**Stabilization Centres (Inpatient care) establishment Guide**

**Northwest Syria**

**A person holding a baby

Description automatically generated with medium confidence**







**Northwest Syria Nutrition Cluster**

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# Abbreviation

|  |  |
| --- | --- |
| SC  SAM  NWS  OTP  PLW  CHW  CVP  ICU  IMCI  IYCF  MAM  MUAC  OTP  RUTF  SD  SFP  UN  UNICEF  VAD  WHZ  WAZ  WHO | Stabilization Center  Severe Acute Malnutrition  North West Syria  Outpatient Treatment Program  Pregnant and lactating women  Community Health Worker  Central Venous pressure  Intensive Care Unit  Integrated Management of Childhood Illness  Infant and Young Child Feeding  Moderate Acute Malnutrition  Mid-Upper Arm Circumference Solution  Outpatient Therapeutic Programme  Ready-to-Use Therapeutic Food  Standard Deviation  Supplementary Feeding Programme  United Nations  United Nations Children's Fund  Vitamin A Deficiency  Weight for Height Z score  Weight for Age Z score  World Health Organization |
| IDP  LOS  AWG | Internally displaced population  Length of Stay  Average Weight Gain |

# Background

More than 10 years of conflict in Northwest Syria (NWS) has led to displacement, economic crisis, water scarcity and Cholera outbreak that is heavily impacting women and children. NWS is home to 4.3 million people including 2.8 million IDPs; 78% of whom are women and children. A total of 1.7 million of these IDPs reside in formal and informal settlements. As the complex and interlinked needs continue to increase across the area, the critical humanitarian response needs to be sustained.

Assessments show that under five Severe Acute Malnutrition (SAM) rate has increased from 1.0% in 2021 (20,000 children) to 1.7% in 2022 (46,000 children) that are most likely to sustain lifetime physical and/or cognitive negative consequences and are at higher risk of dying. Moreover, underlying causes such as increase in cholera cases, scarcity of water services, deteriorated health indicators, poor infant feeding practices and heightened economic situation necessitates scale up treatment and prevention of acute malnutrition among young children to reduce mortality and morbidity in this age group.

Nutrition program data shows that Severe acute malnutrition admissions increased by 48% compared to last year and nutrition cluster has generated evidence that many severely malnourished children remain untreated in the community because of challenging access to health services, security situations and limited coverage of nutrition program due to funding limitations

Areas of high population density, such as over-burdened hosting communities and urban settings, as well as crowded settings like informal settlements, IDP camps, refugee camps, and collective shelters – particularly in the north-west and North-east Syria, remain at high risk for outbreaks of epidemic-prone disease which could further exacerbate the current malnutrition situation Which highlights the increased need where thousands of IDPs reside.

## Purpose of this guideline:

The Purpose of the SC designing/ setting up guideline is to provide guidance on standards in establishing a well-equipped SC and support health and nutrition key partners, program managers and health care professionals in NWS with recommendations on appropriate management of SAM children with medical complication in the health facilities, through providing basis for a consistent set of principles that can be used by all partners for setting up SC within the health facility, and secure functional space for the management of severe acute malnutrition with medical complication. The guide will focus on the required infrastructure, equipment, supplies, and human resources for establishing a SC for the management of SAM children with complication in different settings.

## Rationale

Children who are undernourished start their lives with difficulties. As mentioned above, malnutrition in children contributes to the under-five mortality rate as undernourished child are highly susceptible to infection and disease which needs a longer recovery period. In addition to the increased risk of mortality, undernourishment leads to delay in growth, psychosocial and cognitive development. It is proven that without treatment, children who are affected by severe malnutrition with complication will find it difficult to reach their full potential - if good care is not provided in proper way and they are at higher risk of death if there is no specialized care and area for their stabilization.

Most severely malnourished children die in homes without any care, even when medical care is provided, the mortality rate may be high. Children who suffer from acute malnutrition often die because cases are not diagnosed and treated properly, as the physiology of a severely malnourished child differs from a well-nourished child and need a specialised care hence the need of the SC.

Moreover, to break the transmission of poverty and undernourishment between generations, malnourished children must be reached with proper treatment and SAM children with medical complication need special nursing and special therapeutic treatment provided by trained doctors and nurses on the management of SAM children with medical complication along with improving the skills of mothers and caregivers with proper nutrition practices and psychosocial support. Recognizing this fact, can save many children, if standards and protocols in establishing SCs are applied and if they are compliant with the follow-up treatment for the continuum of care.

## Objectives of SC Services:

* To provide clinical and nutritional management and reduce mortality among children with severe acute malnutrition, particularly among those with medical complications.
* To promote physical and psychosocial growth of children with severe acute malnutrition (SAM).
* To build the capacity of mothers and other care givers in appropriate feeding and caring practices for infants and young children
* To identify the social factors that contributed to the child slipping into severe acute malnutrition (which can enhance referral to needed services) .

## Services provided

The services and care provided for the in-patient management of SAM children include:

* 24 hours Care and monitoring the condition of the child continuously while providing treatment.
* Treatment of medical complications - such as respiratory and skin diseases, oedema and other complications that cause death at any time.
* Therapeutic feeding according to protocol.
* Provide psychosocial support, sensory stimulation and social assessment of the family to identify and address **contributing factors**, including the provision of toys and playgrounds and link beneficiaries to other sectors services based on needs.
* Provide counselling on appropriate nutrition, care and hygiene for mother and child to change lifestyle for the better.
* Demonstrate to mothers/caregivers preparation of energy-efficient baby foods using locally available, culturally acceptable and affordable food.
* The referral of children after stability to the OTP to complete treatment and complete recovery.

# Planning for establishment of SC

Establishment of a SC depends upon:

* Accessibility of inpatient care.
* The prevalence of SAM and expected incidence and **case load** of SAM with medical complications.
* Increased deaths associated with malnutrition and aggravating factors.
* Health facilities with paediatric department working 24h-7 recommended to include a SCs.

**Pre-requisites of establishing and maintaining a SC**

* Existing health infrastructure: Ideally SC is established at Health Facilities with 24 hours with paediatric services to ensure comprehensiveness in approaching a SAM child with medical complication due to the need of daily follow ups, specific treatment and milk preparation, specialised cadre and lab tests.
* Geographic location and access.
* Security and humanitarian access: the safety of mothers and children along with human resources is a prerequisite for establishing SC.
* Availability of resources; human, equipment and financial resources, infrastructure, and guidelines
* Continuous engagement/coordination with local authorities at different levels
* Continuous engagement with the community
* Assessment of the health facility for suitability, coverage, accessibility, bed occupancy and human resource capacity
* Referral system: clear referral system from nearby OTPs to the SC and vice versa for continuation of treatment after discharge from the SC to the OTP. Moreover, a clear referral system for higher level hospitalisation services required for a SAM with complication child if further medical attention is needed.
* IYCF service: counselling and support for optimal infant and young child feeding should be provided, based on general recommendations for feeding infants and young children, breastfeeding and complementary feeding is an integral part of the management of SAM with complication. It is essential to feed the infant with appropriate milk feeds for initial recovery and metabolic stabilisation; however, health workers would provide counselling and encourage breastfeeding, expressed milk if infant is too weak to suckle and provide support for non-breastfed children to re-establish breastfeeding as soon as possible. Support and help to express breast milk

## Calculating bed capacity

**Example:**

**\*The table below is an explanatory and do not reflect the actual situation in NWS.**

|  |
| --- |
| Estimated Total under 5 children with SAM in NWS= 46000    Estimated Total SAM with Medical Complications (10-15%) in NWS= 4600     Average stay in Hospital for management of acute complications is estimated 5 days  Total bed days = 23,000  Total beds required = 63  Agreed upon the average number of beds per SC is a minimum five beds. |

To calculate the total number of beds for each SC, use the following equation:

**Number of SAM with complications cases (10% of total SAM cases) \* average hospital stay /the project time period (Ex: 365 days)**

**Stabilization Centre infrastructure**

A SC is a dedicated unit in a health facility in accordance with the definition and protocols of the World Health Organization (WHO) agreed upon by the Member States in which children with severe acute malnutrition with medical complications according to the specific entry criteria will be treated. The child receives medical and nutritional services until their condition stabilize then they are referred to the outpatient therapeutic phase (OTP) in line with WHO protocols.

The existing health structure normally should be a paediatric hospital with 24 hours’/7 days services and emergency services with a minimum of five beds capacity or a health facility with the capacity needed to provide 24 hours inpatient services.

The SC infrastructure components:

* Specified area for patients 1-2 Rooms (adult beds are kept so that the mother can be with the child with a 1.5meter distance between beds)
* laboratory
* Area to receive cases and take measurements.
* Counselling room to provide specific skilled support to mothers of malnourished children
* **Optional:** Play area for sensory stimulation (audio-visual equipment like TV, DVD player and IEC material).
* **Optional**: Nursing Room.
* **Optional:** A kitchen area to store and prepare therapeutic milk and a suitable space for the preservation of therapeutic nutrition.
* Attached toilet and bathroom facility; for mothers and children along with two separate hand washing areas.
* Intensive care unit room or referral within the hospital
* Store

Civil work requirements for SC for NWS

* Floor surfaces: Floor surfaces should be easy to clean and should minimise the growth of microorganisms.
* **Space between beds is a minimum of 1.5 metres.**
* Walls: As with floors, the ease of cleaning and durability of wall surfaces must be considered. Walls can be brightly painted and decorated and made of material that avoids water retention.
* Water supply: The unit should have a 24-hour uninterrupted running water supply.
* Power supply: The unit should have a 24-hour uninterrupted stabilised power supply. Electrical subscription or could be an electric generator.
* Lighting: The unit should be well-lit.
* Ventilation: heating and cooling should be adequately ventilated. Fans and/or air-conditioning can be used depending on the availability of resources. The heating and cooling system should ensure that temperatures can be maintained to room temperature. children with SAM do not easily regulate their body temperature and thus the room environment should be controlled.
* Mosquitoes and other insects’ screen: Windows should be covered with mosquito and other insect covers.

# Supplies

All medical supplies for saving lives of children including equipment and drugs needs to be available at the SC.

## List of equipment, supplies and Kits

A. Essential ward equipment

|  |  |
| --- | --- |
| Equipment | Number needed / center |
| Thermometers | 2 |
| Weighing scales | 2 |
| infant meter | 1 |
| Stadiometer (to measure standing height) | 1 |
| MUAC tapes including disposable MUAC | 1 pack |
| Suction equipment (low pressure) | 1 |
| Oxygen concentrator | 1 |
| Glucometer | 1 |
| IV stands | 2-3 |
| Reference Z Score charts | 5-6 |
| Clock | 1 |
| Calculator | 1 |
| Beds (adult size) | 5 |
| Mattresses | 5 |
| Bed Linen | 7-10 |
| Blankets | 4-87-10 |
| PPE for cholera and COVID19 | (consumable) |
| Aqua Tabs | (consumable) |

B. Kitchen tools

|  |  |
| --- | --- |
| Tools | Number of items |
| Cooking Gas | 1 |
| Dietary scales (to weigh to 5 gms.), | 1 |
| Water heater | 1 |
| Measuring jars, jugs | 2 |
| electric Blender (or manual whisks), | 1 |
| Water Filter | 1 |
| Refrigerator | 1 |
| Dining table | 1 |
| Large containers (pot) and cooking tools, | 2 sets |
| Kitchen utensils Feeding cups, saucers, spoons, | 7-8 |
| Detergent and Cleaning supplies including soap | (consumable) |

C. Other equipment

|  |  |
| --- | --- |
| Item | Number |
| Storage Cupboard | 1-2 |
| IYCF Corner (Chair, curtains, table( | 1-2 each |
| Office Desk | 1 |
| Chair | 4-5 |
| Working Table for counselling | 1 |
| TV or DVD for education | 1 |
| Toys | Ready set or tools to make toys locally/ECD materials |
| Uniforms for health workers | (consumable) |

## Medication

* F-75
* F-100
* Resomal and ORS
* RUTF
* Amoxicillin
* Ampicillin
* Benzylpenicillin
* Cotrimoxazole (tablets and intravenous)
* Gentamicin
* Metronidazole
* Cloxacillin
* Ceftriaxone
* Mebendazole, albendazole and/or other drugs for treatment of worms

(as on note of drug kit for management of severe acute malnutrition with medical

* complications (See support materials))
* Gentamicin or chloramphenicol eye drops
* Atropine 1% eye drops
* Artemether + Lumefantrine tablets
* Artesunate suppository
* IV dextrose (50%)
* Azithromycin

## Specific consideration

**IV supplies**

* Scalp vein (butterfly) needles, gauge for children (22, 24)
* Poles or means of hanging bottles of IV fluid
* IV fluids – one of the following, listed in order of preference:
  + Half-strength Darrow’s solution with 5% glucose (dextrose)
  + Ringer’s lactate solution with 5% glucose\*
  + 0.45% (half-normal) saline with 5% glucose\*
  + \*If either of these is used, sterile potassium chloride (20 mmol/l) should be added if possible.
* Nasogastric tubes (paediatrics and adults)
* Adhesive plaster
* Syringes (20 and 50 ml for feeds)
* Syringes (2 ml for drugs, 5 ml for drawing blood, 10 ml)
* Sterile needles
* Bandages
* Gauze

**Hygiene for mothers and staff**

* Toilet and hand washing facilities
* Soap for hand washing
* Place for washing bedding and clothes
* Facility for waste disposal
* gloves

**Reference and record keeping**

* Weight-for-Height Reference Card
* BMI- for-age reference charts
* F-75 Reference Card
* F-100 Reference Card
* F-100 diluted reference charts (for children less than 6 months)
* RUTF appetite test chart
* RUTF dosing chart
* Antibiotics Reference Card
* Suitable forms for record keeping, such as the CCP (Critical Care Pathway) or other forms requesting similar information (weight charts, monitoring records)
* 24-Hour Food Intake Charts
* Growth chart
* Patient’s files

**Laboratory resources**

* TB tests (x-ray, culture of sputum, Mantaux)
* Urinalysis
* Stool analysis and culture
* Blood culture
* Cerebrospinal fluid analysis and culture
* Blood sample
* Filter papers
* RDT

**Registers:**

* Nutrition / under-five register
* Laboratory request forms
* Death certificate forms
* Dispensing log

**Resource materials:**

* CMAM/inpatient guidelines
* Drugs BNF (British National formulary), if possible
* IMCI guideline
* Charts/job aides for health education

# Human resources: role and responsibilities

Partners implementing SC must ensure that all medical and nutrition staff recruited are experienced and trained in the management of medical complications.

**Suggested Minimum Standard Staff Requirement per SC:**

**Medical Doctor (G. Physician or Paediatrician)**

Should be a qualified medical doctor trained in inpatient management of SAM S/he will be the overall in-charge of the unit and will be responsible for clinical management of children admitted in the SC, examine each patient every day and will attend to emergency calls as per the need. ( 3 doctors working in shifts).

**Nurse and Medical assistance (one per shift)**

3 nurses at least for five beds will be responsible for nursing care including weight record; measure, mix and dispense feed; give oral drugs; supervise intra venous fluids; assess clinical signs and fill the multi-chart with all the routine information. S/he will chart out specific therapeutic diet plan for each child as per the guidelines in consultation with the Medical Officer. S/he will also be responsible

for monitoring the preparation and distribution of feeds.

**IYCF Counsellor 1**

The provider will counsel mothers/caregivers on IYCF, the emotional needs of her child and encourage them to give sensory stimulation. S/he is also in charge of the structured play therapy.

**Nutritionist** 1

**CNWs** to follow the discharge Child 4

**Psychosocial support workers**

**Data entry**

**Supported staff (Cleaner)**

Cleaners are responsible for managing the cleaning duties. Floors should be cleaned every day with soap and water. toilets should be disinfected with 0.5% active chlorine solution.

\**Note: If there is shortage in medical doctors or paediatric specialists in the facility, doctors who are working as on-calls and trained on inpatient SAM management can cover SC patients.*

*Similarly, if there is shortage of nursing staff, then nursing care can be shared with other the paediatric nurses and/or other departments, provided that the number of admissions does not exceed the national for nurses – patients’ ratio. If IYCF counsellor is not available the nurse or medial assistant in coordination with the physician can carry out the counselling.*

## Capacity strengthening

The severely malnourished child is likely to suffer many serious health problems in addition to malnutrition. In many cases, these problems may not be clinically apparent. In some cases, the usual treatment for a problem may be harmful or even fatal for a severely malnourished child which emphasize the importance of capacity building of health cadres in SCs. It is an essential part of the setup of inpatient facility and it could be formal (initial training, refreshers etc.) and/or informal (on-job training, supervisory visits etc.)

SC training course is a hospital-based training for health personnel and the training manual updated by WHO in 2021. It includes 8 training modules, the course director’s guide, the clinical instructor’s guide, the facilitator’s guide, and supporting materials.

Types of training in SC

* Standard course for inpatient training WHO 2021 for all doctor and nurses/medical assistants.
* Master training of trainers to be executed by nutrition cluster, WHO & UNICEF to create a pool of trainers.
* On-the-job training for any new doctor, nurse, or medical assistants in a stabilisation centre as part of quality improvement.
* Refresher training every 2 years for all staff in SC.
* IYCF training and communication skills

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of training** | **Personnel to be trained** | **Duration** | **Package to be used** | **Place of Training** |
| SC/inpatient | Health workers | 5 to 7 days | training Package on ‘Facility Based Care of Severe Acute Malnutrition 2021 | Hospital with SC |
| IYCF and IYCF -E | Health workers | 3 day | IYCF and YCF training | Training Hall |
| Refresher training | All Staff | 2ays course/2 yrs | All types of training | Training Hall and SC |
| On-job coaching and supportive visits. | All Staff | One day | Gaps according to the visit | Health facility |
| IPC training | All staff | Two days | WHO guidelines | Training Hall |

|  |
| --- |
| **Training on inpatient care of severe acute malnutrition (Foundation)** |
| **Trainees**: Medical Doctors, Staff Nurses (IYCF Counsellor may be included in the training).  **Venue**: Training shall be organized at a medical hospital with at least 5 sick children admitted in the SC  **Duration of training**: 5-7  **Trainers**: Senior paediatricians or well expert physician.  **Participant facilitator ratio**: 6:1  **Number of participants**: 12 -15 per workshop.  **Training Package**: Approved training package |

# Establishment of SCs in exceptional circumstances.

* In limited space in a health facility
* In lower levels of health care without paediatric unit
* Informal camps
* Frontline and highly insecure areas where SCs cannot run 24 hours a day

Establishing a SC in these exceptional circumstances, requires special measures to ensure children with severe acute malnutrition and medical complication have access to life saving service.

In a health facility with limited space, the stabilization structure may be a special room or underground space. However, health workers should be well-trained in the management of medical complications. They should be well trained in treating medical complications.

In very special situations, SC can work during the daytime. In lower levels of health care without paediatric unit and inability to run service for 24 hours a day, “a day care system” could be applied after assessment of a child to ensure initial management of complication and receiving 5-6 times therapeutic formula by trained health worker to promote repair of physiological and metabolic functions and electrolyte balance. 24 hours a day care is not required for all in-patients; therefore, a day care modality could be implemented in health facilities that do not have 24 hours shift, provided that the health worker is properly trained.

If a patient is admitted in a health facility without night shifts the service would be called “residential-day-care”. However, if there is no admission possibility due to the structure of the health facility or limitation of space, a “non-residential day care” would be provided to patients. In this modality, patients who live, or are hosted by family or friends, in the immediate neighbourhood of the facility can come each morning and remain in the facility during the day and then return home at night.

Informal camps can be operated by a day care modality as highlighted above through static infrastructure in the area/room or through mobile team that is deployed daily to the camp; however, a strong referral system should be in place along with transfer support when assessment of a child indicates the need of 24 hours services.

For all admitted children, they should continue treatment as outpatients, as soon as they regain their appetites. However, If a patient requires 24 hours follow up after the initial assessment or during the course of treatment, the child would need to be transferred/linked to the nearest 24 hours functional SC or paediatric hospital based on the child’s need. Therefore, a strong referral system should be in place during the planning phase with possibilities of supporting the transfer of the child.

*\*Note It must be ensured that all human resources involved in the management of the children in this special situation are well trained and experienced in the management of cases of SAM with medical complications*

# Special arrangements during outbreaks.

### Cholera

Cholera can kill a SAM child rapidly and children with SAM are even more vulnerable to cholera with low immunity; therefore, SAM children with Cholera should be treated in the cholera/diarrheal treatment centre (CTC/DTC) not in the SC.

SAM child with cholera is not considered for admission in the SC because of :

* High risk of cross infection with the other children
* Correct rehydration of the child with cholera/AWD protocols is lifesaving and the priority; management of SAM will follow once the child is rehydrated

Consider a diagnosis of cholera if:

* There is evidence of high output diarrhoea (one stool an hour)
* Diarrhea appears pale and straw coloured in colour
* Diarrhea can be accompanied by vomiting and nausea
* A child’s family members have been diagnosed or have suspected cholera

Treatment protocol

* In the context of cholera products usually contraindicated with SAM should be used: new formation ORS (low osmolarity ORS) and iv fluids and zinc provided (ReSoMal is not appropriate in this context)
* When diarrhea has stopped, stop ORS, but continue the full course of zinc for the full 10 days
* Once cholera is controlled, the child should be referred to the closest nutrition site (OTP or SC) depending on the child status to continue appropriate nutrition management
* Breastmilk is safe for the child with cholera, ensure the areola, breast, and the mother’s hands are cleaned with soap/water or disinfectant. Rubbing some breastmilk on the nipple will remove the taste of soap from the breast.

Note: The Health worker to refer to the SAM management during cholera outbreak guide

### Respiratory infection outbreak (e.g Covid-19)

Essential health care such as SC will continue to be provided during COVID-19 or contagious respiratory outbreaks. However, there are some adaptations that are required to ensure safe continuation of the essential health services in inpatient wards to avoid nosocomial infection (COVID-19 and others), and to reduce the level of anxiety and stigma related to the disease.

Hospitals including SCs play a critical role in national and local responses to emergencies, such as the COVID-19 Pandemia. For the anticipation, early detection and containment response, from the introduction to the localized transmission phase, is recommended to

* Foreseen a proper triage system at the SC to enable early detection of potential suspected cases. It should include temporary isolation capacity or immediate referral, trained staffs, protocols and all needed supplies.
* Define a clear referral pathway for suspected and confirmed cases in line with the national guideline, in order to facilitate referrals from SCs to identified treatment facilities.

To facilitate the early identification of highly contagious respiratory cases, health care facilities should:

* Encourage health care workers to have a high level of clinical suspicion and efficient assessment of the case.
* Institute the use of screening questionnaires according to the updated national guidance of case definition.

# General IPC measures

Infection prevention and control (IPC) is essential to minimize the risk of potential transmission of nosocomial or gastroenterology infection to patients or to health workers. All health workers have to be trained on IPC measures and procedures to apply. Infection prevention should cover all the aspects of the hospitalization setting including environment, equipment, medical care, food and interpersonal infection prevention.

**Water and Sanitation Disposal and Supply for the ward**

* Availability of running water and Soap along with multiple hand washing stations
* Waste management and cleaning material
  + - General waste collection bins with two-wheel 110 liter
    - Segregation bins red and yellow in hospitals
    - Trolleys for transportation of waste in hospitals
    - Plastic Bags, black and red /yellow color (Large size)100l
    - Plastic Bags, black and red /yellow color (20L &30L)
    - Plastic Bags, black and red/yellow (50l)
    - Multipurpose trolleys (with brooms, brushes, Mop and Mop bucket, disinfectant, waste bags, washing brushes, vipers)
    - Floor mop with the enclosure
    - Broom washing floors
    - Sweepers with a stick
    - Calcium hypochlorite powder / stable bleaching powder, supplied in drums of 45 kg; (ii) Available chlorine – minimum 67% for cleaning
    - Cleaning soap and hand washing soap
    - Soiled linen trolleys

**Accommodation/infrastructure**

* Adequate well-ventilated rooms
* Provision of safe water and sanitation services to maintaining hygiene for patients: availability of latrines and shower room for patient and their care-givers
* Social distancing – maintain 1 to 2 meters space between bed and people
* Provision of clean hospital linen and Safe handling and cleaning of used bed linen
* Provision of hygiene kit for caregivers and their children
* Limited number of caregivers per child - older relatives and siblings of sick child should not be at the SC, nor should anyone who has an underlying illness or is currently sick.
* Availability of toilet for staff male and female

**IPC precautions to be applied by health workers**

Standard precautions include hand hygiene and the use of personal protective equipment (PPE) when in indirect and direct contact with patients’ blood, body fluids, secretions (including respiratory secretions) and non-intact skin. Standard precautions also include prevention of needle-stick or sharps injury; safe waste management; cleaning and disinfection of equipment; and cleaning of the environment. In addition to standard precautions, health care workers should do a point-of-care risk assessment at every patient contact to determine whether additional precautions (e.g. droplet, contact, or airborne) are required.

**IPC Precautions for Milk preparation**

It is necessary to apply hygienic conditions described in the national guideline when preparing F75 and F100 and the appetite test with RUTF for the child in transition period.

**IPC Precautions for Patient and Caregiver health workers should promote**

* Promote personal hygiene habit with caregivers to prevent corss infection through counselling caregivers on IPC practices; washing hand regularly and thoroughly with soap and water or hydroalcoholic gel, and instruct all patients and caregivers to cover nose and mouth during coughing or sneezing with tissue or flexed elbow and perform hand hygiene after contact with respiratory secretions.
* Promote healthy eating through counselling caregivers since when you are well nourished the body is better able to fight infection through improved immunity
* Hygiene- Patient’s and/or caregivers’ hand washing: before examination, before admission, before and after feeding, before appetite test, before IYCF individual counselling

**Equipment needed**

* Alcohol-based hand rub.
* Medical masks.
* Tissues for patients to cover their mouth/nose when coughing or sneezing
* Patient mask for suspected cases
* Thermometer

**Identification and Referral of suspected infectious cases**

Suspected infectious case as updated by health cluster to be isolated if possible and communication is initiated with the CDC of the country and/or call the hotline or RRT for the referral procedures.

**During IYCF session in SCs health workers should:**

* Teach mothers who breast feed on breastfeeding and IPC precautions for breastfeeding protection and promotion especially on the continuation of the breast feeding.
* Counsel/advise mothers to continue breastfeeding should the infant or young child become sick with suspected, probable, or confirmed infectious illness
* Counsel/ advise caregivers on the importance of healthy diet during complementary feeding and safe food preparation/ handling.
* Counsel/ advise caregivers on the importance of healthy eating for all the family members
* Counsel caregivers on IPC precautions and personal hygiene habit.
* Counsel caregivers on basic psychosocial support.

# Monitoring and evaluation

Monitoring and evaluation is an integral part of the program. Indicators help in interpreting trends as the programme proceeds. The data are critical for planning services, opening and closing SCs, ordering supplies and knowing where additional training or help is required. It also forms part of the surveillance system to assess the state of nutrition of the population.

A well-designed monitoring system at different administrative level assess the degree to which the program objectives are being met and also helps in understanding what factors affect access and uptake of the services and identify improvement needed in a timely manner where appropriate action can then be taken to improve individual care, organisation of care and overall quality of care. Therefore, there is a need to focus on and strengthen timely collection of relevant information, aggregation, and disaggregation of data at various levels of the system, and subsequent analysis and reporting.

Effective monitoring of the stabilization centre requires:

* Monitoring of the individual child during the treatment in SC
* Monitoring and reporting on the effectiveness of the service in SC:
* Regular supervision of SC

Main components for monitoring are:

* Health workers’ capacity: Performance of tasks: anthropometric measurements, medical examination, appetite test, medicinal treatment and provision of RUTF
* Ward procedures
* Supply chain management
* Nutrition information system; filling system, registries (completeness, accuracy, validity)
* Adherence to guidance
* Counselling
* Referral system
* Food preparation
* Hygiene

**Individual child-level monitoring:**

Individual child treatment records are documenting the clinical status of a child at admission, treatment progress and discharge outcomes. When monitoring the overall patient outcomes, procedures and discharge, the efficiency of the ward can be evaluated and changes to the process can be proposed. At the same time, this information can be useful to understand how the management of severe acute malnutrition is implemented in the ward and identify issues that can be modified and improved. This could identify issues related to failure to gain weight, staff performance, food preparation, or ward procedures. Analysis of the individual treatment cards helps to identify and highlight problems which might contribute to failure to respond to treatment. Also, it is important to systematically review the individual treatment cards during supervision visits to ensure that proper treatment is given and adherence to protocols.

The child’s information should be entered on the inpatient care treatment card. Medical history, physical assessment at admission and daily surveillance information should be recorded. This helps monitor the child’s progress and inform decision-making during treatment. The outcome of the treatment is also marked on the card.

**Monitoring and reporting on the effectiveness of the service in SC**

It is important to ensure quality control of the SC and monitoring is an important tool for quality assurance. Quantitative data are collected from the SC registries that could be augmented by qualitative data to feed into regular monitoring and corrective measures. This information also allows monitoring of trends over time; helps to inform program design and a better allocation of resources.

Monitoring is used to measure the monthly performance and report on effectiveness. Monitoring system should encompass individual monitoring of admission, treatment process, operational management and outcome.

## Performance Indicators

There are three basic sets of indicators for measuring the performance of SCs’ services for children 0-59 months:

* Output indicators measure whether SC service has completed the planned activities needed to achieve the established objectives. They are measured as numbers.
* Process indicators directly measure the performance of key processes, which in this case relates to the treatment process.
* Outcome indicators measure whether SC service has achieved its objectives and planned outcomes. They are measured as percentages.

**Indicators Measuring Output**

* Functionality of SC
* Number of functioning SC and outpatient care sites
* Number of health care providers trained on SC
* Report on use of F75, F100, RUTF, ReSoMal
* Total number of new admissions
* Total number of children under treatment

**Indicators Measuring Outcome**

* % discharged cured (cure rate) = proportion of children discharged cured of total discharged\*
* % discharged died (death rate) = proportion of children who died when under treatment of total discharged\*
* % discharged defaulted (default rate) = proportion of children recorded as absent for third consecutive week or outpatient care session of total discharged\*
* % discharged non-recovered (non-recovery rate) = proportion of children who do not meet the discharge criteria after four months under treatment of total discharged\*

\* Total number of discharged = cured + died + defaulted + non-recovered

*Note: Inpatient care site reports only calculate these indicators if children 6-59 months remain in the inpatient care service until full recovery*

**Indicators Measuring Process**

**Barriers to Access and Utilization**

Assessing this information can help identify problems with knowledge, attitudes and practice (KAP) on malnutrition and health service utilisation, and determine where strengthened support, training and mobilisation might be needed. It can also refine key messages on social and behaviour change and communication.

**Cause of Death**

Assessing and compiling this information can help identify problems with treatment and use of action protocols, and determine where strengthened support, training and supervision might be needed.

**Reasons for Defaulting and Non-Response to Treatment**

Compilation of this information can help identify common reasons for default or non-response to treatment. Reasons for non-response might include a high prevalence of TB and/or HIV, or poor access to water and sanitation. This information might indicate a need for stronger service linkages with other sectors. It is also important to understand the reasons for defaulting, barriers to accessing services and/or unrecorded death.

**Average Length of stay (LOS) of Discharged Cured**

Length of stay (LOS) is the period in number of days that a child spends in treatment from admission to discharge. LOS in inpatient care varies from a week to 4 weeks. Average LOS reflects effectiveness of the services. A long average LOS might be the result of, e.g., a high proportion of children who do not respond to treatment (non-responders or non-recovered), default, and/or unresolved illness. A short average LOS might indicate that children are discharged too soon. Average LOS is calculated on a sample of cured discharges for kwashiorkor and marasmus separately, as the sum of LOS divided by number of cards in the sample.

Calculation:

Average LOS = sum of LOS divided by number of cards in sample

**Average weight gain (AWG) of Discharged Cured**

A low AWG may indicate ineffective treatment and/or non-compliance to the treatment protocol. AWG is calculated on a sample of cured discharges for kwashiorkor and marasmus separately, as the sum of weight gains divided by number of cards in the sample.

Calculation:

Daily weight gain (g/kg bodyweight/day) = [discharge weight in g - minimum weight in g] divided by [minimum weight in kg multiplied by the number of days between minimum weight and discharge day]

Average daily weight gain = sum of weight gains (g/kg bodyweight/day) divided by number of cards in sample

**Referral Rate**

Children are referred from outpatient care to inpatient care per the action protocol in inpatient care to a higher level of care when their condition deteriorates or when the child is not responding to treatment. After treatment in higher level, the child returns to inpatient care and/or outpatient care based on child’s assessment to continue treatment from malnutrition. The child was not discharged from the SAM treatment, but had temporarily exited the respective SAM treatment site.

The referral rate provides information on severity of cases that are admitted and/or non-response to treatment and hence highlights weaknesses in the care system (e.g., late presentation of cases, quality of care, endemic patterns).

Calculation:

Referral rate = Number of children referred per number of children in treatment during the time period of reporting

**Supportive supervision**

As part of the monitoring system, it is important to have focused attention on having a continuous quality improvement system in place. Supportive supervision visits and use of a standardized checklist assess and address service performance. At the same time, the supervisor is a mentor and s/he should use the opportunity to provide support to health care providers on their identified needs, observed needs and strengthen capacities for improving quality.

Supervision for improving quality of protocol implementation entails monitoring admission and discharge trends and adherence to protocols. Accurate recording and compilation of information regarding admissions, re-admissions and referrals, and discharges from inpatient care sites are important. Analysis of the inpatient care site data is essential for both supervisor and implementer as it provides important information about the performance of individual sites and can be used to ensure actions be taken to improve service quality.

Before each visit, supervisors should examine all the available documentation for each health facility, the records of previous supervision and routine monitoring outcomes. That will allow identification of the priority areas requiring observation thus making the supervision more efficient.

During the visit, gaps and discrepancies should be identified in consultation with the health workers and, as much as possible, with representatives of the community. Immediate feedback should be given to the health workers and the communities, jointly searching for solutions to the problems identified. Supervisions are also essential for improving staff capacities of formal or informal refresher training and mentoring (on-the-job training) during the visits, mainly in less accessible areas where staff movement is difficult.

## Monitoring Tools

**MONITORING AND REPORTING TOOLS**

Inpatient Care Treatment Card

Daily Feeds Chart

Referral Form for Inpatient Care/Outpatient Care

Site Tally Sheet

Site Reporting Sheet

Checklists for Supportive Supervision

**MANAGEMENT TOOLS**

Set-up of Inpatient Care and Outpatient Care

Checklist of Materials for Inpatient Care

Forecasting Nutrition supply needs

Checklist for monitoring hygiene

Checklist for monitoring ward procedures Guidance for calculation of indicators included in supervisory checklist and reporting formats

Monthly reporting format

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# Annexes

Annex 1 Human recourses and job responsibility

|  |  |  |
| --- | --- | --- |
| Job | Qualification | Job aids |
| **The Medical officer (MO) or**  **P**aediatric specialist | should be a qualified medical doctor (MBBS) | * Overall, in charge of the unit responsible for the medical and nutritional treatment * S/he is responsible for the clinical management of children admitted to the SC. * Conduct initial medical assessments (triage, medical history, needed investigations) * Take the history of each patient and conduct the clinical examination (looking after medical complications; diarrhoea, dehydration, hypothermia, hypoglycaemia, anaemia, skin disease, pneumonia, and other infections) and prescribe treatment. * Examination of each patient every day and attending to emergency calls as per the need. * Assess patients that fail to respond to treatment and make decisions on the actions to take for children failing to respond to treatment * Ensure that the admission criteria are respected in the SC (severely malnourished cases with medical complications admitted in the SC and non-medical complications are referred to the OTP). * Ensure the accuracy of anthropometric measurements taken in the SC. * Ensure the dispensing of sugar water or F75 upon admission. * Check the immunization status of every child in the SC. * Re-check any measurements or information that appears to be incorrect or is critical to clinical decision-making. * Ensure that systematic treatment and drugs are given correctly by the phase nurses. * Identify patients who need to be transferred to another phase (phase transition, OTP, etc.) , patients with failure to respond to treatment and patients who need to be discharged. * Decide which patients are at high risk and need to be transferred to a more specialized facility * Make sure that breastfeeding counselling is given to all lactating mothers and the Supplementary Suckling Technique is implemented for the lactating mothers with children less than 6 months with IYCF health worker. * Establish a good working relationship with all the staff of SC working * Timely communication of program-related progress with them. * Make sure that a close follow-up and feedback system is in place for the referral cases between (SC, and OTP). * Make sure proper communication, and collaboration arein place with other programs (mental health, food security) at the camp level.   Conduct three visits at least per 24 hours for the SC, in addition to the emergency calls, and record each visit in the patient registry |
| **Nurse** | Nurse supervisor should be a qualified graduate medical nursing school  2 years experiences dealing with infant and children  Trained or had experiences with IMCI program | * Functions as a supervisor of the unit supporting the medical officer and other nurses * S/he is responsible for admission; anthropometric measurements, registration, follow-up, medical and nutrition treatment, as well as discharge of the admitted children in the SC.   Roles include:   * Chart out a specific therapeutic diet plan for each child as per the guidelines in consultation with the medical officer. * Ensures the in-patient care procedures are respected and followed. * Maintaining SC records (filing in information in registers, in-diet, treatment sheets and preparing reports of the SC. * Monitor, and record the vital signs of the children and inform the MO of any emergencies. * Monitor the feeding acceptance, register the consumed and residual amounts, * Install NGT for children when needed. * Monitor and record the vomiting and diarrhoea episodes and estimate the amount lost. * Assess the feeding problem in each child. Counselling, sensitization, awareness and information sharing among the mothers/caregivers. * Communication with the OTPS to inform them about the referral of stabilized children. * Ensure the dispensing of sugar water and F75 upon admittance. * Monitor, prevent and treat hypothermia in consultation with the in-charge doctor. * Monitor, prevent and treat hypoglycaemia in consultation with the in-charge doctor. * Diagnose and treat dehydration were present (strictly using the protocol) in the consultation with the in-charge doctor * Explain the treatment and follow-up procedures in the SC, especially 24 feeding form and follow-up of the medical and nutrition treatment. Follow up of the registration of all the beneficiaries in the SC (registration book ID number, medical and nutrition, treatment sheets, follow-up card ID number if applicable * Explain the importance of hygiene and sanitation in the centre and at home (nail cutting, washing hands before taking meal and after latrine. * Implement systematic treatment according to the protocols (vitamin A, folic acid, de-worming, antibiotics, and vaccinations). * Follow-up and implementation of the medical treatment for severely acute malnourished children in the SC. Calculation, preparation, distribution, and monitoring of therapeutic milk according to the standard protocols for the beneficiaries. * Encouragement of breastfeeding and initiate supplementary Suckling technique (SST) for appropriate infants. * Ensure that the systematic treatment and drugs are given correctly to the beneficiaries. * Identify patient who need to be transfer to another phase or OTP, patient with failure to respond to treatment and patients who need to be discharged. * Follow up of the hygiene and sanitation rules in the Centre and during treatment follow up. * Check if all the procedures completed before discharge (anthropometric measurements, medical and nutritional treatment, systematic treatment, and health and nutrition educations). * Record all the necessary information on the registration book and card for each beneficiary. * Take photos of the child at the admission time , during treatment and at the discharge, to show the improvement ( Consent form should be filled and signed before taking photos * Keep a tally of all the beneficiaries admitted and discharged from the nutrition Centre (admission, cured, defaulters, death, transfer and referral) by age group and admission criterion used. Know the complement of the beneficiaries (number in the   centre, census of the patient) on a daily and weekly basis.. * Prepare therapeutic feeding products requisitions, consumptions and balance stock, Prepare medical requisitions, consumptions, and balance stock * He or she should work in close collaboration with the staff of SC nurses, doctors |
| IYCF counsellor | At least 2 years experience in the related field IN IYCF program | * To ensure the promotion of infant and young child feeding practice through the application of the IYCF protocol and Nutrition Harmonization strategy * Advising and counselling mother’s on infant and young child feeding practice. * Conduct on-going assessment of all mothers with children Under 24 Months * Complete and maintain individual breastfeeding beneficiary report cards. * Perform close monitoring of all beneficiaries, including follow up * Maintain clear communication with all other health workers. * Provide tailored one to one counseling sessions, based on initial assessments, offering practical advice and education to mothers on the key issues of Infant and Young child feeding practices. * Ensure all mothers/caregivers are aware of the importance of exclusive breastfeeding for the initial 6 months. * Educate mothers on the dangers of feeding bottles through creating strong awareness in the community. * Provide mothers with practical advice on correct attachment and positioning when breastfeeding, timely introduction of complementary foods and respond to any concerns or local taboos associated with IYCF. * Ensure a comfortable, calm environment for counseling sessions and maintain good relationships with the beneficiaries. * Disseminate BCC/ICC materials on IYCF in the local language if mothers read * Organize demonstration sessions on breast feeding and complementary feeding for the Mother to Mother support groups * Submit a monthly and weekly statistical and narrative report to immediate supervisor on time. * Provide psychosocial support |
| **Attendant/Cleaner:** | Orientation about cleaning and infection control and use of disinfectant | The cleaners are responsible for managing the cleaning duties and the provision of detergents, hand soaps, chlorine etc. Floors should be cleaned every day with soap and water. toilets should be disinfected with 0.5% active chlorine solution |
| Nutritionist |  | The will function as a supervisor of the unit, She will chart out specific therapeutic diet plan for each child as per the guidelines in consultation with the Medical officer. She will also be responsible for monitoring the preparation and distribution of feeds as per diet charts, maintaining SC records in registers, preparing reports of the SC and in diet and treatment sheets  2- Anthropometric measurements every alternate day as per requirements.  3- Maintenance anthropometric measurements of patient records & case sheets.  4- Preparation of menu planning as per calorie requirement & supervision of cooking & feeding practices of the children with SAM & demonstration activities as well as preparation of F75 and F100  5- a nutritionist will assess the feeding problem in each child and give individual counselling to mothers. the nutrition counsellor will bring all mothers and caregivers of the admitted children together and give demonstrations on making low- cost nutritious energy dense culturally acceptable child foods; and also provide group counselling on various topics like nutrition and malnutrition, hygiene and sanitation, infant and young child feeding practices, immunisation, etc. |
| CHW |  | -Identify high-risk cases and transfer them to specialised centres  -Nutrition screening of children from 6 to 59 months  -Nutrition screening of the Pregnant and Lactating Women PLW.  -Collect the relevant health and nutrition information.  -Documentation on records  -Determining signs of violence in children and women.  -Raising awareness of health-care services provided at the health centre  -Encourage demand (nutrition services, family planning services  and reproductive health /clinics/vaccine)  -dissemination of health messages (IYCF , Hygiene, Covid 19,  Pregnant Feeding, Disease Prevention, Group Awareness  Sessions)  -Follow public safety procedures while dealing with beneficiaries  -Attend scheduled training as needed.  -Commitment to the organisation  -Maintaining the dignity of beneficiaries and the confidentiality of information. |
| PSW |  | The social worker should make a social assessment of the family and the community in which the child lives. If needed, she will work together with the family to advise them on their eligibility and social rights in order to improve their living situation and prevent further malnutrition and impoverishment.  She can facilitate and activate the external referral and linkages with other local service providers , Public Distribution System and public welfare schemes as may be relevant to the child and the family. |

Annex 2 clinical record and daily monitoring

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| **SC- Clinic Patient Record** | | | | | |
| **Administrative data** | | | | | |
| First Name |  | | Surname |  | |
| Gender | Male ◯ | Female ◯ | Date of Birth | D D M M Y Y Y Y | |
| Address | District | Sub-district | Community | Host community | IDP |
|  |  |  |  |  |  |
| Consultation type | New admission ◯ Re-admission ◯  *Re-visit: Patient visited the HF and revisit same facility and same clinic during one week* | | | | |
| **Source** | Home ◯ | | Referred from Other facility ◯ | | |
| consultation Site | Outpatient clinic ◯ | | Emergency Room: ◯  *No re-visit in emergency* | | |
| *Only curative visit is included (i.e. exclude preventive care visit, e.g. ANC, immunization)* | | | | | |

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| **Admission criteria** | | |
| W/H (z-score) < -3 ◯ | MUAC < 115mm ◯ | Oedema +++ ◯ |
| *Tick only one according to the visited clinic, in case of more one clinic separate form for each clinic must be filled* | | |

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| **Patient complain on admission** | | | | | | | |
|  | | | **Days** | | | **Others** | |
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| **Clinical examination (**physical and general appearance) | | | | | | | |
| General condition |  | | |  | | | |
| Level of conscious | Very weak, apathetic ◯ | | | Unconscious ◯ | | | |
| Vital Sign at admission | Body Temperature | Pulse rate  (PR) | | | Respiratory rate  (RR) | | Capillary Refill Time  (CRT) |
|  |  | | |  | |  |
| Blood glucose test (BGT) |  | | | | | | |
| Eyes |  | | | | | | |
| Ears |  | | | | | | |
| Oral |  | | | | | | |
| Respiratory |  | | | | | | |
| Cardiovascular s |  | | | | | | |
| Abdomen |  | | | | | | |
| Genitourinary |  | | | | | | |
| Skin |  | | | | | | |
| Musculoskeletal |  | | | | | | |
| Neurological |  | | | | | | |
| Patient past medical history |  | | | | | | |
| Surgical history |  | | | | | | |
| Family history |  | | | | | | |
| Medication allergic history |  | | | | | | |
| Vaccination history |  | | | | | | |

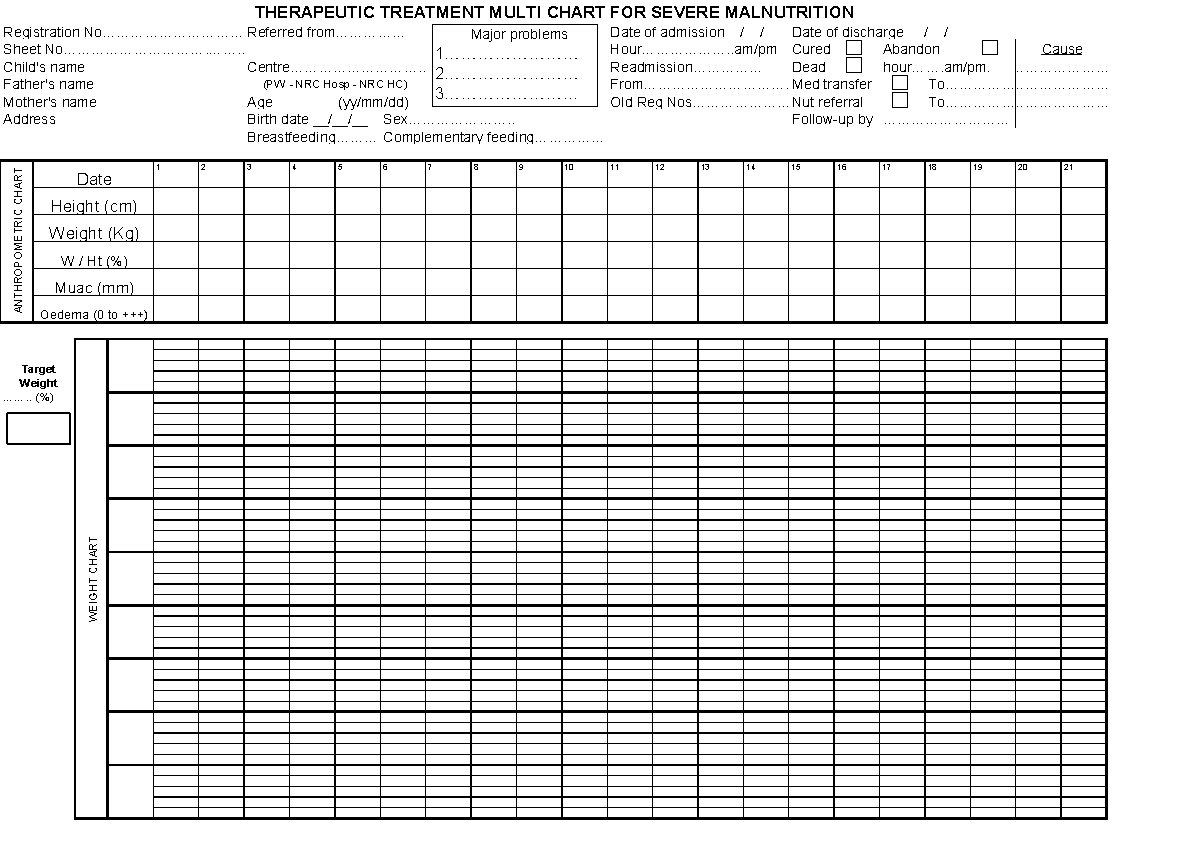
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| ***Initial diagnosis (DD)*** | |
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| ***Initial Management plan:*** |  |
| Feeding and fluid plan |  |
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| Management plan |  |
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| ***Daily follow up***  *Date DD/ MM/Year* | | | | | |
| *Complain* | | | **Days** | **Others** | |
| 1 | | |  |  | |
| 2- | | |  |  | |
| 3- | | |  |  | |
| 4- | | |  |  | |
|  | | |  |  | |
| **Clinical examination (**physical and general appearance) | | | | | |
| General condition | stable ◯ | Very weak, apathetic ◯ | | | Unconscious ◯ |
| Vital Sign | Body Temperature | Pulse rate (PR) | | | Respiratory rate (RR) |
|  |  | | |  |
| Eyes |  | | | | |
| Ears |  | | | | |
| Oral |  | | | | |
| Respiratory |  | | | | |
| Cardiovascular s |  | | | | |
| Abdomen |  | | | | |
| Genitourinary |  | | | | |
| Skin |  | | | | |
| Musculoskeletal |  | | | | |
| Neurological |  | | | | |

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| --- | --- | --- |
| **Laboratory test** | | |
|  | **Result** | **Remarks** |
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| --- | --- |
| ***Daily follow up*** | |
| On history | Action plan |
|  |  |
|  |  |
|  |  |
|  |  |
| On examination | Action plan |
|  |  |
|  |  |
|  |  |
|  |  |
| Lab and other investigation | Action plan |
|  |  |
|  |  |
|  |  |
|  |  |
| Feeding and fluid plan |  |
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| Management plan |  |
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| Annex 3 performance indicator | |
| Definition | % Of children who died from any cause (related to malnutrition or complication) while registered in the treatment program (SC) during time period. |
| Purpose | The death rate is one important of the four core performance indicators of malnutrition treatment programs (recovery rate, death rate, default rate and non-recovery rate).  It represents the proportion of discharged children who died from any cause while registered in the inpatient management program.  Reflect Quality of care in SC. |
| Calculation | Mortality rate (%) = (number of total children patients’ deaths in the SC from any cause / total number of children patients’ admission in SC) \*100. |
| Required Data | To **calculate the indicator’s:**  Determine the number of children (patients) admitted to the ward (SC) in the previous month diagnosed with complicated SAM.  Determine the number of those children (patients) who died in the ward (SC) from any cause ((related to malnutrition or complication).  Divide the number of deaths by the number of children admitted and express the result as percentage.  Determine the duration (monthly, yearly) and all data need will be during time period. |
| Result type | Percentage (%). |
| Standard | Less than 10 % is acceptable. |
| Abnormal result | More than 10% is unacceptable  Needs to be investigated.  Any high death rate needs to be investigated  Detailed review of death cases.  Determine co morbidity.  It is important to look at the day (after admission) and hour (Day or night) of death as well as the causes. |
| Disaggregating by | Disaggregate the data by:  Gender.  Geographic area.  Age group. |
| Comment | Possible reasons for high death rate:  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.  Unavailability of intensive care. |

Annex 5 recovery rate

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| Recovery rate: | |
| Definition | % Of children discharged from the treatment program as successfully recovered program (SC) during time period. |
| Purpose | Recovery (cure) is one of the four core performance indicators of malnutrition treatment programs.  It represents the proportion of all children discharged from the treatment program who reached the “recovery” criteria defined for the inpatient program management (SC).  Reflect Quality of care in SC. |
| Calculation | Recovery rate (%) = (number of children discharged as “recovered” / total number of children patients’ admission in SC) \*100. |
| Required Data | To **calculate the indicator’s:**  Determine the number of children (patients) admitted to the ward (SC) in the previous month diagnosed with complicated SAM.  Determine the number of those children discharged as “recovered”.  Divide the number of discharged by the number of children admitted and express the result as percentage.  Determine the duration (monthly, yearly) and all data need will be during time period. |
| Result type | Percentage (%). |
| Standard | More than 75% is acceptable. |
| Abnormal result | Less than 75 % is unacceptable.  Needs to be investigated. |
| Disaggregating by | Disaggregate the data by:  Gender.  Geographic area.  Age group. |
| Comment | Possible reasons for low recovery rate:  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. |

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| Non-Recovery Rate: Annex 4 | |
| Definition | % Of children discharged as medical referrals and as non-response from inpatient management program (SC) during time period. |
| Purpose | Non-recovery rate is one of the four core performance indicators of the malnutrition treatment programs.  It is a combination of two indicators: medical referral rate and non-response rate.  Reflect Quality of care in SC. |
| Calculation | Recovery rate (%) = ((number of children referral + number of children referral non-response) / total number of children patients’ admission in SC) \*100. |
| Required Data | To **calculate the indicator’s:**  1) Count the number of  a) children who have been referred outside the nutrition program for medical care and could not continue nutritional treatment (medical referrals) plus  b) the number of children who have not reached discharge criteria after a pre-defined length of time despite all investigations and transfer options (non-response cases).  2) Divide the number by the total number of discharged children.  Multiply the result by 100 to convert it to a percentage.  3) The resulting number is the non-recovery rate (in percentages).  Determine the duration (monthly, yearly) and all data need will be during time period. |
| Result type | Percentage (%). |
| Standard | Less than 25% is acceptable. |
| Abnormal result | More than 25 % is unacceptable.  Needs to be investigated.  Staff needs to investigate beneficiary that do not gain body weight or increase MUAC/Z score as expected.  Staff should follow the action protocols.  Consider stronger to improvement of quality of care amongst staff. |
| Disaggregating by | Disaggregate the data by:  Gender.  Geographic area.  Age group. |
| Comment | Non-response 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 program (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.  Medical referral rate:  Serious medical illness and/or medical complications that cannot be diagnosed/treated in the program and need external specialized care outside the program. |

Annex 7 Bed occupancy rate

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| Bed Occupancy Rate (BOR): | |
| Definition | The Occupancy Rate is calculated by dividing total bed days in a period by the available beds and the days in the period usually 1 year. |
| Purpose | Bed occupancy rate (BOR) is a measure of utilization of the available bed capacity in the hospital, and it indicates the percentage of beds occupied by patients in a given period of time, usually 1 year.  Reflect Quality of care in SC, accessibility and efficiency in the use of hospital beds. |
| Calculation | Bed Occupancy Rate (BOR) % = (Inpatient Days of Care/Bed Days Available) x 100.  during time period. |
| Required Data | To **calculate the indicator:**  Bed Days available: the maximum number of inpatient days of care that would have been provided if all beds were filled during the period.  Example: if 10 beds were available for use each day during the year, bed days available would be 10 x 365 = 3650. For one month it will be 10 x 30 = 300 admission day.  Total Inpatient Days of Care: total inpatient Days is the sum of each daily inpatient census for the time period examined, for each patient it is equal the difference between the admission date and the discharge date.  Example: if the time period examined is taken as a week, and the daily inpatient census was as follows: Day 1 = 7, Day 2 = 8, Day 3 = 6, Day 4 = 10, Day 5 = 10 Day 6 = 9, Day 7 = 8, then the total inpatient Days of care for one week would be 7+8+6+10+10+9+8 = 58.  Determine the duration (monthly, yearly) and all data need will be during time period. |
| Result type | Percentage (%). |
| Standard | 75% |
| Abnormal result | More than 80 % need review.  Less than 50% need to be investigated |
| Disaggregating by | Disaggregate the data by:  Gender.  Age group. |
| Comment | Bed Occupancy Rate will be improving quality of care and efficiency of health systems. |

Annex 5

|  |  |
| --- | --- |
| Average length of stay (ALS): | |
| Definition | Length of stay is the number of days elapsed between admission and discharge. |
| Purpose | These indicators can be calculated for all beneficiaries of the same age group (e.g., children 6-59 months) who are discharged as recovered.  Reflect Quality of care in SC, accessibility and efficiency in the use of hospital beds. |
| Calculation | Average Length of Stay = Sum of Individual Length of stay (recovered beneficiaries) in days /Number of recovered beneficiaries. |
| Required Data | To **calculate the indicator:**  Total Inpatient Days of Care: total inpatient Days is the sum of each daily inpatient census for the time period examined, for each patient it is equal the difference between the admission date and the discharge date (as above).  Total recovered Admissions - the total number of individuals formally accepted into inpatient ward of the hospital during the time period examined. |
| Result type | days |
| Standard | 1-7 days |
| Abnormal result | Short or Long stay needs to be investigated.  Consider improvement of quality of care amongst staff.  Make sure that absentees are traced and return to the program.  The beneficiaries are discharged on the same day that the exit criteria are reached. |
| Disaggregating by | Disaggregate the data by:  Gender.  Age group. |
| Comment | Factors that negatively influence 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 |
| Average length of stay (ALS): | |
| Definition | Length of stay is the number of days elapsed between admission and discharge. |
| Purpose | These indicators can be calculated for all beneficiaries of the same age group (e.g., children 6-59 months) who are discharged as recovered.  Reflect Quality of care in SC, accessibility and efficiency in the use of hospital beds. |
| Calculation | Average Length of Stay = Sum of Individual Length of stay (recovered beneficiaries) in days /Number of recovered beneficiaries. |
| Required Data | To **calculate the indicator:**  Total Inpatient Days of Care: total inpatient Days is the sum of each daily inpatient census for the time period examined, for each patient it is equal the difference between the admission date and the discharge date (as above).  Total recovered Admissions - the total number of individuals formally accepted into inpatient ward of the hospital during the time period examined. |
| Result type | days |
| Standard | 1-7 days |
| Abnormal result | Short or Long stay needs to be investigated.  Consider improvement of quality of care amongst staff.  Make sure that absentees are traced and return to the program.  The beneficiaries are discharged on the same day that the exit criteria are reached. |
| Disaggregating by | Disaggregate the data by:  Gender.  Age group. |
| Comment | Factors that negatively influence 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 |

Annex 6 referred outpatient and inpatient ratio

|  |  |
| --- | --- |
| Referred OUT/IN Ratio: | |
| Definition | Number of Serious medical illness and/or medical complications that cannot be diagnosed/treated in the programme and need external specialized care outside the program. |
| Purpose | Beneficiary who has a serious illness that requires diagnosis and/or treatment beyond the scope of available nutrition program (SC) 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.).  Reflect quality of care (medical and diet). |
| Calculation | 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 |
| Required Data | To **calculate the indicator:**  Referred-IN: all cases referred to admitted in the SC from RRTs or another health facilities.  Referred-OUT: all cases referred from the SC ward to anther department (upper level as ICU in same, isolation), to other facility or to Turkey. |
| Result type | % |
| Standard | Less than 20% |
| Abnormal result | More than 20% needs to be investigated.  Consider quality of services.  Staff should follow the action protocols.  Consider stronger to improvement of quality of care amongst staff |
| Disaggregating by | Disaggregate the data by:  Gender.  Age group. |
| Comment |  |

| Annex 7 Discharge form | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Discharge form | | | | | | | | | | | | |
| First Name |  | | | | Surname | | |  | | | | |
| Gender | Male ◯ | | Female ◯ | | Date of Birth | | | D D M M Y Y Y Y | | | | |
| Admission Information | | | | | | | | | | | | |
| Source | | Clinic ◯ Emergency Room ◯ Referred from Other facility ◯  *Please tick only one* | | | | | | | | | | |
| Date of Admission | | D D M M Y Y Y Y | | | | Date of Discharge | | | | D D M M Y Y Y Y | |
| Ward Admission | | □ yes | | Count of Days | | |  | | | | |
| ICU Admission | | □ yes | | Count of Days | | |  | | | | |
| Date of Discharge | | D D M M Y Y Y Y | | | | | | | | | | |
| Discharge Destination | | Cured ◯ | | ◯ referred to | | | | | | | Died ◯  *Please fill Death form* |
|  | |  | | | | | | |  |
| *Summary of admission history:* | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| *Discharge Diagnosis* | | | | | | | | | | | | |
| Diagnosis according to ICD10 list  *Fill more than one diagnosis if applicable* | | | | Type of case | | | | | Certainty | | |
|  | | | | Newly diagnosed◯  Follow up case◯ | | | | | Presumed ◯  Confirmed ◯ | | |
|  | | | | Newly diagnosed◯  Follow up case◯ | | | | | Presumed ◯  Confirmed ◯ | | |
|  | | | | Newly diagnosed◯  Follow up case◯ | | | | | Presumed ◯  Confirmed ◯ | | |
|  | | | | Newly diagnosed◯  Follow up case◯ | | | | | Presumed ◯  Confirmed ◯ | | |
|  | | | | Newly diagnosed◯  Follow up case◯ | | | | | Presumed ◯  Confirmed ◯ | | |
| *Recommendation:* | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
| *Prescription:* | | | | | | | | | | | |
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|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
| *Next visit date (follow up visit and further investigation if need) :* | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |

Annex 8 supervision checklist with scoring

General information

1-  SC is a special unit, located in a health facility and dedicated to the initial management and nutrition rehabilitation of children with severe acute malnutrition.

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Paediatric care spaces which conform to the Baby-Friendly Hospital Initiative guidelines |  |  |
| storage area in proper way |  |  |
| Separate /hygienic preparation area therapeutic milk |  |  |
| Privacy for caregivers (especially when breastfeeding) |  |  |
|  |  |
| A screened area for weighing/assessing children |  |  |
|  |  |
| Separate hygienic cooking facilities |  |  |
| Safely security .separation of male and female ,water availability |  |  |
|  |  |
| Children’s play area with age-appropriate toys |  |  |

2- protocols

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Protocol for management of SAM for in patient |  |  |
| Age group 6- to 5 years |  |  |
| Less than 6 month |  |  |
|  |  |  |
| Last protocol updated less than 2 years |  |  |
| More than 2 year |  |  |

PART I – CASE MANAGEMENT

Please tic appropriate

|  |  |
| --- | --- |
| Management of admission and discharge as per national protocol-  What is admission criteria  Referred from Outpatient Care (b) Bilateral pitting Oedema +++  Any grade of bilateral pitting Oedema with severe wasting (MUAC < 115 mm or WFH < −3 z-score)  Any grade of bilateral pitting Oedema with medical complications and or poor appetite  severe wasting (MUAC < 115 mm or WFH < −3 z-score) with medical complications and or poor appetite  INFANTS<6 MONTHS with SAM (or poor weight gain) or bilateral pitting Oedema  Discharge refer to OTP appetite return Severe bilateral pitting oedema decreasing and medical complication resolved less than 7 days d) Child clinically well and alert | |
| Is the SAM inpatient ward separate from the general paediatric wards?  Yes= 1; No=0  \_\_\_\_ | Does the facility provide SAM inpatient care 24 hours a day 7 days a week?  Yes= 1; No=0  \_\_\_ |
| Admission criteria followed according to the protocol?  Yes= 1; No=0 | Discharge criteria followed according to the protocol?  Yes= 1; No=0 |
| Measurement | |
| Oedema correctly identified?  Yes= 1; No=0 | MUAC measured accurately?  Yes= 1; No=0 |
| Length and height\* measured accurately?  Yes= 1; No=0 | Are scales standardized weekly? (The standard weights should be available for calibration of Scales 1Kg, 5Kg, 10 Kg or etc.  Yes= 1; No=0 |
| Are scales functioning correctly?  Yes= 1; No=0 | Does staff adjust the scale to zero before weighing children?  Yes= 1; No=0 |
| Are children weighed at about the same time each day, 1 hour before or after a feed (to the extent possible)?  Yes= 1; No=0 | Does staff correctly read weight to the correct degree of precision?  Yes= 1; No=0 |
| Are children consistently weighed without clothes?  Yes= 1; No=0 | Are weights correctly plotted on the Weight Chart?  Yes= 1; No=0 |
| Overall admission/discharge (score out of 14) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Comments: | |
| treatment management by observation | |
| Was a CCP used to monitor Child  Yes= 1 No=0 | |
| Was Initial management Completed?  Yes= 1; No=0 | Was the Daily care Completed?  Yes= 1; No=0 |
| Was the Monitoring record (respiratory rate, pulse rate, temperatures) filled?  Yes= 1; No=0 | Was the Weight chart filled  Yes= 1; No=0 |
| Was 24-hour food intake chart complete (one chart for every 24 –hour period)  Yes= 1; No=0 | Was comment and outcome filled  Yes= 1; No=0 |
| Was the vital singes Monitored?  Yes= 1; No=0 | Was the vital singes Monitored every10 mentis for shock(IV fluids) child  Yes= 1; No=0 NA= no shock cases |
| Was the child’s progress Monitored every half hour for the first 2 hours when on ReSoMal (diarrhoea)?  Yes= 1; No=0 NA= no dehydration cases | Was the vital singes Monitored (every 4 hours) during initial treatment?  Yes= 1; No=0 |
| Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Comments: | |

|  |  |
| --- | --- |
| 3. Antibiotics and Other Medications and Supplements | |
| Are antibiotics given as prescribed (correct dose[s] at correct time[s])?  Yes= 1; No=0 | When antibiotics are given, do staff immediately make a notation on the Inpatient Management Recording forms?  Yes= 1; No=0 |
| Are vitamin A given I according to the SAM protocol?  Yes= 1; No=0 NA= if no need cases | NG tube used according to the SAM protocol?  Yes= 1; No=0 NA= if no need cases |
| Is iron factored in where Formula milks are not in use?  Yes= 1; No=0 NA= if no need cases |  |
| Overall Antibiotics and Other Supplements | |
| Comments: | |
| follow up of the mother | |
| Was the caregiver given sufficient information about her child situation?  Yes= 1; No=0 | Mother taught the Importance of Stimulation and How to Make and Use Toys?  Yes= 1; No=0 |
| Did Giving Advice on Referral to Outpatient Care, Continued Treatment at Home and Follow-Up Visits  Yes= 1; No=0 | Do mothers/caregivers have a place to bathe, and do they use it?  Yes= 1; No=0 |
| Do mothers/caregivers wash hands with soap after using the toilet or changing nappies (diapers)?  Yes= 1; No=0 | Do mothers/caregivers wash hands before feeding children?  Yes= 1; No=0 |
| Is there breastfeeding corner in the hospital?  Yes= 1; No=0 | Is there IYCF counselling for mothers/caregivers inside the SCs  Yes= 1; No=0 |
| Overall Mothers and follow up (\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Comments: | |

|  |  |
| --- | --- |
| 5.hygenine and sanitation | |
| Are mothers offered a place to sit and sleep?  Yes= 0.5; No=0 | Are mothers taught and encouraged to be involved in care?  Yes= 0.5; No=0 |
| Do mothers/caregivers wash hands with soap after using the toilet or changing nappies (diapers)?  Yes= 1; No=0 | Do mothers/caregivers wash hands before feeding children?  Yes= 1; No=0 |
| Are staff consistently courteous?  Yes= 0.5; No=0 | Is there any space for stimulation/appetite test?  Yes= 0.5; No=0 |
| As children recover, are they stimulated and encouraged to move and play?  Yes= 0.5 No=0 | Do staff consistently wash hands thoroughly with soap?  Yes= 0.5; No=0 |
| Are there working hand-washing facilities in the ward?  Yes= 0.5; No=0 | Are floors swept?  Yes= 0.5 No=0 |
| Is trash disposed of properly?  Yes= 0.5; No=0 | Is the ward kept as free as possible of insects and rodents?  Yes= 0.5; No=0 |
| Are leftovers discarded?  Yes= 0.5; No=0 | Is all therapeutic food stored in a hygienic manner?  Yes= 0.5; No=0 |
| Are cup/dishes washed after each meal?  Yes= 0.5; No=0 | Are cup/dishes washed in hot water with soap?  Yes= 0.5; No=0  Is there Safety boxes available for the needles and sharps  Yes= 1; No=0 |
| Overall Ward Environment and Hygiene  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Comments: | |
| 6. Monitoring Food Preparation and feeding; | |
| Are correct feeds served in correct amounts?  Yes= 1; No=0 | Are feeds given at the prescribed times, even on nights and weekends?  Yes= 1; No=0 |
| Are children held and encouraged to eat (never left alone to feed)?  Yes= 1; No=0 | Is RUTF appetite test done as soon as appetite returns and medical complications are resolving?  Yes= 1; No=0 |
| Overall Food Preparation and feeding score out of 4: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Comments: | |

PART II – RECORDING AND REPORTING

|  |
| --- |
| 7. Recording and Reporting (by observation). Check all SC cards and report formats are latest FMOH versions |
| Performance indicators | | | | | | |
| Total beginning of the month |  | DISCHARGES | |  | PERFORMANCE LAST MONTH | |
| ADMISSIONS |  |  | |  | Cure Rate (%): | |
| New Admissions: |  | Cured: | |  |
| Oedema: |  | Death: | |  | Death Rate (%): | |
| MUAC <115mm |  |
| W/H < -3 Z score |  | Defaulter: | |  |
| Relapse: |  | Non-responder: | |  | Defaulter rate (%): | |
| Readmission after defaulting: |  | Total Discharges | |  |
| Transfer from another Therapeutic Unit: |  | Transfer out to out-patient: | |  | Average Length of Stay (in days): | |
| Total Admissions: |  | Transfer in-to another in-patient: | |  |
| Total cases at the end of the month = | | | | |  | |
| Comments: (include comments on children >5 yrs. , <6 months and adults admitted) | | | | |  | |
| a) Registration books filled in accurately and completely? (check completion of previous weeks) | | | c)Monthly report accurate and complete, | | | d) Report submitted last month to Locality on time? |
| Yes = 1; No=0 | | | Yes = 1; No=0 | | | Yes = 1; No=0 |
| e) Cure rate is within SPHERE/national standard (>75%) | | | f) Defaulter rate is within SPHERE/National standard (>15%) | | | g) Death rate is within SPHERE/national standard (>10%) |
| Yes = 1; No=0 | | | Yes = 1; No=0 | | | Yes = 1; No=0 |
| Recording and reporting: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Comments: | | | | | | |

PART III – SC staffing human recourses

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | |  | | | | |
| a). doctors are trained in SC | | b). Nutrition trained were trained on Inpatient care guide SC | | c) nurse | d) cook | e social worker |
| Yes = 1; No=0 | | Yes = 1; No=0  NA= if no Nutrition educators | | Yes = 1; No=0  NA= if in rural hospital | Yes = 1; No=0  NA= if no in rural hospital | Yes = 1; No=0 |
| Overall SC staffing assessment (score out of 5) \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Comments: |  | |  | | | |

PART IV – SUPPLY management update accordingly

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 7. Supplies & Logistics  Check the availability and expiry date of all supplies to emphasize the importance of the stock control balance. | | | | | | | | | |
| Bin card or supply registration correctly completed? | | | | | | | | | |
| Y = 1 | | | | | N=0 | | | | |
| Supplies | | |  | | |  | |  | |
| Supplies and Therapeutic milk (one point) | F75 | |  |  | |  | |  |  |
| F100 | |  |  | |  | |  |  |
| RUTF | |  |  | |  | |  |  |
| ReSoMal | |  |  | |  | |  |  |
| Equipment | Salter scale | |  |  | |  | |  |  |
| MUAC tapes | |  |  | |  | |  |  |
| Thermometer | |  |  | |  | |  |  |
| Haemglobinometer | |  |  | |  | |  |  |
| Board for measuring length and Height | |  |  | |  | |  |  |
| Weighing scale | |  |  | |  | |  |  |
| NG Tube | |  |  | |  | |  |  |
| Mask and Ambu Bag | |  |  | |  | |  |  |
| Weight-for-Height Look-Up Table | |  |  | |  | |  |  |
| Look-Up Table of & F75 | |  |  | |  | |  |  |
| Look-Up Table of & F100 | |  |  | |  | |  |  |
| RUTF Look-Up | |  |  | |  | |  |  |
| F-100-Diluted (and F-75) Look-Up Tables | |  |  | |  | |  |  |
| Stationery | CCP | |  |  | |  | |  |  |
| Registration Book | |  |  | |  | |  |  |
| SAM guide at SC | |  | | |  | |  |  |
| Drugs | Amoxicillin | |  |  | |  | |  |  |
| Ampicillin | |  |  | |  | |  |  |
| Ceftriaxone | |  |  | |  | |  |  |
| Tetracycline / chloramphenicol eye drops | |  |  | |  | |  |  |
| Vitamin A | |  |  | |  | |  |  |
| Folic acid | |  |  | |  | |  |  |
| Iv fluids (half normal saline / ringers lactate /half strength darrow) | |  |  | |  | |  |  |
| Antimalarial | |  |  | |  | |  |  |
| Flagyl | |  |  | |  | |  |  |
| Antifungal | |  |  | |  | |  |  |
| Septrin | |  |  | |  | |  |  |
| Mebendazole/Albendazole | |  |  | |  | |  |  |
| Iron and Folic Acid | |  |  | |  | |  |  |
| Injectable Diazepam | |  |  | |  | |  |  |
| Paracetamol | |  |  | |  | |  |  |
| Gentamicin | |  |  | |  | |  |  |
| Lab Test Kits |  | |  |  | |  | |  |  |
| Adequacy of available supply | | | | | | | | | |
| Storage condition: Secure, dry and with good ventilation. Supply are off ground by pallets | | b) Bin card used for each item | | | | | c) Expiry date monitored and supplies with short expiry prioritized for use | | |
| Yes = 1; No= | | Yes = 1; No= | | | | | Yes = 1; No= | | |
| Storage condition and monitoring \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Comment on supplies and stocks (comment on level of NGO input where appropriate) | | | | | | | | | |

|  |
| --- |
| Overall Performance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Main Challenges:  1.  2.  3.  Recommendations:  1.  2.  3.  4. |

Part V: IYCF

*The mentor must attend at least one one-on-one counselling session:-*

|  |  |  |
| --- | --- | --- |
| Child’ IYCF gap message Community IYCF tools exists Yes= 2No= 1 | | |
| Case Management | Importance of Colostrum | Yes … NO ….NA |
| Importance of Exclusive breastfeeding up to 6 months | Yes … NO ….NA |
| No water for children less than 6 months | Yes … NO ….NA |
| Importance of the first hour after birth. | Yes … NO ….NA |
| Importance of the skin-to-skin contact( kangaroo position) | Yes … NO ….NA |
| Breastfeeding positioning and good attachment | Yes … NO ….NA |
| Expression of breast milk | Yes … NO ….NA |
| Feeding a low birth weight baby | Yes … NO ….NA |
| Feeding a sick baby under six months | Yes … NO ….NA |
| Feeding sick baby older than six months | Yes … NO ….NA |
| Starting complementary feeding when completed 6 months | Yes … NO ….NA |
| Complementary feeding from 6 months up to 9 months | Yes … NO ….NA |
| Complementary feeding from 9 months up to 12 months | Yes … NO ….NA |
| Complementary feeding from 12 months up to 23 months | Yes … NO ….NA |
| Good hygiene and practice to prevent the disease | Yes … NO ….NA |
| Importance of food variety | Yes … NO ….NA |
| Mother breast complications addressed and or referred to specialist (flat and inverted nipples, engorgement, blocked duct and mastitis, sore nipples and nipple fissure). | Yes … NO ….NA |
| Recording and Reporting per quarter: | Check if most topics covered within the mother support group counselling identified | Yes … NO ….NA |
| Supervision visits scheduled | Yes … NO ….NA |
| Mother support groups scheduled to be formulated | Yes … NO ….NA |
| Community Mobilization per quarter: | Community workers assigned to supervisor | Yes … NO ….NA |
| Planned supervision visits completed | Yes … NO ….NA |
| Mother support groups formulated | Yes … NO ….NA |
|  | | |

Checklist for monitoring hygiene

|  |  |  |  |
| --- | --- | --- | --- |
| Observe | Yes | No | Comments |
| Hand washing | | | |
| Are their working hand washing facilities in the ward? | | | |
| Does staff consistently wash hands thoroughly with soap? | | | |
| Are their nails clean? | | | |
| Do they wash hands before handling food? | | | |
| Do they wash hands between each patient? | | | |
| Mothers’ cleanliness | | | |
| Do mothers have a place to bathe, and do they use it? | | | |
| Do mothers wash hands with soap after using the toilet or changing diapers? | | | |
| Do mothers wash hands before feeding children? | | | |
| Bedding and laundry | | | |
| is bedding changed every day or when soiled/wet? | | | |
| Are diapers, soiled towels and rags, etc. stored in bag, then washed or disposed of properly? | | | |
| is there a place for mothers to do laundry? | | | |
| is laundry done in hot water? | | | |
| General maintenance | | | |
| Are floors swept? | | | |
| is trash disposed of properly? | | | |
| is the ward kept as free as possible of insects and rodents? | | | |
| Food storage | | | |
| Are ingredients and food kept covered and stored at the proper temperature? | | | |
| Are leftovers discarded? | | | |
| Dishwashing | | | |
| Are dishes washed after each meal? | | | |
| Are they washed in hot water with soap? | | | |
| Toys | | | |
| Are toys washable? Are toys washed regularly, and after each child uses them? | | | |

Checklist for monitoring ward procedures

|  |  |  |  |
| --- | --- | --- | --- |
| Observe | Yes | No | Comments |
| Feeding | | | |
| Are correct feeds served in correct amounts? |  |  |  |
| Are feeds given at the prescribed times, even on nights and weekends? |  |  |  |
| Are children held and encouraged to eat (never left alone to feed)? |  |  |  |
| Are children fed with a cup (never a bottle)? |  |  |  |
| is food intake (and any vomiting/diarrhoea) recorded correctly after each feed? |  |  |  |
| Are leftovers recorded accurately? |  |  |  |
| Are amounts of Starter diet kept the same throughout the initial phase, even if weight is lost? |  |  |  |
| After transition, are amounts of Catch-up diet given freely and increased as the child gains weight? |  |  |  |
| Warming | | | |
| is the room kept between 25° - 30° C (to the extent possible)? |  |  |  |
| Are blankets provided and children kept covered at night? |  |  |  |
| Are safe measures used for re-warming children? |  |  |  |
| Are temperatures taken and recorded correctly? |  |  |  |
| Weighing | | | |
| Are scales functioning correctly? |  |  |  |
| Are scales standardized weekly? |  |  |  |
| Are children weighed at about the same time each day? |  |  |  |
| Are they weighed about one hour before a feed (to the extent possible)? |  |  |  |
| Do staff adjust the scale to zero before weighing? |  |  |  |
| Are children consistently weighed without clothes? |  |  |  |
| Do staff correctly read weight to the nearest division of the scale? |  |  |  |
| Do staff immediately record weights on the child’s case sheets? |  |  |  |
| Are weights correctly plotted on the Weight Chart? |  |  |  |

Annex pharmacy supplies

|  |
| --- |
| Pharmacy Supplies |
| Antibiotics: (Ampicillin/Amoxicillin/Benzyl penicillin  Third generation cephalosporin  Vancomycin Chloramphenicol Cotrimoxazole Gentamycin  Metronidazole tetracycline or Chloramphenicol eye drops Atropine eye drops |
| Resomal  electrolyte and minerals Potassium chloride Magnesium chloride/sulphate iron syrup Multivitamin Folic acid vitamin A syrup Zinc Sulphate or dispersible Zinc tablets Glucose (or sucrose) iv fluids (ringer’s lactate solution with 5% glucose; 0.45% (half normal) saline with 5% glucose; 0.9% saline (for soaking eye pads) |
| Consumables  Cannulas, iv sets, paediatric nasogastric tubes |

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|  |  |  |
| --- | --- | --- |
| DesItem description  Description item | Presentation | Quantity |
|
| AMOXICILLIN, 120mg/5ml, powder oral susp., 100 ml, bot | BOT-100ml | 20 |
| AMOXICILLIN, 250 mg, dispers. tab., in blister | pck -100 | 2 |
| AMOXICILLIN125mg / CLAVUL.ac. 31mg, eq. 156mg/5ml, oral susp., 100ml, bot. | Bot-100ml | 10 |
| AMPICILLIN, 500 mg, powder for injection, vial | unit | 100 |
| BENZATHINE BENZYLPENICILLIN, 1.M IU(600mg), powder for injection | unit | 100 |
| CEFTRIAXONE sodium, eq. 250mg, powder for injection, vi | unit | 100 |
| CEFTRIAXONE sodium, eq. 500mg, powder for injection, vi | unit | 100 |
| CHLORHEXIDINE digluconate 5%, solution, 1L, bottle | 1liter bottle | 1 |
| CIPROFLOXACIN, 250mg, tab. in blister | pack -10 | 50 |
| CLOXACILLIN sodium, eq. 250 mg base, caps., in blister | unit | 1 |
| DEXAMETHASONE 4mg/1ml inj, 100 amp | box-100 | 1 |
| DEXTROSE (GLUCOSE) 5%, 250mL, plastic bottle, w/IV giving set | bags of 250 or 100 ml | 30 |
| DEXTROSE (GLUCOSE) 50%, 50 ml | box-10 vials | 1 |
| EPINEPHRINE (adrenaline) tartrate, eq.1mg/mL base, IM injection, 1mL, ampoule | unit | 10 |
| ERYTHROMYCIN ethylsuccinate. 125mg / 5ml, powder oral susp., 100ml, bottle | Bot-100ml | 15 |
| FUROSEMIDE, 10mg/mL, 2mL, ampoule | unit | 10 |
| GENTAMICIN sulphate, eq. 10 mg/mL base, 2 mL, amp., | unit | 100 |
| MAGNESIUM sulphate, 500mg/mL, 10mL, ampoule | unit | 10 |
| METRONIDAZOLE, 200mg/5ml, oral susp., 100 ml, bottle | Bot-100ml | 10 |
| METRONIDAZOLE, 500 mg/100ml for inject., 100ml, vial | unit | 50 |
| MICONAZOLE nitrate, 2%, cream, 30 g, tube | unit | 20 |
| NYSTATIN, 100.000 IU/ml, oral susp. | BOT-30 ml | 50 |
| PARACETAMOL (acetaminophen), 120 mg/5 ml, syrup, 60 ml, bottle | BOT-60ml | 30 |
| PERMETHRIN, 1 %, shampoo/lotion , 100ml, bottle | BOT- 100ml | 10 |
| PYRANTEL 50mg /ml oral suspension 15-30ml | unit | 10 |
| RESOMAL, rehydration acute complications. malnutrition., sach. 42g/1L, | box-100 | 1 |
| RETINOL (vitamin A), 200.000 IU, soft gelatin caps | box-100 | 1 |
| RETINOL (vitamin A)100,000IU, soft | unit | 500 |
| RINGER lactate, 500 ml, plastic bottle, w/ IV giving set | bag of 250ml | 30 |
| SULFAMETHOXAZOLE 100mg + TRIMETHOPRIM 20mg (cotrimoxazole 120mg), tab | box-100 | 1 |
| TETRACYCLINE hydrochloride, 1%, eye ointment, 5 g, tube | Tube -5g | 40 |
| WATER for injection, 10 mL, ampoule | unit | 50 |
| WATER for injection, 5 mL, ampoule | unit | 50 |
| ZINC OXIDE, 10%, ointment, 50g, tube | Tube x 50g | 15 |
|  |  |  |
| 1 flash drive with documents |  |  |



