculations, etc.
- Discuss how you would mentor the staff to improve performance