SUPERVISED SUPPLEMENTARY FEEDING PROGRAMME (SSFP)

Training program for Anganwadi Teachers (AWTs),
Auxiliary Nurse and Midwife (ANM) and ICDS supervisors

2019 | ICMR-NIN, NCoESAM
at Kalawati Saran Children's Hospital

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Commissioner

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Message from Commissioner's Desk

The newly formed Telangana State is geographically the 12th largest state in the country with a population of 3.50 crores (as per Census 2011) of which 61.12% resides in the rural, tribal areas and the remaining 38.88% in the urban areas. Telangana, being one of the youngest State in country, is also grappling with the challenges of malnutrition among children.As per Comprehensive National Nutrition Survey (CNNS) 2018 report, the prevalence of wasting, an indicator of acute malnutrition (inclusive of both Moderate and Severe Acute malnutrition), among under 5 years is 17.9% and out of this 5.6 % children are with severe acute malnutrition (SAM).

The young child is more prone to be lockedin a vicious cycle of recurring illness and faltering growth - diminishing their physical health, irreversibly damaging theirdevelopment and their cognitive abilities, and impairing their capabilities as adults.This stresses the fact that acute malnutrition among children is a public health problem and which needs focussed attention. Currently in State, children with SAM are managed through networks of Nutrition Rehabilitation Centres (NRCs).For a sustained solution to manage the children with acute malnutrition (including children with both SAM and MAM), it is desirable to strengthen 'Community led Management' along with facility-based component for children with acute malnutrition.

The Supervised Supplementary Feeding Program (SSFP) is onesuch attempt to strengthen the community based management of acute malnutrition in State. Under SSFP, a newly formulated calorie and protein dense fortified supplementary food called Balamrutham-Plus' is being introduced for children with SAM and MAM. Along with food, skill building of caregivers will also be done to ensure home based quality care for such children.

The present training manual will be utilised to guide and train the field functionaries- Anganwadi Teachers (AWTs) and Auxillary Nurse and Midwifes (ANMs) and ICDS supervisors for service delivery under SSFP. Manual providesinformation on the care and management of children with SAM and MAM in a community set up. This manual is envisaged fora collective action from both Women Development and Child Welfare department & Health and Family Welfare Department to address the challenge of acute malnutrition in the State.Technical and programmatic support from ICMR-NIN Hyderabad and UNICEF office for Andhra Pradesh, Telangana and Karnataka, for the program is noteworthy.

I congratulate everyone involved in this crucial effort of implementing the SSFP program in the State.

Commissioner,
WD &CW
Telangana

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ABBREVIATIONS

AAY - Antyodaya Anna Yojana

ANM - Auxiliary Nurse Midwife

ARI - Acute Respiratory Infection

ASHA - Accredited Social Health Activist

AWC - Anganwadi Centre

AWT - Anganwadi Teacher

AWH - Anganwadi Helper

Balamrutham + - Balamrutham plus

BMO - Block Medical Officer

°C - Centigrade

CDPO - Child Development Project Officer

DPM - District Programme Manager

DPO - District Programme Officer

DPT - Diphtheria, Pertussis, Tetanus

°F - Fahrenheit

FSAM - Facility based Management of Children with Severe Acute Malnutrition

GI - Gastrointestinal

HAZ - Height-for-age Z-score

ICDS - Integrated Child Development Services

IEC - Information Education and Communication

IFA - Iron Folic Acid

IMNCI - Integrated Management of Neonatal and Childhood Illnesses

IPC - Inter-personal Communication

IYCF - Infant and young child feeding practices

LS - Lady Supervisor

MAM - Moderate Acute Malnutrition

MCP - Mother Child Protection

NHD - Nutrition Health Day

NRC - Nutrition Rehabilitation Centre

OPV - Oral Polio Vaccine

ORS - Oral Rehydration Solution

PDS - Public Distribution System

PHC - Primary Health Centre

RR - Respiratory Rate

SAM - Severe Acute Malnutrition

SD - Standard Deviation Score

SNP - Supplementary Nutrition Programme

SSFP - Supervised Supplementary Feeding Programme

VHSNC - Village Health Sanitation and Nutrition Committee

WASH - Water Sanitation and Hygiene

WAZ - Weight-for-Age Z-score

WHZ - Weight-for-height Z-score

WHO - World Health Organization

Supervised Supplementary Feeding Programme (SSFP)
Training Plan for AWTs, Supervisors and ANMs
Telangana

Day 1

S. No.	Session Detail
1	Welcome and Introduction
2	Pre-test
3	Session – 1: Introduction to Malnutrition
	Break
4	Session – 2: Components of SSFP for children with Acute Malnutrition and Community Mobilization • What is community mobilisation? • Why is community mobilisation important? • Who can play a critical part in community mobilisation? • Stages of community mobilisation • Role of community mobiliser/frontline worker • Major challenges in community mobilisation • Points for discussion during sensitisation • Key messages
5	Session – 3 (Step 1): Identification of Children with Acute Malnutrition (SAM/MAM) and treatment modalities

Day 2

S. No.	Session Detail
	Recap of Day 1
6	Session – 4 (Step 1 to 3): Management of children with acute malnutrition at community level- Supervised Supplementary Feeding Programme (SSFP) • Anthropometric Assessment • Appetite Test • Medical Assessment and danger signs
7	Session – 4 (Step 4): Supervised Supplementary Feeding Programme (SSFP) • Decision for admission – SSFP/ NRC
	Break
8	Session – 4 (Step 5 to 7): Supervised Supplementary Feeding Programme (SSFP) • Nutritional Treatment • Medicine • Nutrition Health Education including WASH
	Break
9	Session – 4 (Step 8 to 10): Supervised Supplementary Feeding Programme (SSFP) • Follow-up during SSFP Programme • Discharge criteria from SSFP Programme • Post discharge follow-up
10	Session – 5 : Record Keeping, Monitoring and Reporting
	Break

11	Session – 6: Inter-personal Communication • Skills for greeting and building rapport • Skills for listening and learning • Skills for giving relevant information • Skills for checking, understanding and solving problems • Practical Counselling Process • How to conduct Group counselling sessions

Day 3

12	Session – 10 : Roles and Responsibilities of AWT, ANM, ASHA and Supervisor under SSFP
13	Session – 11 : For ANMs • Medical Assessment • Step 6 of SSFP (medication)
	Break
14	Session – 12: Anthropometric Hands on training sessions
	Post-test
	Consolidation and Closure

Note: For Telangana, training sessions were spanned over three days. Starting, post lunch on Day 1 and ending at lunch on Day 3.

User guide for facilitators

Introduction

This manual will be used as facilitator manual, which will work as reference material for the facilitators in conducting the training programme. This will also be used as a reference/instruction guide for the Community Health Workers (CHWs) like ANMs, AWTs and ASHAs, who would be trained on SSFP for managing children with acute malnutrition and further implement the programme in their respective villages.

What methods of instruction are used in this course?

This course uses a variety of methods of instruction, including reading, written exercises, discussions, role plays, demonstrations, videos and practice in a real AWC (Clinic/Session). Practice, whether in written exercises or on the centre, is considered a critical element of instruction.

For whom is the training intended?

The training course is intended for frontline workers i.e. Anganwadi Teachers (AWTs), Auxiliary Nurse Midwifery (ANMs) and Accredited Social Health Activists (ASHAs) in the health sector and in ICDS sector who help in managing the children with SAM at the community level.

What is the role of the facilitator?

A facilitator is a person who helps the participants in learning the skills presented in the course. The facilitator devotes much of his/her time in discussions with the participants, either individually or in small groups. In your assignment to teach this course, you are a facilitator. As a facilitator, you need to be very familiar with the material being taught. It is your job to give explanations, do demonstrations, answer queries of participants related to the topic, talk to participants about their answers to exercises, conduct role plays, lead group discussions and generally give participants any help they need to successfully complete the training.

- You are not expected to teach the content of the course through formal lectures.
- (Nor is this a good idea, even if this is the teaching method to which you are most accustomed.)

What, then, does a facilitator do?

As a facilitator, you do 3 basic things:

1. You instruct:

- Make sure that each participant understands how to work through the materials and what she/he is expected to do in each module and each exercise.
- Answer the participant's questions as they occur.
- Explain any information that the participant finds confusing, and help him understand the main purpose of each exercise.
- Lead group activities, such as group discussions, oral drills, video exercises, and role plays, to ensure that learning objectives are met.
- Promptly review each participant's work and give correct answers.

- Discuss with the participant how he/she obtained his answers in order to identify any weaknesses in the participant's skills or understanding. Provide additional explanations or practice to improve skills and understanding.
- Help the participant to understand how to use skills taught in the course in his/her own hospital.
- Assist the clinical instructor as needed during clinical practice sessions.

2. You motivate:

- Compliment the participant on her correct answers, improvements or progress.
- Make sure that there are no major obstacles to learning (such as too much noise or not enough light).

3. You manage:

- Plan ahead and obtain all supplies needed each day, so that they are in the classroom or taken to the hospital ward when needed.
- Monitor the progress of each participant.

Components of the facilitator manual

- The modules are designed to help each participant develop specific skills necessary for the case management of acutely malnourished children. The skills that participants will develop are - as they can read the modules, observe case live demonstrations and practice skills in written exercises, group discussions, or role plays.
- A contents page has been provided at the beginning of this guide for easy navigation.
- A detailed session plan for the three days training programme has also been provided so that participants are well aware about the methodology of the training programme and time distribution in each session taken for the next three days.
- A list of abbreviations is also given for the user's quick reference.
- This training program is composed of 9 sessions and each session is mentioned with the time plan to be followed. This is to help facilitators to organise and conduct the training within the time limits to allow better time management.

- Learning objectives at the beginning of each chapter have to be read aloud by the participants so that they understand what each session would teach them.
- All the materials required and preparations that have to be made by the facilitator before conducting the session are mentioned at the beginning of each session. The facilitator is expected to be ready with all the materials required well in advance and have the knowledge when and where he/she should use the materials within the session.
- At the end of each session, key learning - take home messages from that session should be summarised for the better understanding of the participants.
- Lastly the manual contains the annexes; the references of which are given in the session. So that, participants refer to those annexes as and when required.

Methodology and instructions

- Instructions regarding how to conduct the activities, sub-sessions, exercises etc. are given in the manual for facilitators to maintain consistency/reliability in the methodology & the way the training is conducted by different facilitators to get the same results.
- Wherever required, along with the text, illustrations have been used in the manual in order to support the text as well as for understanding the subject matter better.
- For understanding the technical details clearly; methods and processes, use of videos and job aids have been suggested in the manual. This would help the participants for gaining practical knowledge as well about the subject.
- Without hesitation, each participant should freely discuss any problems or questions with a facilitator, and receive prompt feedback from the facilitator on completed exercises. It is necessary for the facilitator to answer all the queries raised after exercises by the participants so that doubt regarding anything should be dealt that time only.

How to conduct the training?

- Begin each session by highlighting the learning objectives so that each participant is aware about the main focus of the training program.
- All the session related activities use effectively to make each session interesting and interactive.
- Session should be more into discussion rather than lecture based so the involvement of all participants should be there.

- Conduct the session keeping in mind the methodology and time suggested in the manual for each session.
- Encourage participants to ask questions during the session without any hesitation.
- Use of job aids should be appropriate and at appropriate time.
- Do not rush through the sessions. You might like to pace your session according to the new subject that has been introduced to facilitate a smooth structuring of the session as well as a logical summation.
- Ensure that the participants have understood the subject completely. Explain any information that the participant finds confusing, and help him/her understand the main purpose of each exercise.
- For any exercise or role play, give clear instructions and ensure first, that they have understood what has to be done. Lead group activities, such as group discussions, exercises and role plays, to ensure that learning objectives are met.
- Promptly review each participant's work and give correct answers.
- Provide additional explanations or practice to improve skills and understanding if required. Help the participant to understand how to use skills taught in the course in his/her own setting as part of the SSFP programme.
- Give pre and post assessment questionnaire to the participants before and after the training respectively. Collect the filled questionnaires and evaluate them as soon as possible.
- This will help you in evaluating the impact of the training and understanding of your participants regarding the topics dealt in the training program.

General instructions for conducting role play

1. Explain the role play to the participants on the basis
2. Explain the story
3. Motive of conducting that particular role play
4. Explain to participants that they have to closely observe the role play and then give their comments on
   A. Communication Skills
   B. Messages Conveyed
5. After the role play, discuss and brainstorm
   - First take comments from the participants on positives done and then suggestions to improvements and important messages missed. Have a discussion
   - After getting comments from participants give your opinion and summarize the role play focusing on
   - What positive done
   - What all messages missed and importance of those messages
   - Discuss the communication skills used and emphasize the need of using them

DO'S

- Show enthusiasm for the topics covered in the course and for the work that the participants are doing.
- Be attentive to each participant's questions and needs. Encourage the participants to come to you at any time with questions or comments. Be available during all times.
- Watch the participants as they work, and offer individual help if you see a participant looking troubled, staring into space, not writing answers, or not turning pages. These are clues that the participant may need help.
- Promote a friendly, cooperative relationship. Respond positively to questions (by saying, for example, "Yes, I see what you mean," or "That is a good question.") Listen to the questions and try to address the participant's concerns, rather than rapidly giving the "correct" answer.
- Devote enough time with each participant to answer his questions completely (that is, so that both you and the participant are satisfied)

DON'TS

- During times scheduled for course activities, do not divert yourself or letting participants from the topic or discuss matters not related to the course.
- In discussions with participants always show empathy and avoid using facial expressions or making comments that could cause participants to feel embarrassed.
- Do not call on participants one by one as in a traditional classroom, with an awkward silence when a participant does not know the answer. Instead, ask questions during individual feedback.
- Do not lecture about the information that participants are about to read.
- Give only the introductory explanations that are suggested in the Facilitator guide. If you give too much information too early, it may confuse participants. Let them read it for themselves from the modules.
- Avoid being too much of a showman. Enthusiasm (and keeping the participants awake) is great, but learning is most important. Keep watching to ensure that participants understand the materials. Difficult points may require you to slow down and work carefully with individuals.
- Do not be condescending. In other words, do not treat participants as if they are children. They are adults. Do not show superiority.
- Be a good listener. Do not talk too much. Encourage the participants to talk.
- Do not be shy, nervous, or worried about what to say. This Facilitator Guide will help you remember what to say. Just use it!

Checklist of instructional material needed in each group

S. No	Item Needed	Number Needed
1	Training manual	1 set for each facilitator and 1 set for each participant
2	TV/ DVD/ Computer with projector	Lead facilitator will inform you where you can show the video
3	Set of wall charts, markers, tape	1 set for each group
4	Flip charts	1 set for each group
5	Case recording form (reporting formats) / Exercise for clinical session	2 set for each participant and few extra
6	Pretest questionnaire	2 for each participant
7	Weighing scale (Digital)	1 set for each group
8	Stadiometer and infantometer	1 set for each group
9	Stationary items (pen, note pad and folder)	1 set for each participant and few extra

Pre-Post Assessment test

(Each question is for one mark)

1. Which one of the following criteria will be used for screening in the community for identification of SAM children, above 6 months?

a. WHZ (>-2SD) and non occurrence of bilateral pitting edema

b. WHZ (>-1SD) and non-occurrence of bilateral pitting edema

c. WHZ (<-3SD) and/or occurrence of bilateral pitting edema

d. WHZ (>+2SD) and non-occurrence of bilateral pitting edema

2. What is the current prevalence of SAM children in Telengana?

a. 7.5 % b. 8.4% c. 4.8% d. 12.5%

3. In presence of SSFP programme SAM children with diarrhea& dehydration will be managed at

a. PHC b. CMAM Programme c. NRC d. District Hospital

4. Which one of the following criterion is not an indication for admission of SAM child to NRC in presence of SSFP programme?

a. Cough with fast breathing b. Edema c. Fever due to cold d. Lethargy

5. Approximately, what percentage of SAM children can be managed in SSFP programme?

a. 40 – 50 % b. 20 – 25 % c. 85 – 90 % d. 60 – 70 %

6. A 13 months old child during screening drive has weight for length of < -2 SD & has bilateral pitting edema. His nutritional status will be classified as

a. MAM b. Stunting c. SAM d. Normal

7. A 15 months old child during screening drive has weight for length of < -2 SD. His nutritional status will be classified as

a. MAM b. Stunting c. SAM d. Normal

8. What is not a component of SSFP Programme?

a. Community Mobilization

b. Screening and Identification of Children with SAM and MAM

c. Management of Children aged 6-59 months with SAM and MAM at Community Level

d. Management of Children < 6 months with SAM and MAM at Community Level

9. Which one of the two treatments is not recommended under SSFP programme

a. Injection Ampicillin and Gentamicin b. Amoxicillin and Multivitamin c. Amoxicillin and Folic Acid

10. Which of the following is true about Community Mobilization?

a. It is one time community sensitization

b. It helps to identify barriers in the community and to find solutions

c. community mobilization may disrupt the programme

d. It is not cost a effective strategy

11. Which of the following criteria is correct to enrol the child in SSFP programme?

a. Good Appetite with medical complication

b. Good Appetite without medical complication

c. Poor Appetite with medical complication

d. Poor Appetite without medical complication

12. Write two methods by which energy density of complementary foods may be increased?

a. _____

b. _____

13. Which one of the following is correct for Complementary feeding?

a. It should be initiated to the infant at the age of 9 months

b. It should be started with dal- pani

c. Animal origin food items should not be given before 1 year of age

d. Early initiation of complementary feeding (before 6 months) may cause diarrhea in children

14. Which one of the following should not be done if a child has diarrhea?

a. Encourage the child to drink and to eat – with lots of patience

b. Give zinc supplementation

c. Give ORS after each loose stool

d. Stop breastfeeding for 72 hours

15. In the SSFP programme a SAM child will treated for the maximum period of ..... weeks.

a. 8 weeks b. 12 weeks c. 16 weeks d. No time limit is specified.

16. In the SSFP programme a MAM child will treated for the maximum period of ..... weeks.

a. 8 weeks b. 12 weeks c. 16 weeks d. No time limit is specified.

Welcome and introduction

S. No	Detail	Methodology
1	Welcome and introduction	Self-introduction
2	Pre-assessment questionnaire	Filling of questionnaire
3	Expectations of the participants	Brainstorming
4	Overview and objectives of the training	Trainer's presentation/discussion
5	Ground rules of the training	Brainstorming

Material required and preparations to be done by the facilitator

1. Plain white chart, markers, tape
2. Write objectives of training on the chart
3. Keep copies of pre-assessment questionnaire (one for each participant)

Welcome and introduction

Welcome the participants enthusiastically.

1. Introduction

Ask participants to pair up with the person sitting next to them. Explain that in each pair, the participants have to obtain information such as each other's names, areas they work in and key roles/responsibilities/competencies. Both participants in each pair, instead of giving their own introduction will introduce their partner.

2. Pre-assessment questionnaire

After the introduction, tell the participants that they will have to fill a pre-assessment questionnaire. Ask them to write name/number and remember the code which they have written on the test paper. Distribute the pre-assessment questionnaire to the participants, explain it and request them to complete it in 15 minutes. Collect the completed questionnaires and evaluate them at the earliest.

3. Expectations of the participants

Ask the participants about their expectations from this training. Write down these expectations on a chart and display it on the wall with the help of tape.

4. Overview and objectives of the training

Present a summary of the training for the next three days.

Display the objectives written on the chart and ask any one participant to read out the first objective, ask another participant to read the second and so on. After one participant has read an objective, clarify it and then ask the other participant to read the next objective.

Objectives of the training

By the end of the training, participants will be able to:

I. Identify children with SAM and MAM in their community

II. Decide which children with SAM should be referred to the NRC and which can be managed in the community based management of children with SAM Supervised Supplementary Feeding Programme (SSFP Programme) for managing children with acute malnutrition

III. Treat admitted children with SAM and children with MAM in the SSFP according to the protocol

IV. Monitor the health status of children with SAM regularly during follow-ups

V. 5 Ground rules of the training

Start a conversation with the participants and explain the following ground rules of the training:

I. Mobile phones must be switched off

II. One participant speaks at a time

III. Active participation

IV. Active listening

V. Punctuality

VI. Co-operate with each other

VII. Respect each other

SESSION 1

Introduction to malnutrition

S. No	Detail	Methodology
1.1	What is Malnutrition • Types of malnutrition • Determination of nutritional status • Causes of malnutrition • Why acute malnutrition should be treated early?	Chart and discussion
1.2	How common is malnutrition in Telangana	Case study, job aid and discussion
1.3	Summary - Take home message	Discussion

LEARNING OBJECTIVES

By the end of the session, participants will be able to:

- Explain clearly about malnutrition and types of malnutrition.
- Describe the causes of malnutrition.
- Describe why children with SAM and MAM need immediate attention all during the sessions will be encouraged.

1.1 What is Malnutrition?

Malnutrition is a general term which is most often referred to under nutrition resulting from inadequate consumption, poor absorption or excessive loss of nutrients for an extended period of time. Malnutrition is both a medical and a social disorder.

Types of Malnutrition:

There are two types of malnutrition: 1) Acute Malnutrition. 2) Chronic Malnutrition.

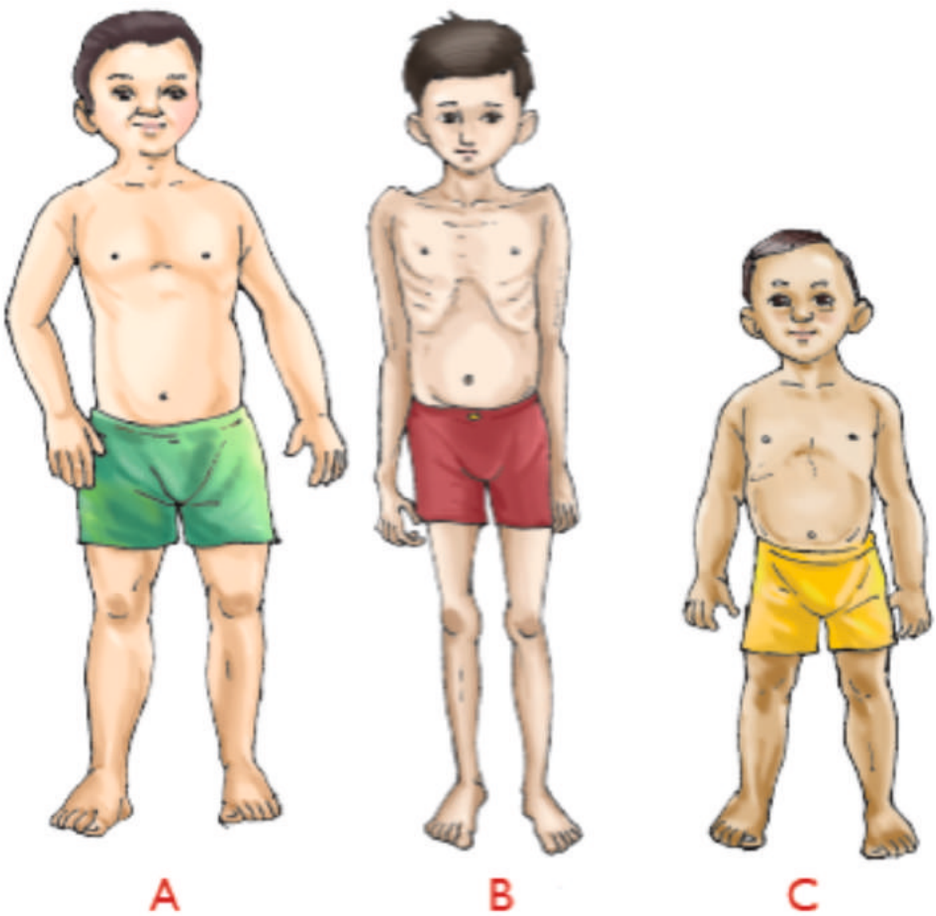


Image 1: Children depicting different nutritional status

Child A	Child B	Child C
Age: 17 months Weight: 10 kg Length: 80 cm WHZ > -2SD	Age: 17 months Weight: 7.12 kg Length: 79.8cm WHZ > -3SD	Age: 17months Weight: 10 kg Length: 80 cm WHZ > -2SD

You can see three children of same age who have different nutritional status (Image 1). Child A and B have similar height, but the child A looks more muscular, ribs are not visible. Child B has height similar to child A but he looks thin, his ribs can be seen easily.

Child A is healthy because he has appropriate weight and height for his age, muscle and fat. Child B is having similar height but he looks thin, has loose skin folds, ribs easily seen. This happens when there is acute malnutrition i.e. malnutrition of shorter duration.

Child C has shorter height than Child A & B but his muscle and fat looks normal. There are no loose skin folds. This happens when there is long standing (chronic) malnutrition.

Although, both the forms of malnutrition needs treatment, risk of mortality is much higher in acute malnutrition. Hence treatment of acute malnutrition is more important for preventing mortality.

In this training, you will learn about the management of acute malnutrition.

Determination of nutritional status:

Anthropometric measurements are most commonly used methods to determine nutritional status.

There are three different systems by which a child or a group of children can be compared to the reference (Table 1).

1. Underweight

An underweight child has a weight-for-age Z-score that is at least two standard deviations (-2SD) below the median in the World Health Organization (WHO) Child Growth Standards. Low weight (Underweight), may result from both chronic malnutrition (stunting) and wasting (acute malnutrition). Additional measurements are required to differentiate these two types of malnutrition.

2. Stunting

Failure to achieve expected height/length as compared to healthy, well-nourished children of the same age is a sign of stunting. Stunting may be associated with delayed mental development, poor school performance and reduced intellectual capacity. A stunted child has a height-for-age Z- score that is at least two standard deviations (-2 SD) below the median for the WHO Child Growth Standards.

3. Wasting

Wasting represents a recent failure to receive adequate nutrition and or recent episodes of diarrhoea and other acute illnesses. Wasting indicates current or acute malnutrition resulting from failure to gain weight or actual weight loss. A wasted child has a weight-for-height Z- score that is at least two standard deviations (-2SD) below the median for the WHO Child Growth Standards.

W.H.O Classification of Malnutrition

SD SCORE	Table 1: Growth indicator		
	Height / Length-for-age	Weight-for-age	Weight-for-height/length
0 (median) to – 2 SD	Normal	Normal	Normal
< – 2 SD to –3 SD	Stunted	Underweight	Wasted or moderate Acute malnutrition (MAM)
< – 3 SD	Severely stunted	Severely underweight	Severely wasted or severe Acute malnutrition (SAM)

Notes: Severely underweight is referred to as very low weight.

Causes of malnutrition

Risk factors like low birth weight, inappropriate feeding practices like not breastfed or top fed, non-exclusive breastfeeding, delayed introduction and poor quality of complementary feed, lack of hygiene and food scarcity, lack of hygiene and infections makes a child more prone to become malnourished.

In practice, malnutrition and infection often occur together. Malnutrition lowers the immunity of the child and increases the risk of infection. At the same time, infection results in loss of appetite, increased nutrient requirements and/or decreased absorption of nutrients consumed which can further deteriorate malnutrition. A malnourished child, whose resistance to illness is poor, has an increased likelihood of falling ill for longer duration and becoming more malnourished, which reduces his/her capacity to fight against illness even more and so on. This is called the infection-malnutrition vicious cycle (Image 2).

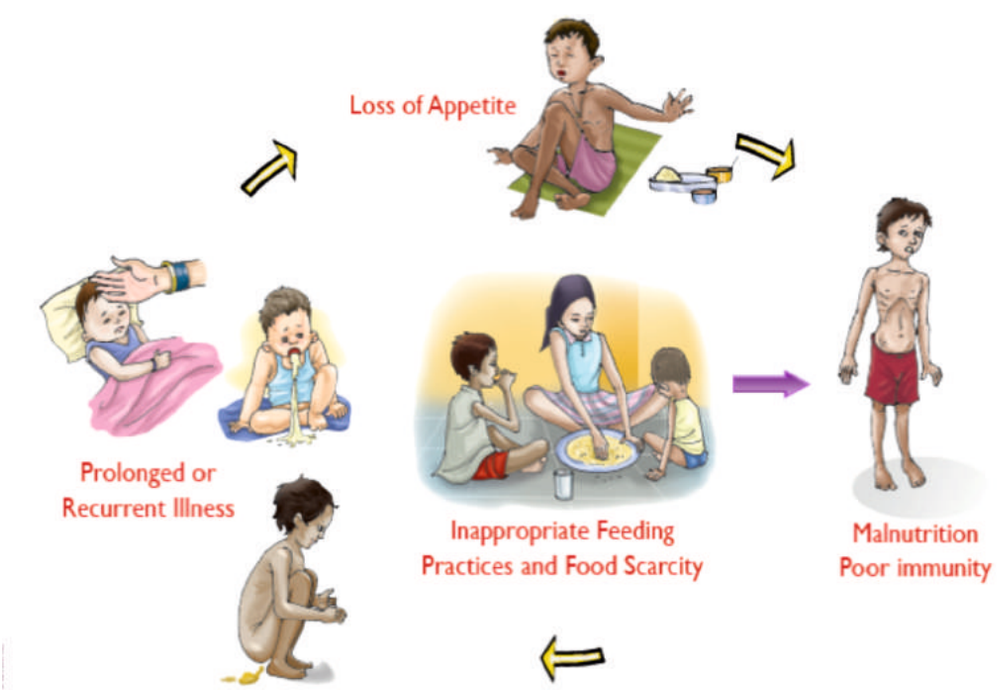


Image 2: Vicious cycle of malnutrition and infection

Why acute malnutrition should be treated early?

Severe Acute Malnutrition significantly increases the risk of death in children under five years of age, by making them susceptible to common illnesses such as diarrhea, acute respiratory infections, malaria and measles (Figure 1). Children with MAM are more likely to be affected with SAM, thus early intervention helps in reducing the burden of SAM and associated complications. The effects of malnutrition on the health and survival of a child

- Impaired physical growth
- Impaired brain development
- Increased risk of infection and death

A child with severe acute malnutrition has 11 times higher risk of death with common illness as compared to a child with normal nutrition.

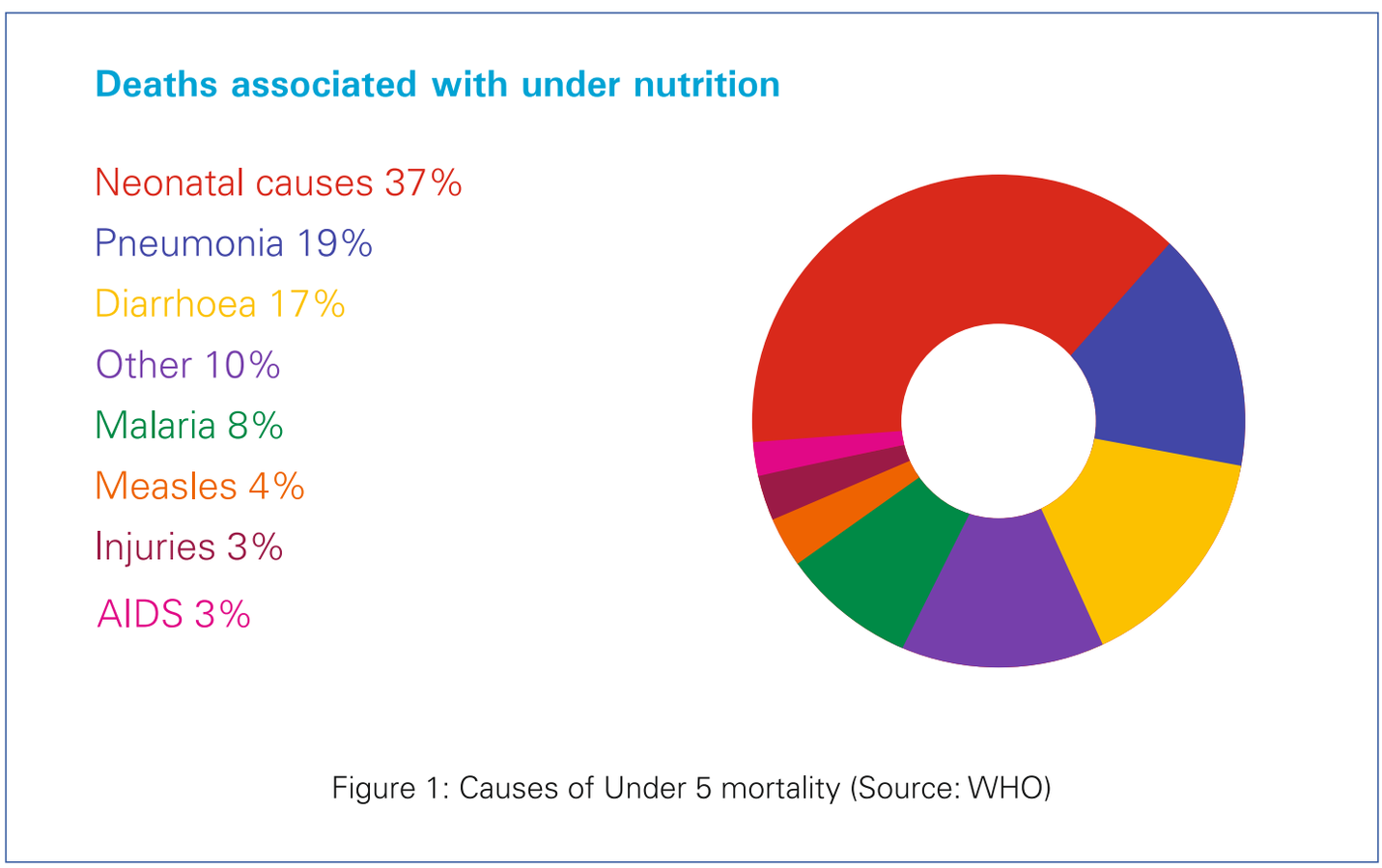


Figure 1: Causes of Under 5 mortality (Source: WHO)

1.2 How common is malnutrition in Telangana

Undernutrition is one of the most concerning health and development issues in India as in other parts of the world. The disease burden and high mortality resulting from under nutrition call for urgent implementation of interventions to reduce their occurrence and consequences. This would also include determined action on the social determinants of Undernutrition.

The prevalence of stunting, underweight, wasting and severe wasting in the state of Telangana are 28%, 38.4%, 18.1% and 4.8% respectively (Figure 2). There are some states which are having better indicators of malnutrition compared to Telangana and the state should adopt some of the good practices of these states to combat malnutrition among children in its state. Further, the overall wasting in India has increased over the last one decade and is a cause of concern.

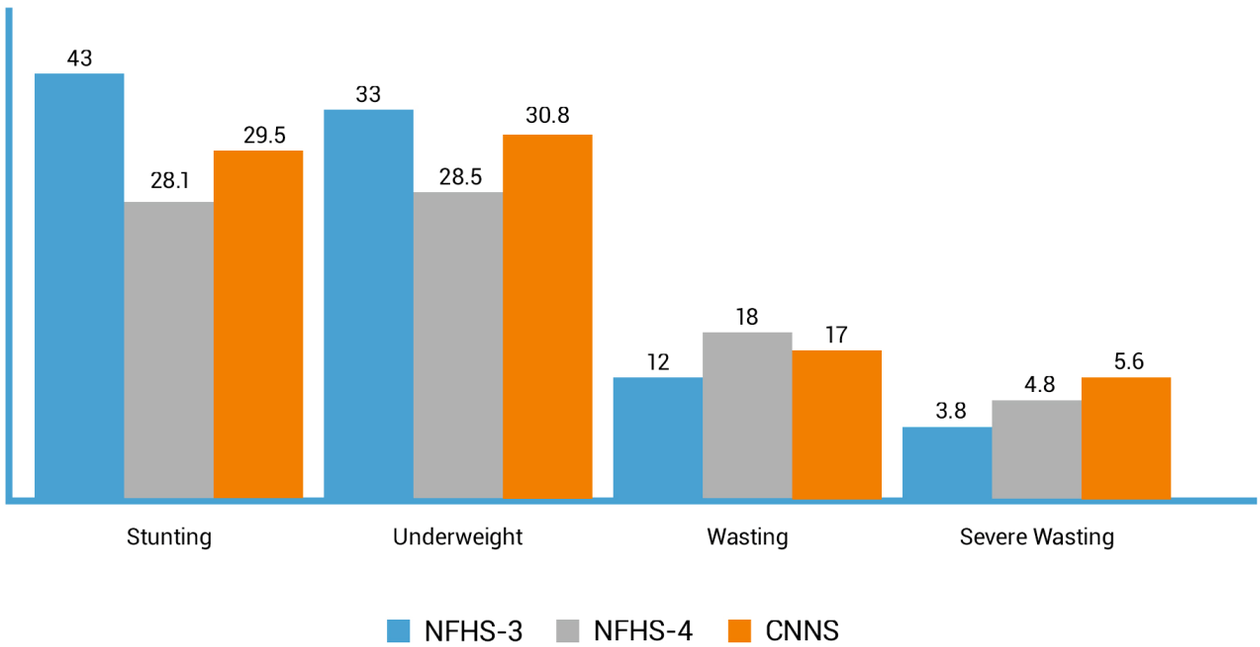


Figure 2: Nutritional status of children under 5 years of age - Telangana

1.3 TAKE HOME MESSAGES

- Malnutrition may be of acute onset or chronic in nature
- Malnutrition and infections makes a vicious cycle
- Children with SAM have higher risk of mortality i.e 8-9 times higher than normal children if they develop common illnesses like diarrhoea, pneumonia etc
- The levels of child malnutrition in Telangana is lower than the national average. However, the indicators are higher compared to other better performing states
- Overall in India, wasting has increased over the last decade

SESSION 2

Components Of Supervised Supplementary Feeding Programme (SSFP) for children with acute malnutrition & community mobilization

S. No	Detail	Methodology
2.1	Understanding community	Game and Discussion
2.2	Components of SSFP - Community Mobilisation - Screening and Identification of Children with SAM and MAM	Role Play, Discussion and brainstorming
2.3	Summary: Take Home message	Discussion

LEARNING OBJECTIVES

By the end of the session, participants will be able to:

- Sensitize and mobilise the community in identifying children with SAM and MAM.
- Screen and identify children with SAM and MAM through case finding methods in the community.
- Provide information to the community about the services available for management of SAM and MAM in the SSFP and Nutrition Rehabilitation Centre (NRC).

2.1 Understanding community

Understanding the community is very important for the success of any community based programme. A community will have people with diverse educational and economic status. For the success of the programme, we will need to reach each and every under-five child. This problem may be minimized by community mobilization. In this chapter, we will learn about components of SSFP.

2.2 Components of SSFP:

A. Community Mobilization

B. Screening and Identification of Children with SAM and MAM

C. Management of Children with SAM and MAM at Community Level

We will discuss these three components in detail;

A. Community mobilization

It refers to a range of activities designed to help implementers to interact with the community especially families with SAM and MAM children to understand the affected communities, build relationship with them and foster their participation in the programme. It covers three activities; community sensitization, follow up and ongoing sensitization (Figure 3)

Figure 3: Stages in community mobilization process

Why is community mobilization important?

- A lot of practices including health seeking behaviour are influenced by community perception about the problem.
- Any intervention in the community cannot succeed without knowing the cultural and social milieu of the community. This can only be learnt from the people belonging to that particular community.
- When people of the communities are involved in matters affecting them, they feel honoured, respected & also the ownership & involvement in the activities are increased.
- When the community is mobilised and on board, implementation of the programme becomes easier.

Who can play a critical part in community mobilization?

- Panchayat members
- Sarpanch
- Religious and local leaders
- Traditional healers
- Teachers
- Mahila mandal/leaders of women's group
- Local youth groups
- Mother's groups
- Self-help groups

Along with support from the people mentioned above, community workers like AWTs/ ASHAs/ANMs, Village Health Sanitation and Nutrition Committees (VHSNCs) also play a very important role in mobilising and sensitising the community. If this committee actively participates and conducts their responsibilities fully, it will help the workers in early identification of children with SAM and children with MAM and will also help in better involvement of the community.

Community sensitization

Assessing community perceptions prior to community mobilization is necessary to identify the barriers as well as potential boosters to service access and uptake.

RULE technique for community mobilization:

Four key points need to be kept in mind for community mobilization

1. Resist Righting reflex: Don't be critical of any beliefs that you feel are inappropriate
2. Understand the beliefs: Know your community well and be aware of existing beliefs and practices prevalent in the community
3. Listen and negotiate: Always listen to the community members carefully. Try to analyse community dynamics and try to negotiate
4. Educate, Empower and Empathize: Impart the right information, help them in decision making and empathize if necessary. Recognize their negative experiences if any and try to minimize their impact

Undernutrition is one of the most concerning health problems and such messages are important, to be communicated to the community:

Malnutrition is very often invisible. Parents whose children are malnourished may believe that their children are growing well and often don't come out or share within the community about children with SAM and children with MAM. Many of these families are marginalised, labour etc. Therefore, efforts are required to create awareness in the community about the physical characteristics of undernourished children. Families of at-risk children need encouragement from community to seek and continue appropriate care.

Before implementation, it is necessary for the community to know about the programme and give approval.

They should understand the objectives of the programme. Active support from Panchayati Raj Institution, School Teachers, Block and District Administrative Officers, Political and social activists is important to reach to each and every SAM and MAM child in the community.

Community should be sufficiently involved to take ownership of the programme once it is established and shown to be effective.

Key community members, must be clear about how the programme will affect them and their community in practice: what will it do, who will be eligible to benefit and why they will be selected, who will not benefit or be excluded, where it will operate, who will implement it, how people access it and what the programme will do for the selected individuals. Any misunderstanding at this stage can lead to frustration and disillusionment.

Common features of a sensitization campaign include:

- Information sessions with village leaders and community. This should happen few days, prior to screening sessions
- Announcing schedule of activities (eg. Screening drive; growth monitoring sessions) to community members
- Undertaking appropriate IEC campaign locally for describing the physical characteristics of children with SAM and children with MAM based on local understanding of, and the terminology used to describe malnutrition

Platforms for community mobilization:

In Telangana's context, there are several initiatives being undertaken or services being provided by different departments

Community mobilisation through information dissemination, providing health and nutritional services and counselling by ASHAs/AWTs/ANMs

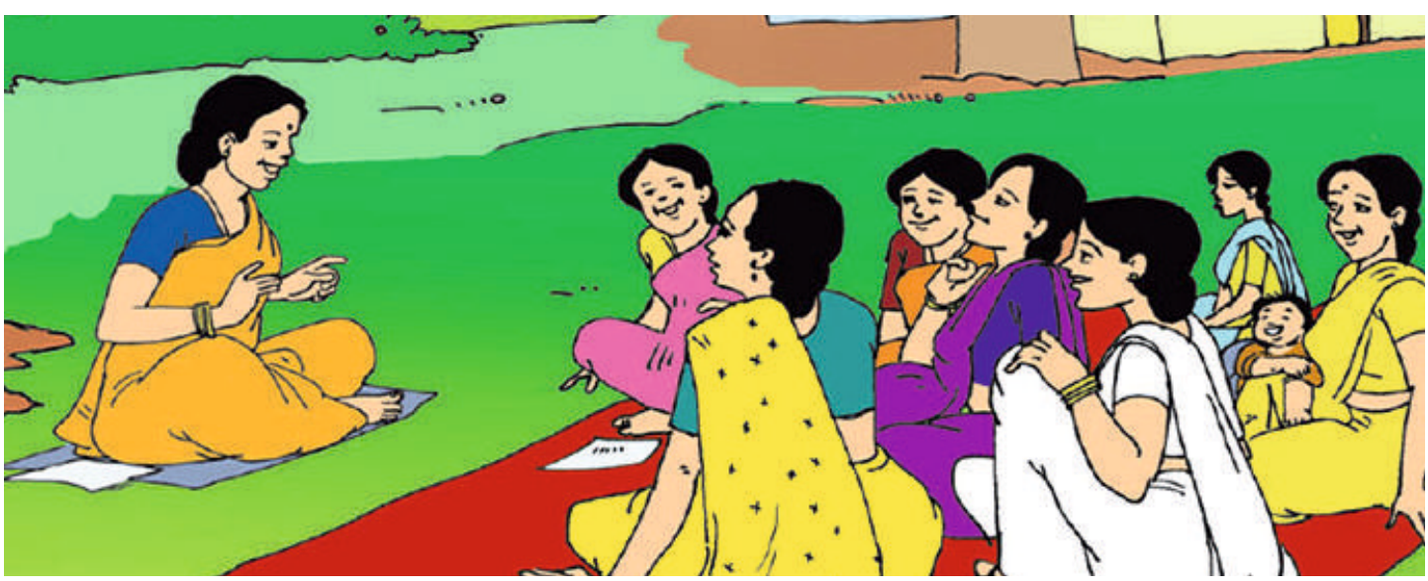
ASHAs and AWTs are seen as responsible for disseminating health and nutritional information and through home visits and counselling motivate women to avail various health and nutritional programme supported by the government. They maintain lists of eligible beneficiaries and through individual and group meetings, they educate and motivate them for availing the government health and nutritional programme on timely basis. ASHAs also work as link workers to doctors

and nurses, particularly in remote villages, and support the health system in the identification and delivery of health services for mothers and children during outreach programmes such as immunisation and health camps. They also conduct referral and escort services for Reproductive & Child Health (RCH) and other healthcare programmes, provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilisation of health & family welfare services.

ASHAs and AWTs counsel women on birth preparedness, care during pregnancy, importance of safe delivery, breast-feeding and complementary feeding, importance of nutritious food, personal hygiene, immunization and care of the young child. They mobilise the community and facilitate them in accessing health and nutritional services available at the Anganwadi/sub-centre/primary health centers, such as immunisation, Ante Natal Check-up (ANC), Post Natal Check-up supplementary nutrition, sanitation and other services being provided by the government. Anganwadi Teacher is a depot holder for drug kits.

Auxiliary Nurse Midwife (ANMs) is a resource person for ASHAs and AWTs. They hold weekly/fortnightly meeting with ASHA and provide on-job training by discussing the activities undertaken during the week/fortnight and provide guidance in case ASHA encounters any problem. ANM also guides AWTs on how to provide effective nutritional services to women and children during the Village Health Nutrition Health Days (VNHNDs).

The above health and nutritional services being provided by the three frontline workers viz. ANMs, AWTs and ASHAs are very important for overall health and nutritional well-being of mothers and children. These services would be the building block of the proposed program and efforts should be made to strengthen these programs alongside the program through effective monitoring and supportive supervision.



Village health, sanitation & nutrition day (VHSND)

The VHND is organized twice every month at the AWC in the village. The AWC is identified as the hub for service provision in the RCH-II, NHM, and also as a platform for inter-sectoral convergence. VHND is also to be seen as a platform for interfacing between the community and the health system. On the appointed day, ASHAs and AWTs mobilize the villagers, especially women and children, to assemble at the nearest AWC. On the VHND, AWTs and ASHAs should encourage the villagers to interact freely with them and with ANMs and other health personnel and obtain basic services and information. They should also make them learn about the preventive and promotive aspects of health care, which will encourage them to seek health care at proper facilities. Since the VHND holds at a site very close to their habitation, the villagers will not have to spend money or time on travel. Health and nutritional services are provided at their doorstep. During VHND, services related to child health like counselling for care of children and feeding, immunization, vitamin A, food supplementation, referral for cases of severe malnutrition, case management of those suffering from diarrhea and ARI, counselling on personal hygiene, growth monitoring etc. are provided. VHND can become an important platform to deliver services under the proposed program especially provide Augmented THR (Balamrutham+ also known as Balamrutham with a + symbol) to the children enrolled in the program, medical examination/checkups by the ANMs, referral to NRC if any enrolled children develops medical complications, counselling of mothers on feeding, cleanliness, child care etc and growth monitoring.

Community follow up

Community follow up aims at investigating the reasons for the absence and defaulting of children with SAM and MAM and encourage their return to the programme. It also aims at investigating the reasons in case of poor response and providing support for any problems that care providers may have with the protocols, e.g. appetite test interpretation, providing right amount of food, timely follow ups etc.

Community follow up takes place at the community level, hence the key stake holders need to assess the level of participation of the community by interacting with them from time to time. Meetings with the community representatives and care givers of the children in the programme are undertaken by AWT/ ASHA. Community meetings with key stakeholders at the block and village levels with community members and/or the caregivers for the children in the programme need to be held periodically to raise awareness about the programme and to investigate any issues such as high defaulter rates. Interact with families and community heads to understand difficulties e.g. distance, no one is available at home to feed the child when parents go for work. Discuss and try to find a solution with the family members.

On going community sensitization

Community sensitization is an ongoing two way process between the programme and the community. The process should be seen as a constant dialogue, in which communities periodically voice their views and suggest alternative courses of action. Regular community contact can help identify new barriers to access, and can provide timely, jointly – developed solutions.

B. Screening and identification of children with SAM and MAM

There are two methods by which cases of SAM and MAM can be identified in the community

I Case finding (Screening)

II Self-referral

I) Case finding (Screening)

To determine the SAM and MAM case-load in the SSFP program, active screening will be done every month

Who will do screening

Anganwadi Teacher will ensure that all the children of her village are screened including the ones residing in the hamlets. ASHA will support AWT in this activity.

What is done during screening

Height and Weight of all children attending VHND will be measured

Where and When is screening done

Identification of children with SAM will be through AWC on 1st VHND of the month

II) Self-referral

All children who are brought to the center on any given day by the caretaker for SAM and MAM will also be enrolled.

2.3 TAKE HOME MESSAGES

- Community involvement and awareness are major components of SSFP programme
- For early identification of SAM and MAM children, community sensitization is important
- ASHA AWT will screen all children for SAM and MAM on 1st VHND
- ASHA AWT will inform ANM about all SAM children screened for medical check up

SESSION 3

Identification Of children with severe acute malnutrition (SAM & MAM) & treatment modalities

S. No	Detail	Methodology
3.1	How do we identify children with acute malnutrition?	Discussion
3.2	How to identify SAM and MAM children in community? - How to measure weight and height/length - How to look for Edema	Discussion, demonstration and video
3.3	Measurements at AWC/health facilities for identification of children with malnutrition and monitoring their progress - Weigh the child	Discussion, demonstration and video, exercise
3.4	Identification of malnutrition by combined use of WHZ, and Edema	Discussion & exercise
3.5	Modalities of SAM management	Discussion and brainstorming
3.6	Principles of SSFP programme	Job aid and discussion
3.7	Mechanism of SSFP programme	Discussion
3.8	Strategy of SSFP program - Preventive approach - Community based therapeutic care for treatment of SAM and MAM	Discussion
3.9	Summary: Take home message	Discussion

LEARNING OBJECTIVES
By the end of the session, participants will be able to:

- Define and differentiate between Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM)
- Describe the need for community based management of children with SAM and MAM (SSFP)
- Measure anthropometric measurements weight, height or length and Assess Bilateral Pitting edema
- Identify nutritional status by combined use of WHZ, and Edema
- Explain modalities of SAM and MAM management

3.1 How do we identify children with acute malnutrition?

- Severe acute malnutrition is defined by weight-for-height/length z-score below -3SD of the median WHO child growth standards, AND/OR, by the presence of bilateral pitting edema.

- Moderate acute malnutrition is defined by weight-for-height/length z-score between -3SD and -2SD of the median WHO child growth standards, AND no edema.

- It is important to measure weight, height/length, and check bilateral pitting edema correctly to identify children with SAM and MAM. Incorrect measurements can cause missing if cases or admission of children who are having severe acute malnutrition.

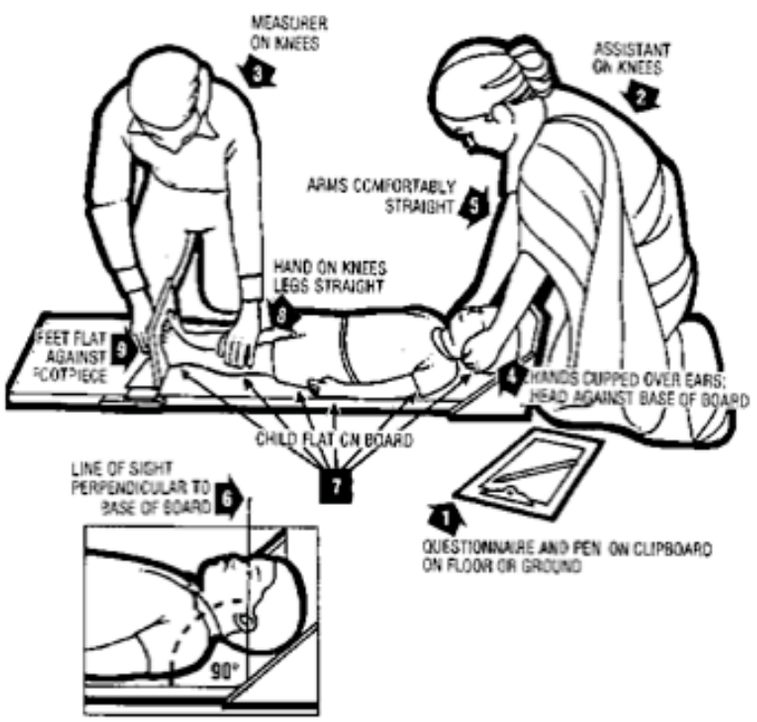


Image 3: Steps to measure child's length

3.2 How to identify SAM and MAM children in community?

Malnourished children are usually identified at the community level by two methods:

- By measuring their weight and height/length
- By checking for bilateral pitting edema

Key points to remember while taking length (Image 3)

- Use length board (Infantometer), which has been standardized
- Ask mother to remove hair braids, clothes to minimal clothing which don't interfere while taking measurement (if the child is visibly wasted with signs of emaciation or edema, do not remove clothes while measuring [KT1])
- Make one staff (AWT) or mother stand behind head board & position the crown of the head against the head board (two persons required)
- Hold the head with two hands and tilt upwards until the eyes look straight upwards
- The ANM should stand along the measuring board and place one hand on the knees and press gently but firmly.
- With the other hand, place the foot piece firmly against the feet, the soles of the feet should be flat on the foot piece and toe pointing up
- Measure length in cm up to 0.1 cm & enter in the SSFP card
- Repeat the measurement & record
- In case the difference of two measurements is more than 0.5 cm, take third measurement and take the average of two nearest measurements
- Tell mother to cover the child with clothes immediately after taking measurements

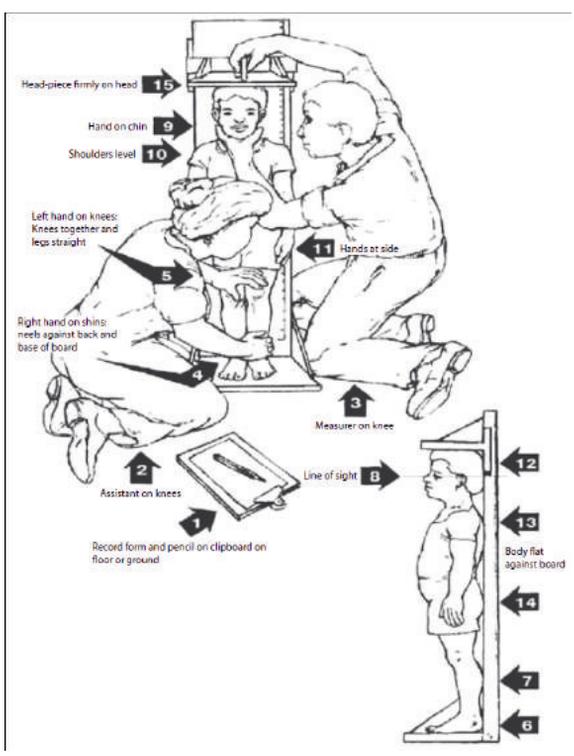


Image 4: Steps to measure child's height

Key points to remember while taking height (Image 4)

- Use height measuring rod/ Stadiometer which has been standardized
- Remove hair braids, shoes and excess clothing which may interfere while taking measurement
- Make mother/care taker stand at the side of vertical board and other partner sitting & position the knees against the back and base of the board (two persons required)
- Hold the head firmly with hand and straighten it until the eyes look straight and are in Frankfurt plane
- The AWT should stand along the measuring board and place one hand on the face. With the other hand, place the head piece firmly against the head. Measure height in cm up to 0.1 cm & enter in the SSFP card
- In case the difference of two measurements is more than 0.5cm, take third measurement and take the average of two nearest measurements
- Tell mother to cover the child with clothes immediately after taking measurements

Depending on a child's age and ability to stand, Measure the child's length or height.

Measuring length/height

- If a child is < 2 years old (or < 87 cm, if the age is not available), measure recumbent length (lying down position)
- If the child is aged 2 years or more (or 87 cm or more, if the age is not available) and able to stand, measure standing height
- If a child is less than 2 years old and does not lie down for measurement, measure standing height and add 0.7 cm to convert to length
- If a child aged 2 years or older cannot stand, measure recumbent length and subtract 0.7 cm to convert to height

A. How to calculate weight for length/height SD score?

An SD-score is a way of comparing a measurement, in this case a child's weight-for-length, to an "average." Reference values for weight-for-height and weight-for-length are provided in table 1.

To use the reference table

Use SD Chart to decide weight for length SD Score.

First find the child's length or height in the middle of the table. If the length or height is between those listed, rounds up or down as follows: If the length/height is 0.5 or more cm greater than the next lower length/height, round up. Otherwise, round down.

• Look at the top of the column to see what the child's SD-score is. The child's weight may be between two SD-scores. If so, indicate that the weight is between these scores by writing less than (<). For example, if the score is between – 1 SD and –2 SD, write < -1 SD Refer to the reference table for "weight for length". Remember to use left side for male gender and right for female. There are separate charts for children less than 87 cms and more than 87 cms (Table 2 and Table 3).

B. How to look for Edema

Edema due to malnutrition starts from dependent part (dorsum of feet), is pitting type and is bilateral. With increasing severity it extends upwards to involve the feet, legs, upper limbs and face. If edema is on one side then it is not due to nutritional Edema (Image 5).

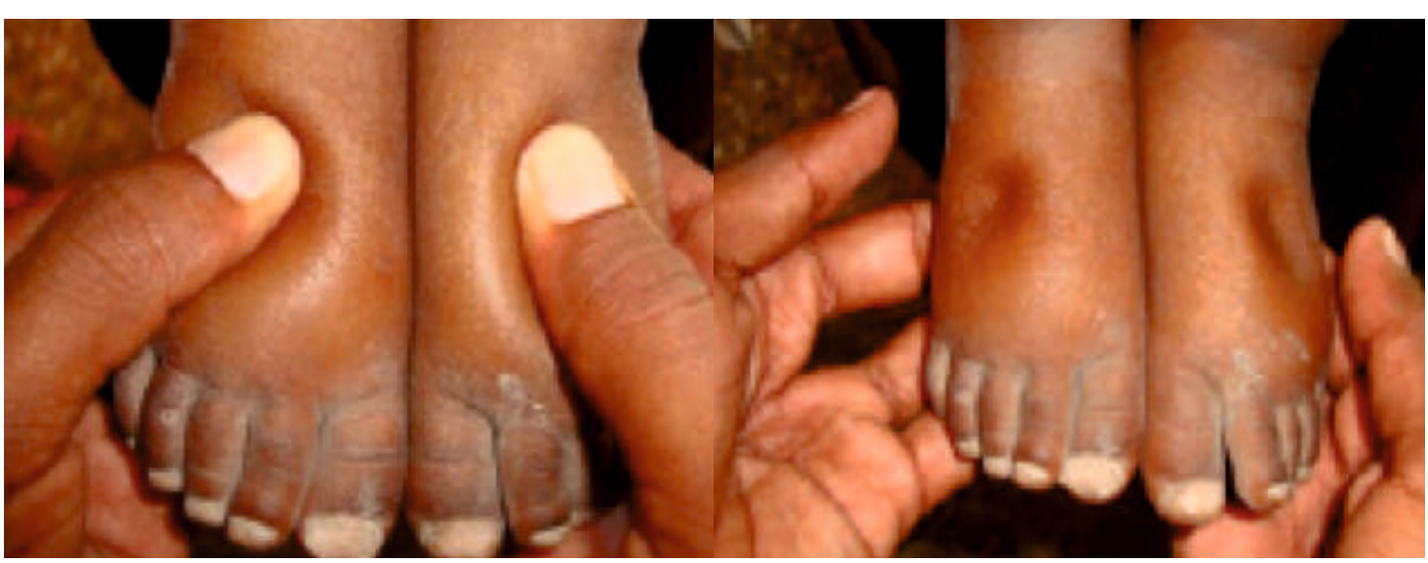


Image 5: Edema Identification

Examination For Edema

- To check for edema, grasp the foot so that it rests in your hand with your thumb on top of the foot. Press your thumb gently for a few seconds (approx. >3 seconds). Count 1001, 1002,1003 …..
- The child has edema if a pit (dent) remains in the foot when you lift your thumb.

3.3 Measurements at AWC for identification of children with malnutrition and monitoring their progress

A. Weigh the child

Weight of all under-five children should be measured during VHND and other contacts. Weight should be plotted on MCP chart every month. Identifying growth faltering (static weight or decline) gives opportunity to prevent children from becoming malnourished.

EXAMPLE 1

A boy has 63 cm length and weighs 6.5 kg.
- Take the table, look in the length column and look for the figure 63 cm.
- Take a ruler or a piece of card place it under the figure 63 and the other figures on the same line.

On this line find the figure corresponding to the weight of the boy, in this case it is 6.8. Look to see what column this figure is in. In this case it is in the MEDIAN WEIGHT column. In this example the child's weight is normal in relation to his LENGTH. He therefore has an appropriate weight for his length.

Measuring weight

Key points to remember while taking weight

Use a scale with the following features:

- Solidly built and durable
- Electronic (digital reading)
- Measures to a precision of 0.01 kg (10 g)
- If an adult digital weighing machine is used, it should have tare weighing facility

Tared weighing has following two advantages:

- There is no need to subtract weights to determine the child's weight (reducing the risk of error).
- The child is likely to remain calm when held in the mother's arms for weighing.
- Remove the child's clothes, but keep the child warm with a blanket or cloth while carrying to the scale.
- Put a cloth in the scale pan to prevent lowering the temperature of the child.
- Adjust the scale to zero with the cloth in the pan (by Pressing the tare button) (If using a scale with a sling or pants).
- Measure weight to stabilise.
- Measure weight to the nearest 0.01kg (10g) or as precisely as possible and record immediately.
- Wrap the child immediately.

Note: Weighing machine should be calibrated daily with standard weights e.g. 500gms, 1kg, 2kg to avoid machine errors.

Table - 2: Weight-for-length Reference card (below 87 cm)

Boys' weight (kg)					Length	Girls' weight (kg)				
-4 SD	-3 SD	-2 SD	-1 SD	Médian	(cm)	Médian	-1 SD	-2 SD	-3 SD	-4 SD
1.7	1.9	2.0	2.2	2.4	45	2.5	2.3	2.1	1.9	1.7
1.8	2.0	2.2	2.4	2.6	46	2.6	2.4	2.2	2.0	1.9
2.0	2.1	2.3	2.5	2.8	47	2.8	2.6	2.4	2.2	2.0
2.1	2.3	2.5	2.7	2.9	48	3.0	2.7	2.5	2.3	2.1
2.2	2.4	2.6	2.9	3.1	49	3.2	2.9	2.6	2.4	2.2
2.4	2.6	2.8	3.0	3.3	50	3.4	3.1	2.8	2.6	2.4
2.5	2.7	3.0	3.2	3.5	51	3.6	3.3	3.0	2.8	2.5
2.7	2.9	3.2	3.5	3.8	52	3.8	3.5	3.2	2.9	2.7
2.9	3.1	3.4	3.7	4.0	53	4.0	3.7	3.4	3.1	2.8
3.1	3.3	3.6	3.9	4.3	54	4.3	3.9	3.6	3.3	3.0
3.3	3.6	3.8	4.2	4.5	55	4.5	4.2	3.8	3.5	3.2
3.5	3.8	4.1	4.4	4.8	56	4.8	4.4	4.0	3.7	3.4
3.7	4.0	4.3	4.7	5.1	57	5.1	4.6	4.3	3.9	3.6
3.9	4.3	4.6	5.0	5.4	58	5.4	4.9	4.5	4.1	3.8
4.1	4.5	4.8	5.3	5.7	59	5.6	5.1	4.7	4.3	3.9
4.3	4.7	5.1	5.5	6.0	60	5.9	5.4	4.9	4.5	4.1
4.5	4.9	5.3	5.8	6.3	61	6.1	5.6	5.1	4.7	4.3
4.7	5.1	5.6	6.0	6.5	62	6.4	5.8	5.3	4.9	4.5
4.9	5.3	5.8	6.2	6.8	63	6.6	6.0	5.5	5.1	4.7
5.1	5.5	6.0	6.5	7.0	64	6.9	6.3	5.7	5.3	4.8
5.3	5.7	6.2	6.7	7.3	65	7.1	6.5	5.9	5.5	5.0
5.5	5.9	6.4	6.9	7.5	66	7.3	6.7	6.1	5.6	5.1
5.6	6.1	6.6	7.1	7.7	67	7.5	6.9	6.3	5.8	5.3
5.8	6.3	6.8	7.3	8.0	68	7.7	7.1	6.5	6.0	5.5
6.0	6.5	7.0	7.6	8.2	69	8.0	7.3	6.7	6.1	5.6
6.1	6.6	7.2	7.8	8.4	70	8.2	7.5	6.9	6.3	5.8
6.3	6.8	7.4	8.0	8.6	71	8.4	7.7	7.0	6.5	5.9
6.4	7.0	7.6	8.2	8.9	72	8.6	7.8	7.2	6.6	6.0
6.6	7.2	7.7	8.4	9.1	73	8.8	8.0	7.4	6.8	6.2
6.7	7.3	7.9	8.6	9.3	74	9.0	8.2	7.5	6.9	6.3
6.9	7.5	8.1	8.8	9.5	75	9.1	8.4	7.7	7.1	6.5
7.0	7.6	8.3	8.9	9.7	76	9.3	8.5	7.8	7.2	6.6
7.2	7.8	8.4	9.1	9.9	77	9.5	8.7	8.0	7.4	6.7
7.3	7.9	8.6	9.3	10.1	78	9.7	8.9	8.2	7.5	6.9
7.4	8.1	8.7	9.5	10.3	79	9.9	9.1	8.3	7.7	7.0
7.6	8.2	8.9	9.6	10.4	80	10.1	9.2	8.5	7.8	7.1
7.7	8.4	9.1	9.8	10.6	81	10.3	9.4	8.7	8.0	7.3
7.9	8.5	9.2	10.0	10.8	82	10.5	9.6	8.8	8.1	7.5
8.0	8.7	9.4	10.2	11.0	83	10.7	9.8	9.0	8.3	7.6
8.2	8.9	9.6	10.4	11.3	84	11.0	10.1	9.2	8.5	7.8
8.4	9.1	9.8	10.6	11.5	85	11.2	10.3	9.4	8.7	8.0
8.6	9.3	10.0	10.8	11.7	86	11.5	10.5	9.7	8.9	8.1

Table - 3: Weight-for-height Reference card (87 cm and above)

Boys' weight (kg)					Height	Girls' weight (kg)				
-4 SD	-3 SD	-2 SD	-1 SD	Médian	(cm)	Médian	-1 SD	-2 SD	-3 SD	-4 SD
8.9	9.6	10.4	11.2	12.2	87	11.9	10.9	10.0	9.2	8.4
9.1	9.8	10.6	11.5	12.4	88	12.1	11.1	10.2	9.4	8.6
9.3	10.0	10.8	11.7	12.6	89	12.4	11.4	10.4	9.6	8.8
9.4	10.2	11.0	11.9	12.9	90	12.6	11.6	10.6	9.8	9.0
9.6	10.4	11.2	12.1	13.1	91	12.9	11.8	10.9	10.0	9.1
9.8	10.6	11.4	12.3	13.4	92	13.1	12.0	11.1	10.2	9.3
9.9	10.8	11.6	12.6	13.6	93	13.4	12.3	11.3	10.4	9.5
10.1	11.0	11.8	12.8	13.8	94	13.6	12.5	11.5	10.6	9.7
10.3	11.1	12.0	13.0	14.1	95	13.9	12.7	11.7	10.8	9.8
10.4	11.3	12.2	13.2	14.3	96	14.1	12.9	11.9	10.9	10.0
10.6	11.5	12.4	13.4	14.6	97	14.4	13.2	12.1	11.1	10.2
10.8	11.7	12.6	13.7	14.8	98	14.7	13.4	12.3	11.3	10.4
11.0	11.9	12.9	13.9	15.1	99	14.9	13.7	12.5	11.5	10.5
11.2	12.1	13.1	14.2	15.4	100	15.2	13.9	12.8	11.7	10.7
11.3	12.3	13.3	14.4	15.6	101	15.5	14.2	13.0	12.0	10.9
11.5	12.5	13.6	14.7	15.9	102	15.8	14.5	13.3	12.2	11.1
11.7	12.8	13.8	14.9	16.2	103	16.1	14.7	13.5	12.4	11.3
11.9	13.0	14.0	15.2	16.5	104	16.4	15.0	13.8	12.6	11.5
12.1	13.2	14.3	15.5	16.8	105	16.8	15.3	14.0	12.9	11.8
12.3	13.4	14.5	15.8	17.2	106	17.1	15.6	14.3	13.1	12.0
12.5	13.7	14.8	16.1	17.5	107	17.5	15.9	14.6	13.4	12.2
12.7	13.9	15.1	16.4	17.8	108	17.8	16.3	14.9	13.7	12.4
12.9	14.1	15.3	16.7	18.2	109	18.2	16.6	15.2	13.9	12.7
13.2	14.4	15.6	17.0	18.5	110	18.6	17.0	15.5	14.2	12.9
13.4	14.6	15.9	17.3	18.9	111	19.0	17.3	15.8	14.5	13.2
13.6	14.9	16.2	17.6	19.2	112	19.4	17.7	16.2	14.8	13.5
13.8	15.2	16.5	18.0	19.6	113	19.8	18.0	16.5	15.1	13.7
14.1	15.4	16.8	18.3	20.0	114	20.2	18.4	16.8	15.4	14.0
14.3	15.7	17.1	18.6	20.4	115	20.7	18.8	17.2	15.7	14.3
14.6	16.0	17.4	19.0	20.8	116	21.1	19.2	17.5	16.0	14.5
14.8	16.2	17.7	19.3	21.2	117	21.5	19.6	17.8	16.3	14.8
15.0	16.5	18.0	19.7	21.6	118	22.0	19.9	18.2	16.6	15.1
15.3	16.8	18.3	20.0	22.0	119	22.4	20.3	18.5	16.9	15.4
15.5	17.1	18.6	20.4	22.4	120	22.8	20.7	18.9	17.3	15.6

Table - 4: Interpretation of weight for height/length measurements

Weight for height/length z-score	Nutritional Status
> -2SD	Normal
< -2SD to ≥ -3SD	Moderate Acute Malnutrition
< -3SD	Severe Acute Malnutrition

3.4 Identification of malnutrition by combined use of WHZ and Edema in the community

WHZ, and bilateral pitting edema will be used during screening to identify malnourished child. All children with edema will be immediately referred to NRC for assessment and treatment (Table 5).

AWT will also measure weight for growth monitoring and progress

WHZ, and bilateral pitting edema will be used during screening to identify malnourished child. All children with edema will be immediately referred to NRC for assessment and treatment.

Table 5: Identification of nutritional status in community

Severe acute malnutrition	Moderate Acute Malnutrition	Normal Nutrition
- WHZ < -3SD And/Or	- WHZ <-2SD to ≥ -3SD And/Or	- WHZ > -2SD And/Or
- Edema of both feet	- No edema	- No edema

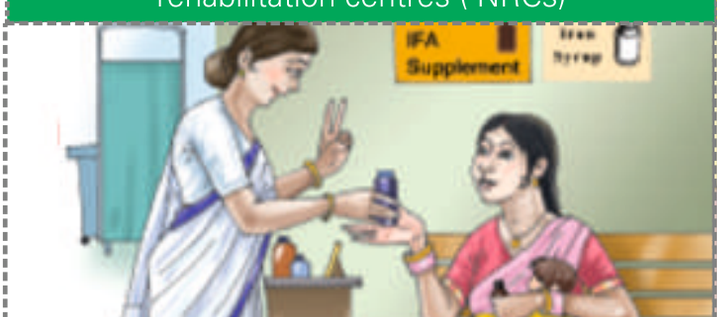
Exercise 1 - Categorize nutritional status

Name	Age (Months)	Weight (Kgs)	WHZ	Bilateral Pitting Edema	Categorize the nutritional status of the child
Ramesh (M)	32	11.5	No	> -2SD	Normal
Pallavi (F)	16	7.1	No	< -3SD	SAM
Vimla (F)	26	8.0	Yes	≤ -2SD to ≥ -3SD	SAM
Abdul (M)	36	9.4	No	< -3SD	SAM
Reena (F)	15	7.6	No	≤ -2SD to ≥ -3SD	MAM
Mannat(M)	7	4.0	No	< -3SD	SAM

3.5 Modalities of SAM management

Facility or hospital care

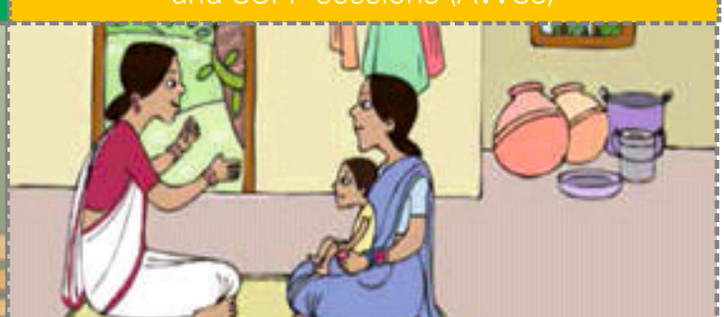
Primarily known as nutrition rehabilitation centres (NRCs)



Children with SAM:
- Medical complication **and/or**
- Bilateral pitting edema and/or
- Poor appetite

Home/community based care

Primarily known as SSFP clinics and SSFP sessions (AWCs)



Children with SAM:
- Without medical complication **and**
- No Edema **and**
- Good appetite

- Even in best circumstances, the Nutrition Rehabilitation Centres (NRCs) will not be able to handle the entire case load of children in a given district or state and neither is required. The coverage of NRCs is small scale both due to limited access and inability of caregivers to stay in the NRCs for a considerable period of time (about 2 weeks) till the child is on the way to recovery.
- It is important to understand that NRCs are mandated to stabilize SAM children with medical complications till the time that the child is stabilized and starts showing weight gain. All children admitted in NRC also should be linked to SSFP after stabilization and discharge.
- Children with SAM who have good appetite and are free of medical complications are treated in the SSFP programme, which provides appropriate quantity of Augmented THR (balamrutham+) and routine medicines. They can be managed at home; the child attends the SSFP sessions regularly for check-ups and to receive more supplies of balamrutham+ till the child has recovered.
- Children with SAM who have poor appetite and/or medical complications are referred to the NRC and treated as inpatients until they are well enough to be shifted to the SSFP.

3.6 Principles of SSFP programme

The core operating principles of SSFP are (Figure 4):

Maximum coverage and access	SSFP is designed to achieve the greatest possible coverage by making services accessible to the highest possible proportion of children in need
Timelines	SSFP aims to identify and treat children with SAM and MAM early i.e. before additional medical complications occur
Sectorial integration	SAM and MAM management is integrated with preventive measures like health and nutrition education, promotion and support of optimal breastfeeding, complementary feeding and hygiene practices
Capacity building	It builds on existing structures like AWC through collaboration, training and ongoing support, rather than establishing parallel systems
Appropriate care	SSFP provides simple and effective outpatient care for those children with SAM and MAM who can be treated at home. Also gives opportunity to identify children with SAM that need clinical care (inpatient treatment)
Comprehensive care to children till they are out of acute malnutrition	SSFP ensures that children stay in the programme until they have recovered, by building local capacities and integrating the programme (including preventive programme) within the existing health and ICDS systems and services It aims to ensure that effective treatment remains available for as long as the child needs

Figure 4: Principles of SSFP program

3.7 Mechanism of SSFP programme

The mechanism of SSFP program is described through (Figure 5):

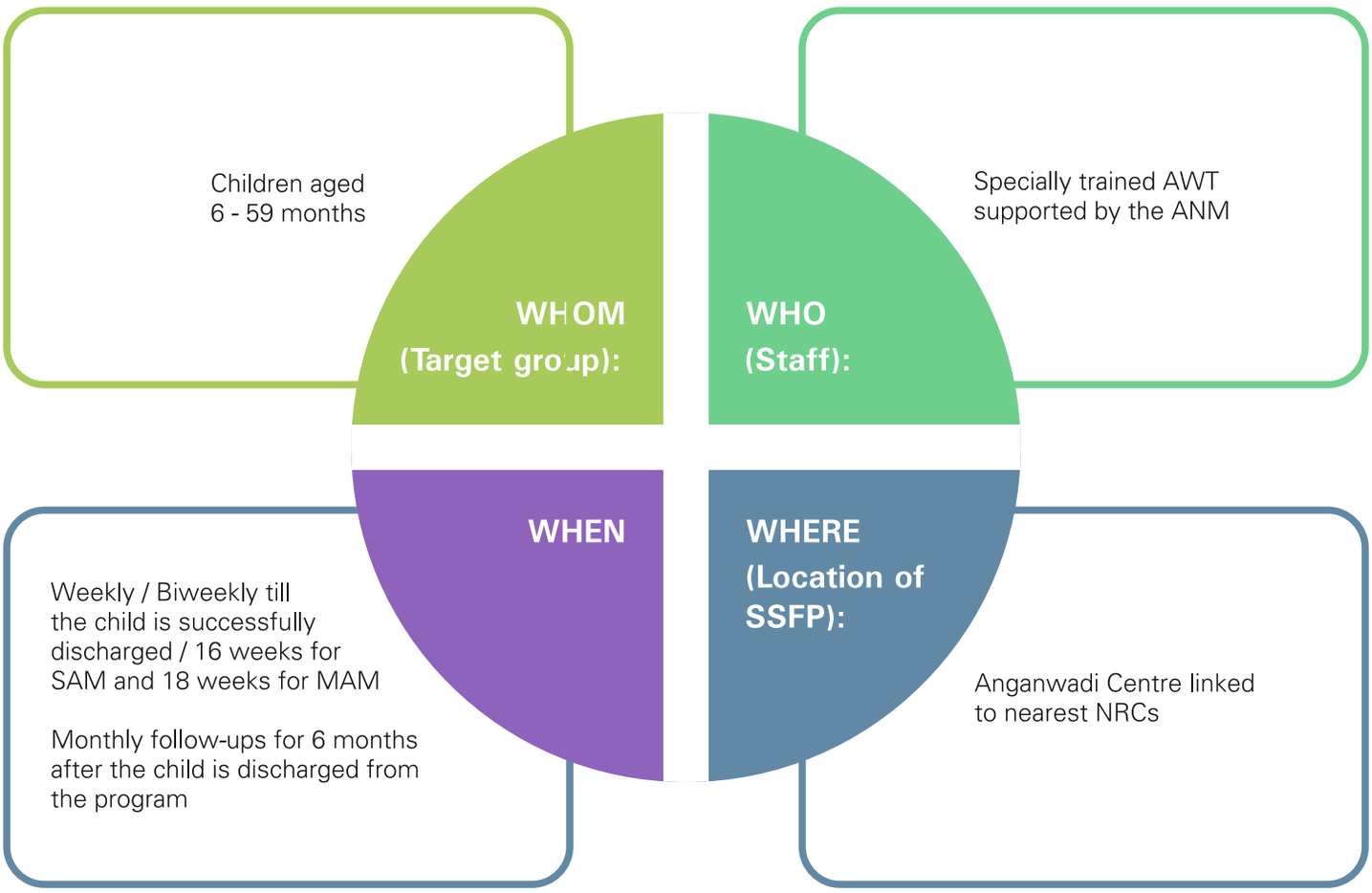


Figure 5: Mechanism of SSFP program

3.8 Strategy for SSFP programme

The strategy includes preventive and therapeutic approaches.

A. Preventive approach:

Optimal nutrition in the first two years of life – early and exclusive breastfeeding for first six months, continued breastfeeding for two years or more, together with nutritionally adequate, safe, age appropriate, responsive complementary feeding starting at six months – are critical to prevent malnutrition and relapse. Along with optimal feeding, safe drinking water, proper sanitation, and hygiene are equally important.

The platform for community mobilization and behaviour change communication.

B. Community based therapeutic care for treatment of SAM & MAM

The community based SSFP programme will focus on making services accessible to the greatest extent possible, providing therapeutic energy dense food and care, referrals and help in the recovery process of children with Acute Malnutrition

3.9 TAKE HOME MESSAGES

- SAM is defined as W/H <-3SD AND/OR EDEMA of both the feet
- MAM is defined as W/H between -3SD and -2SD AND no EDEMA
- There are two approaches for the management of children with SAM i.e. Facility Based and Community Based Management of SAM
- Children without medical complication AND good appetite are managed at the SSFP program
- Children with medical complication AND/ OR poor appetite are managed in NRCs

SESSION 4

Management of children with acute malnutrition at community level

S. No.	Details	Methodology
4.1	How will SSFP programme deliver services to children with SAM & MAM	Discussion and exercises for familiarity with SSFP cards
4.2	SSFP programme is broadly divided into 10 steps - Anthropometric assessment - Medical assessment - Appetite assessment - Decide level of care - Nutritional treatment - Medicines - Nutrition health education - Follow up while in SSFP programme - Discharge criteria for SSFP programme - Follow up after discharge from SSFP programme	Discussion, demonstration and video, exercise, role plays
4.3	Summary: Take home message	

LEARNING OBJECTIVES:

By the end of the session participants will be able to:

- Describe admission and enrolment procedure in the SSFP programme
- Assess for medical complications
- Perform appetite test
- Decide whether the child will be managed at SSFP programme or will need referral to NRC
- Describe treatment of children with SAM in the community
- Enlist key health education messages for mothers/caretakers of children with SAM
- Describe discharge criteria from SSFP programme
- Describe follow-up services for children with SAM enrolled in the programme

You have already learnt that there are two modalities for management of SAM children i.e. Facility based management (NRC) and community based management of acute malnutrition. Both modalities complement each other. Approximately 85-90% children with SAM (children without medical complications and good appetite) may be successfully managed at the community level. 10-15% children with SAM who have signs of medical complications and/or have poor appetite need more specialized treatment at the facility level (NRCs).

4.1 How will SSFP deliver services to children with SAM and children with MAM?

SSFP Clinic: As part of SSFP programme, SSFP clinics would be conducted by ANM and AWT at the AWC every month in which new cases will be enrolled into the programme. Each SAM and MAM child identified during active screening or passive screening will be rechecked by ANM (only for SAM child) for their eligibility within a week.

SSFP Clinics would provide an opportunity to the ANM to medically examine the children; initiate treatment (provide antibiotics, therapeutic balamrutham+ food etc.); monitor progress; identify those not showing adequate weight gain and decide on further referral; discharge children after a child meets the discharge criteria; and do follow-ups of children discharged as per the follow-up protocols.

SSFP session:

As part of SSFP programme, SSFP sessions would be organised by AWT with support of ASHA at AWC every week in which she would examine the child, monitor the progress, and provide therapeutic balamrutham+ food to children with SAM and MAM and counselling to mothers/caregivers.

4.2 SSFP programme will be broadly divided into 10 steps.

Steps	Management of SAM at community level	Management of MAM at community level
Step 1	Anthropometric assessment and medical history taken	Anthropometric assessment and *Medical history taken
Step 2	Appetite assessment	Not done
Step 3	Medical assessment	Not done
Step 4	Decide if the child should be enrolled in SSFP programme or be transferred to NRC. Explain the overview of the SSFP session/clinic to the mothers	Not done
Step 5	Nutritional treatment	Nutritional treatment
Step 6	Medicines	Not done
Step 7	Nutrition health education including WASH practices	Nutrition health education including WASH practices
Step 8	Follow-up while in SSFP programme	Follow-up while in SSFP programme
Step 9	Discharge criteria for SSFP programme	Discharge criteria for SSFP programme
Step 10	Follow-up after discharge from SSFP programme	Follow-up after discharge from SSFP programme

Note: Step 2,3,4 & 6 are not required for management of MAM child.
In case of MAM child, only medical history will be taken. If the child is found to be sick, medical assessment will be done by AWT for danger signs. Child would be referred for assessment by ANM/MO as per the need.

STEP 1:

Anthropometric assessment

All SAM cases identified by AWTs during community screening should be reassessed by ANM by measuring weight, height/length, and looking for bilateral pitting edema to confirm whether the child has SAM or not. If WHZ < -3SD and/or child has bilateral pitting edema then the child is having SAM. If the child is having WHZ < -3SD, child will be assessed for appetite test. (Details of anthropometric measurement have already been discussed in the previous section).

Children with bilateral pitting edema will be referred to NRC for further assessment.

STEP 2:

How to perform appetite test

- Appetite test should be done to all SAM children subsequent to the screening on the first VHND conducted
- Balamrutham+ is to be given for the appetite test. It is a special food made for acutely malnourished children, which has increased energy density, milk protein and micronutrients compared to the regular balamrutham
- The test should be conducted in a separate quiet area
- Explain to the mother/caregiver the purpose of the appetite test and how it will be carried out
- Ask mother/caregiver to wash her/his hands
- The mother/caregiver should sit comfortably with the child on her/his lap

Appetite assessment (for children without edema)

Usually SAM Children with medical complications or infection have loss of appetite. Appetite test helps in identifying children with SAM and with medical complications. Appetite should be tested in all newly identified SAM children and during follow-up visits. At SSFP session on VHHD, appetite test will be done by the AWT.

- The child should not have taken any food for last 2 hrs. The child should eat at least 15-50 g (based on age) of balamrutham+ pass the test.
- The test usually takes a short time but may take up to one hour.
- Offer small amount of balamrutham+ to the child based on the age of the child, encouraging the child all the time.
- For children (7 months-18 months) give at least 15 gm.
- For children (19 months- 36 months give at least 30 gm.
- For children (37- 59 months) give at least 50 gm.
- If the child refuses, then the mother/caregiver should continue to quietly encourage the child.
- The child must not be forced to take the balamrutham+
- The child should have free access to drinking safe / portable water while he/she is taking the balamrutham+

The appetite test must be carried out at each SSFP clinic on the first visit. Failure of an appetite test at any time is an indication for full evaluation and admission/ transfer to NRC. If the child has any danger signs, immediately admit/ refer the child for treatment at NRC health facility without performing the appetite test.

STEP 3:

Medical assessment at SSFP Clinic

When?

- Within 3-7 days after identifying SAM child at the AWC/NHD If AWT finds a child with serious history of morbidity such as fever, difficulty in breathing etc.
- AWT should immediately refer the child to the NRC/other health facility.

Site of assessment

- AWT will inform ANM/MO to visit the identified child at AWC
- AWT will take the child to PHC/Sub-Centre

Initiation/continuation/referral under SSFP

- If the child is found with no complications, child will be enrolled into SSFP management at AWC in the community. If the child is found with medical complications, child will be referred to NRC

How to check for emergency signs/danger signs? (Table 6)

Check all children with SAM for following emergency signs/danger signs:

1) Presence of any of emergency signs (Coma, convulsion, shock)

2) Bilateral Pitting Edema

3) Not accepting feeds, vomits everything

4) Very weak, apathetic

5) High Fever (>39.5 C/>102.2 F)

6) Hypothermia (Axillary temperature <35 C/<95 F)

7) Children with fast breathing/chest in drawing/cyanosis/difficulty in breathing

8) Extensive skin lesions, eye lesions, post-measles states

9) Diarrhoea with dehydration based on history and clinical signs

10) Severe anemia

11) Any other general sign which the ANM thinks warrants transfer to in-patient facility for assessment or care

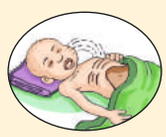
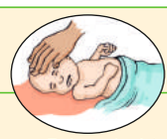
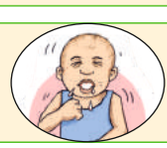
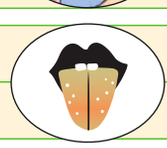
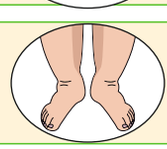
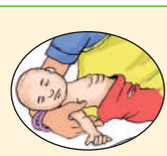
12) In addition all children with history of chronic illness, recurrent pneumonia (>2 episodes in last 6 months), hemoglobinopathy (thalassemia, sickle cell anemia), suspected birth defects (cleft pallet, CHD), abnormal tone, recurrent seizure, jaundice or abnormally protruded abdomen.

13) In addition if the caregiver is unable to take care of the child at home, the child should be referred to NRC.

Table 6 - Action Protocol Based On Assessment

HOW TO CHECK FOR EMERGENCY / DANGER SIGNS

Action Protocol Based on Assessment

Assessment	Findings	Action To Be Taken
Danger Signs	▶ Not accepting feeds ▶ Lethargy and altered sensorium ▶ Severe chest indrawing ▶ Intractable/persistent vomiting ▶ History of convulsion in current illness 	**URGENT REFERRAL to NRC/nearest Health Facility**
Respiratory Rate	▶ ≥60 respirations/minute under two months ▶ ≥50 respirations/minute from 2-12 months ▶ ≥40 respirations/minute from 1-5 years 	**Refer to NRC**
Temperature (Axillary)	▶ > 39 degree Centigrade (>102.2 degree Fahrenheit) ▶ < 35 degree Centigrade (<95 degree Fahrenheit) 	**Refer to NRC**
	▶ Fever - Mild to moderate < 39 degree (<102.2 degree Fahrenheit) ▶ Temperature below 36.5 degree but above 35 degree (above 95 degree Fahrenheit)	**SSFP Programme**
Diarrhoea	▶ Diarrhoea of fourteen days or more duration ▶ Dysentery ▶ Some or severe dehydration 	**Refer to NRC**
	▶ No dehydration	**SSFP Programme**
Cough	More than two weeks 	**NRC**
Pallor	Severe pallor 	**NRC**
	Some Pallor / No Pallor	**SSFP Programme**
Oedema	Bilateral pitting Oedema 	**NRC**
Skin	Extensive skin lesions / denuded skin 	**Refer to NRC**
Others	▶ Mother / caregiver not confident ▶ Age - less than six months ▶ Static weight for three consecutive weeks or weight loss for two consecutive weeks 	**NRC**

If NRC is not able to hande the emergency cases, refer to the nearest Emergency Health Facility for stabilisation.

Presence of above mentioned signs indicate presence of serious underlying illness which requires urgent referral to NRC

Look for general danger signs

1) Ask if the child has had convulsions during current illness?

If there is history of convulsion during the period of current illness, then the child will need URGENT REFERRAL (Image 5).

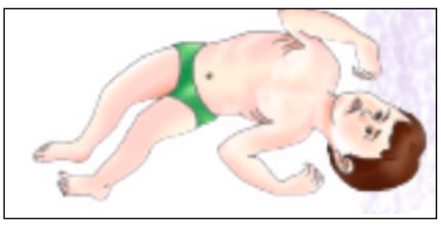


Image 5: Convulsions in child

2) Look for bilateral pitting edema

You have learnt how to check for bilateral pitting edema (Image 6).

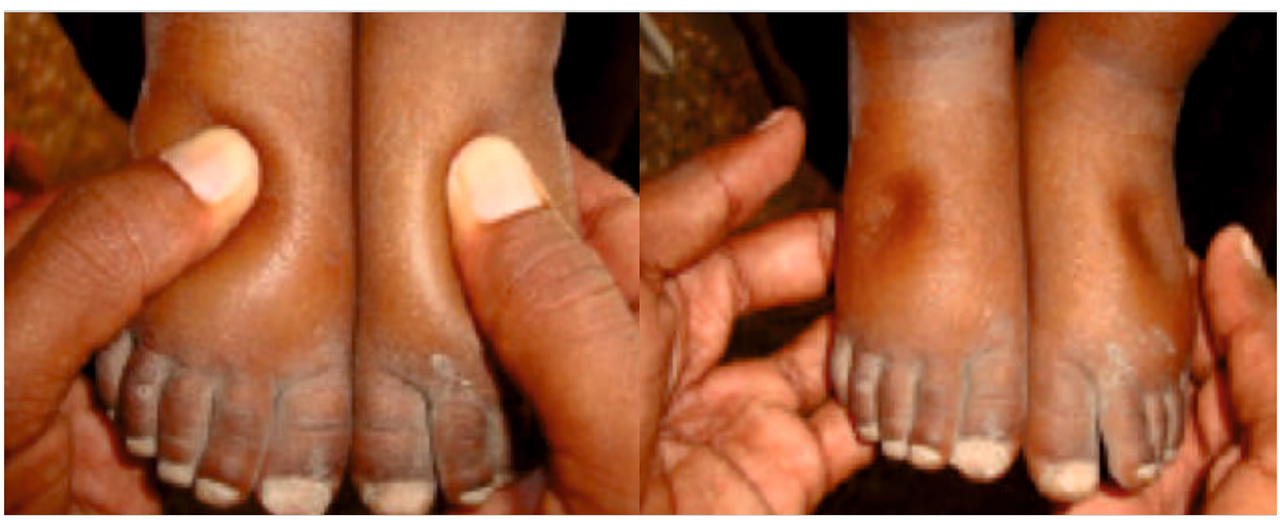


Image 6: Bilateral pitting edema

3) Does the child vomit everything?

If the child is not retaining anything i.e. she/he vomits everything, she/he will need URGENT REFERRAL.

Does the child not accept food orally?

ASK feeding history of the child. If the child is not accepting orally, she/he will need URGENT REFERRAL

4) Does the child look lethargic or unconscious?

Observe child's activity and interaction. If the child is not interacting, is lying with minimal interaction with surroundings he/she is said to be lethargic/unconscious (Image 7).

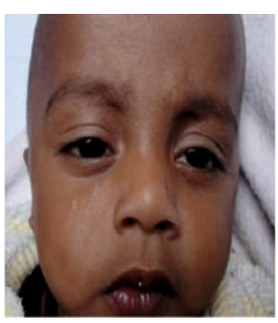


Image 7: Lethargic child

Check vitals by counting pulse rate

How can we count pulse rate?

Find the radial pulse. This is the pulse on the radial side of the wrist. Use the pads of your index finger and third finger. Place these just below the wrist creases on the thumb side (Image 8). Press lightly until you feel a pulse (blood pulsing under your fingers). If necessary, move fingers around until you feel the pulse.

- For a child 2 months up to 12 months of age, a fast pulse is 160 beats or more per minute.
- For a child 12 months to 5 years of age, a fast pulse is 140 beats or more per minute.

Use a watch or clock with a second hand. Count the number of times you Feel a throb for 1 minute (60 s).

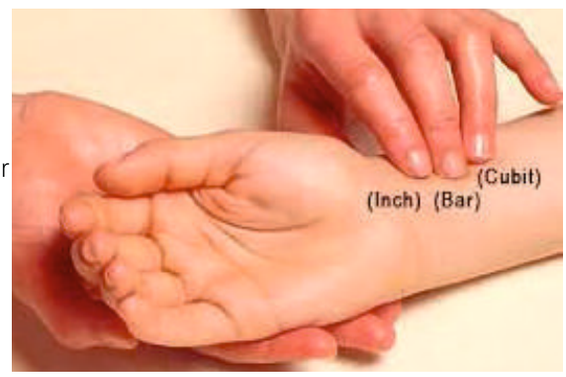


Image 8: Counting pulse rate

High Grade Fever

5&6) Does the child have high grade fever or hypothermia?

Ask history of fever and check temperature. If the child is having high grade fever (>39^{0}C) or hypothermia (<35^{0}C) for more than one day s/he will need URGENT REFERRAL (Table 7).

How to take temperature?

A digital thermometer may be used to take an axillary temperature. It is a small hand-held device with a "window" showing your temperature in numbers.

Steps for using an axillary thermometer

- Take the thermometer out of its holder.
- Clean the pointed end (probe) by rubbing alcohol.
- Put the end with the tip covered securely in your armpit. Hold the arm down tightly at child's side (Parallel to the body).
- Keep the thermometer in the armpit until the digital thermometer beeps.
- Remove the thermometer and read the numbers in the window. Number displayed in the window is temperature of the child.
- Note the temperature on form.
- Place the thermometer back in its holder.

Table - 7: Body temperature range	
- Normal temperature	- 36.5 - 37.5 C/ 97.7˚F- 99.5˚F.
- child has fever if the recorded temperature (warm) is	- > 37.5 C/ 99.5˚F
- child has high fever if the temperature (hot) is	- >39 C/ 102˚F
- child has low body temperature (cold stress) if the temperature is	- 35 - 36.4 C/ 95˚F- 97.5˚F, and is at risk for hypothermia
- Child has hypothermia if axillary temperature (very cold) is	- < 35 C/ 95˚F

7) Does the child have difficulty in breathing?

ASK history of cough or difficulty in breathing. If the child is having cough or having difficulty in breathing she/he will need URGENT REFERRAL

How can we count respiratory rate (RR)?

Count the breaths in one minute when the child is calm. To count the number of breaths in one minute, use watch with a second hand or a digital watch. Put the watch where you can see the second hand and respiratory movements as you count the breaths. Look for breathing movements anywhere on the child's chest or abdomen. Usually you can see breathing movements even on a child who is dressed. If you cannot see this movement easily ask the mother to lift the shirt (Image 9).

When do you say that the child has fast breathing?

If the RR is

- 60 or more in children upto 2 months of age
- 50 or more in children from 2 months up to 1 year of age
- 40 or more in children from 1 year to 5 years of age

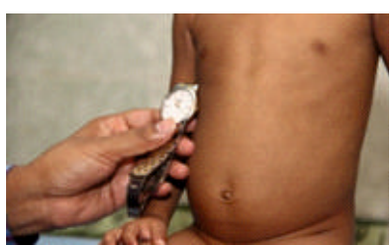


Image 9: Respiratory rate

How to look for chest indrawing?

- If you did not lift the child's shirt when you counted the child's breaths, ask the mother to lift it now.
- In normal breathing, the whole chest wall (upper and lower) and the abdomen move OUT when the child breathes IN.
- When chest indrawing is present, the lower chest wall goes IN when the child breathes IN.
- Look at the lower chest wall (lower ribs). The child has chest indrawing if the lower chest wall goes IN when the infant breathes IN.
- Chest indrawing occurs when the effort the child needs to breathe in is much greater than normal.

8) Look for skin changes

Skin changes are common in children with SAM and are more common in children who have bilateral pitting edema than in wasted children. Look for rash in the nappy area, inner parts of thigh and axilla (Image 10). Any break in the skin will allow dangerous bacteria to get into the body. When the skin lesions are severe, skin may become raw and weeping, and risk of infection is very high in this case.

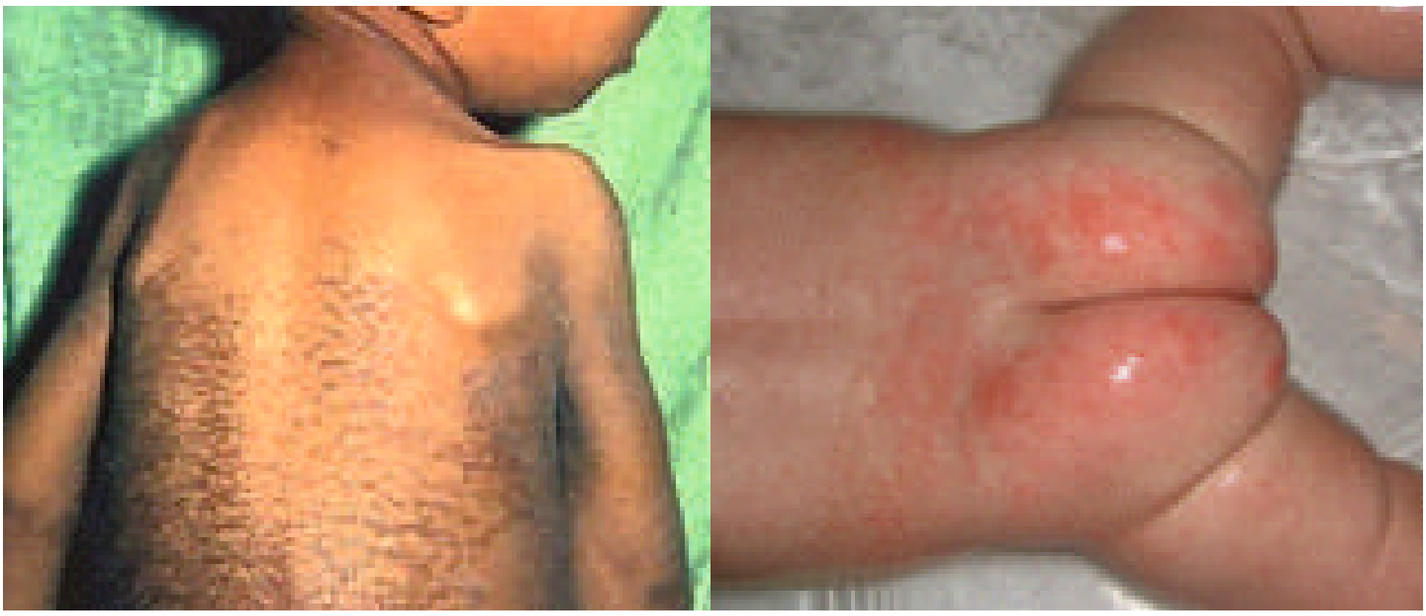


Image 10: Rashes on child skin

Children with severe acute malnutrition may have signs of eye infection and/or vitamin A deficiency. Ask:

- Does the child open his/her eyes in bright light?
- Is the child able to see in evening/ dim light?

If the answer is NO in any case, the child may have vitamin A deficiency. Look for any opacity or discharge in the eyes.

Look for eye complications

Children with severe acute malnutrition may have signs of eye infection and/or vitamin A deficiency (Image 11). Ask:

- Does the child open his/her eyes in bright light?
- Is the child able to see in evening/ dim light?

If the answer is NO in any case, the child may have vitamin A deficiency. Look for any opacity or discharge in the eyes.

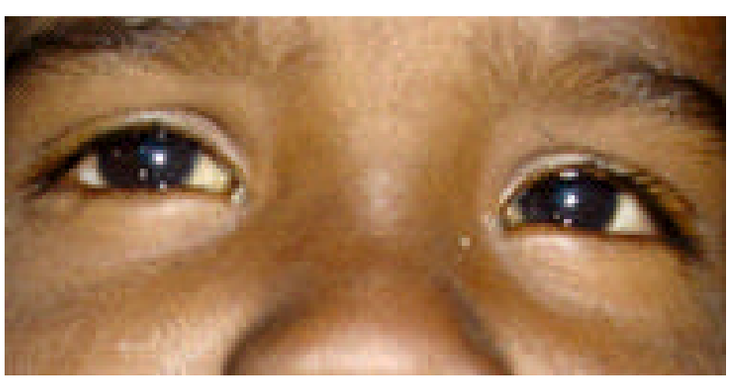


Image 11: Eye Infection

9) Does the child have diarrhea?

ASK stool history of the child. If the child is having loose watery stools for more than 3 episodes she/he will has diarrhea. Look for signs of dehydration. Child will need admission in NRC if she/he is dehydrated.

How to determine dehydration status?

Assessment of Dehydration in children without SAM is done by assessing 4 key signs of dehydration.

A) General condition:

Lethargy: The child is drowsy and does not show interest in what is happening around him.

Restless, irritable: The child is restless and irritable all the time.

Looking for General Condition (Image 12)

Lethargic | Irritable | Normal

Image 12: Assessing child look

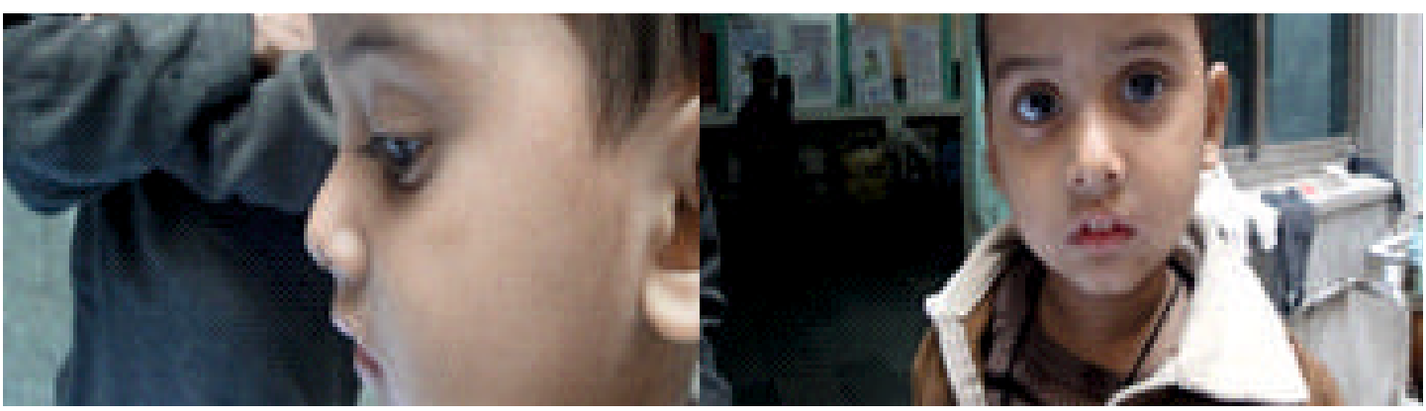


Image 13: Sunken eye

B. Sunken eyes:

Look for sunken eyes. Ask the mother if the child's eyes appear depressed as compared to eyes before onset of diarrhea (Image 13).

C. Offer fluid to check thirst:

See if the child reaches out for the cup when you offer fluids (water/ ORS) and when it is taken away; see if the child wants more (Image 14).

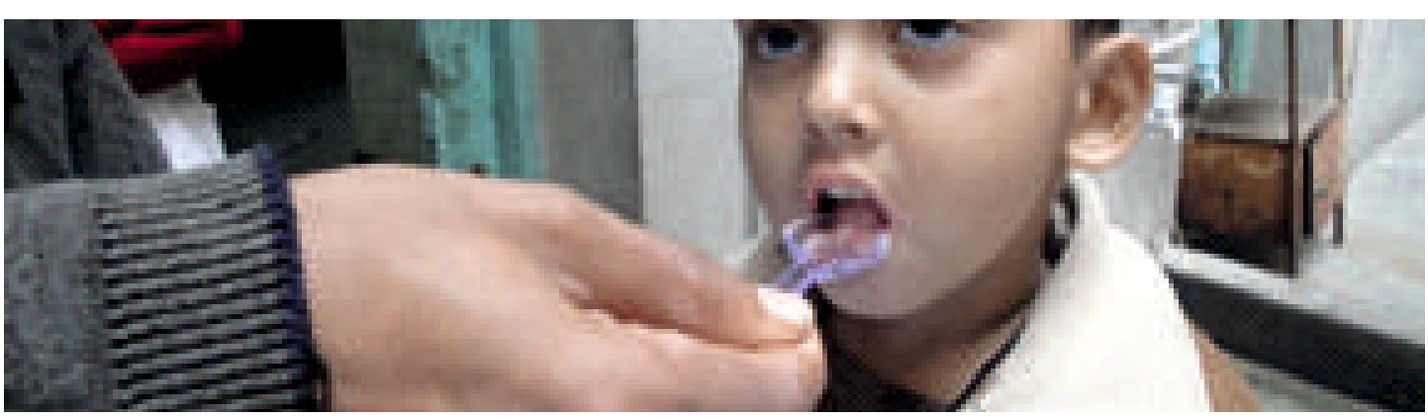


Image 14: Assessing thirst

D. Skin pinch goes back immediately or slowly or very slowly (Image 15)

It is difficult to reliably determine dehydration status in a child with SAM, as the usual signs of dehydration (such as lethargy, sunken eyes) may be present in these children all of the time, whether or not they are dehydrated. The main diagnosis comes from the HISTORY rather than from the examination. There should be a definite history of diarrhea i.e. history of a recent CHANGE in the child's stool consistency.

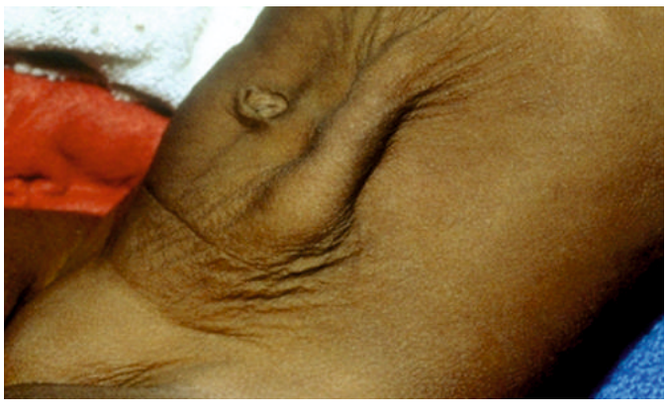


Image 15: Children with very slow skin pinch

10) Look for Anemia

Pallor is unusual paleness of the skin. To see if the child has palmar pallor, look at the skin of the child's palm (Image 16). Hold the child's palm open by grasping it gently from the side. Do not stretch the fingers backwards. This may cause pallor by blocking the blood supply. Compare the colour of the child's palm with your own palm. If the skin of the child's palm is pale, the child has some palmar pallor. If the skin of the palm is very pale or so pale that it looks white, the child has severe palmar pallor.

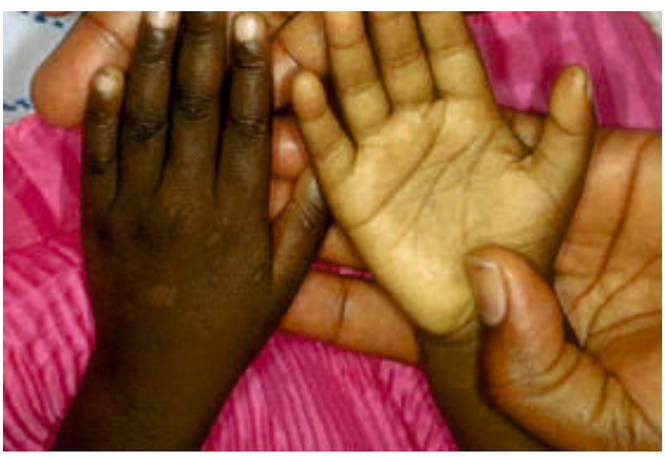


Image 16: Pale hand of anemic child

STEP 4:

Decide if the SAM child should be enrolled in SSFP programme or will be admitted in NRC. Explain the overview of the SSFP session/clinic to the mothers (Figure 6)

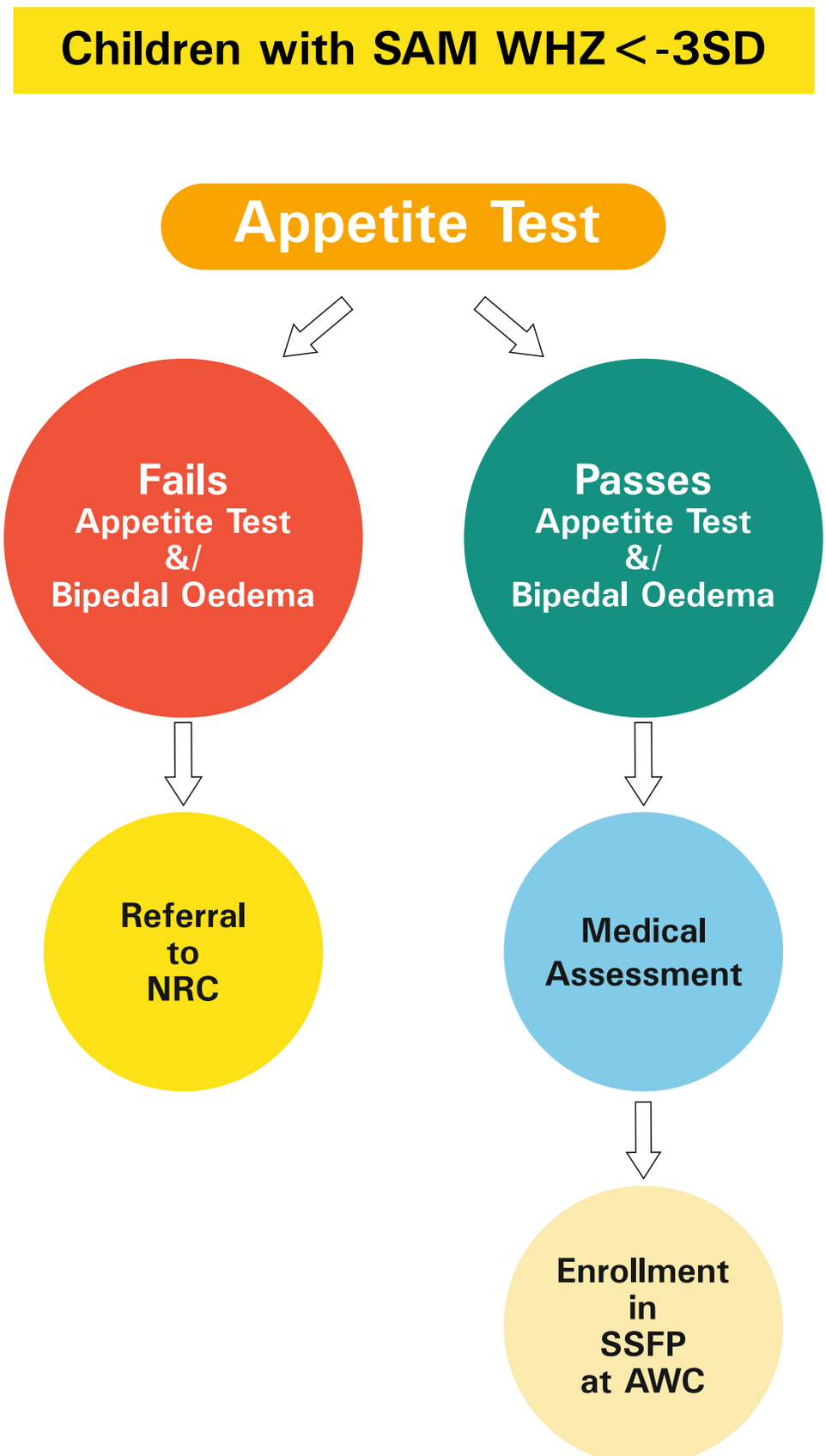


Figure 6: Enrollment criteria in SSFP program

Exersise 2

Decide level of care on basis of appetite test and medical complications

Name	Age (Months)	Appetite test	Medical assessment	Level of care SSFP/NRC
Rani	7	Pass	Normal	SSFP
Abdul	18	Fail	No complication	NRC
Soni	36	Pass	Temperature 38°C/100˚F	SSFP
Iqbal	9	Pass	No complication	SSFP
Sunil	28	Pass	Fever for 2 days H/o convulsion in morning	NRC
Meeta	20	Fail	Diarrhea for 2 days with dehydration	NRC

Actions to be taken while referring child to inpatient Care/NRC

Note that if you are referring the child to inpatient care in a health facility and/or NRC after evaluation at SSFP programme, then the mother/caregiver must be given a referral slip (Annexure 3).

Referral slip should have following details:

- Name, age, sex and SSFP number of child.
- Mother's name, address, date of admission to SSFP programme.
- Admission details and transfer details.
- Reasons for referral of child with SAM and information on treatment the child has received.
- Name and contact number of healthcare provider making the referral.

Measures to be taken when referral is needed

1) Mother/caregiver should be informed and counselled on the need for referral.

2) Ensure that Mother carry the referral card given to her by AWT

3) At NRC Feed should be given if the child has not received it in the last two hours to prevent hypoglycaemia.

4) If child is not able to swallow, give 50 ml of feed or 10% glucose.

5) Explain to the mother how to keep the child warm on the way

6) If child has diarrhoea, tell mother to give ORS on the way

EXERCISE 3

Case study 1

Sita aged 20 months lives in -———— village, Sirpur Mandal, belongs to the district Asifabad. She had mild cough for a week and was identified by the ASHA. The ASHA sent her to the AWC with her mother, Renuka on March 1, 2019. There are six members in her family. Her house is a 15 minute walk to the AWC. At the AWC she was again screened by the ANM/AWT. She weighed 5.9 kg and her WHZ was < -3SD. She did not have bilateral pitting edema. She is being breastfed and some complementary food is also being given to her. When tested by the AWT, her appetite was found to be good. She passes 2 stools per day and also passes urine normally. She has received all doses of OPV, Hepatitis B, DPT and measles vaccine. The ANM assessed her for danger signs and complications. Sita's respiration rate was 38/minute and she did not have chest indrawing. Her temperature was 37˚C/98.6˚F. Her alertness was normal. She did not have cough, dehydration, diarrhea, vomiting or skin infections. She was not anemic and did not have any medical complications. She was the fifth child admitted in the programme.

Case study 2

Shiv, 13 months old from the -———- tribe, was found in a household screening initiative in ———— village, Manopad mandal of Gadwal district on April 12, 2019. He was called to the AWC and his anthropometry was rechecked. This time he weighed 4.5 kg. Shivs's length was 68m. He did not have bilateral pitting edema. His family has 8 members and his home is a 30 minute walk to the AWC. His mother, Mamta said that he is being breastfed. He passes three stools/day and passes urine. He has received all doses of OPV, Hepatitis B, DPT and measles vaccine. He ate the balamrutham+ after some encouragement. The ANM assessed him for danger signs and medical complications. Shiv's respiration rate was 43/minute and he did not have chest indrawing. His temperature was found to be 36˚C/96.8˚F. He had normal alertness. He did not have diarrhea, vomiting, dehydration, cough or other medical complications. He was the 15th child admitted in the programme.

STEP 5:

Nutritional treatment

Nutritional treatment is a critical component of SAM and MAM management. Children with SAM and MAM need safe, palatable foods with a high energy content and adequate amount of protein, vitamins and minerals, to rebuild the lost body mass. For successful rehabilitation, food provided should achieve intakes that will promote catch up growth and improve immune function

How much Balamrutham + to be given?

The balamrutham+ can be kept safely for several days after the package is opened provided it is protected from flies, insects and rodents. The amount of food given to the child should be sufficient to take care of the caloric requirement of 125 kcal per kilogram of body weight per day for children with SAM child and 75 kcal per kg per day for children with MAM child (The rest of the calories for SAM and MAM come from home foods or foods given at AWC). You will have to calculate the number of packets of balamrutham+ according to the weight band table (Table 8).

TABLE - 8
Nutritional Care: How much Balamrutham+ is to be given

Body Weight in Kg	For MAM 2 feeds per day (75 kcal/Kg Body Weight/Day)		For SAM 4 feeds per day (125 kcal/Kg Body Weight/Day)	
	Packets per Week	Scoops per Feed	Packets per Week	Scoops per Feed
4 - 4.4	1	1.0	1	1.0
4.5 - 4.9	1	1.0	1	1.5
5 - 5.4	1	1.0	1	1.5
5.5 - 5.9	1	1.5	2	1.5
6 - 6.4	1	1.5	2	1.5
6.5 - 6.9	1	1.5	2	1.5
7 - 7.4	1	1.5	2	2.0
7.5 - 7.9	1	1.5	2	2.0
8 - 8.4	1	1.5	2	2.0
8.5 - 8.9	1	2.0	2	2.0
9 - 9.4	2	2.0	2	2.5
9.5 - 9.9	2	2.0	2	2.5
10 - 10.4	2	2.0	2	2.5
10.5 - 10.9	2	2.0	2	2.5
11 - 11.4	2	2.0	3	2.5
11.5 - 11.9	2	2.5	3	3.0
>12	2	2.5	3	3.0

Note: Equal quantity of water/milk to be added for every scoop

EXERCISE 4

Calculate the total number of Balamrutham+ packets you will give to the mother of a SAM child.

(A) SAM

Name	Weight (Kg)	Feeds per day	Scoops to feed a SAM child	Packets for one week for a SAM child	Packets for two week for an SAM child
Sushma	4.2	4	1	1	1
Ravi	7.8	4	2	2	4
Mohan	9.4	4	2.5	2	4

Note: During the first week of admission for children with SAM/MAM child, ask the care taker to feed the child at the AWC during the day time, so that AWT can observe how the mother is feeding and guide her on how to feed her child when she is at home. The mother also gets confidence to feed her child, observing other mothers who have come at the center.

Taking Balamrutham+ at home: Messages for the caregiver at the time of enrolment

- Balamrutham+ is a medicinal food for children with SAM/MAM children only. It should not be shared.
- Sick children often don't like to eat. Give small regular meals of balamrutham+ and encourage the child to eat often (if possible, eight meals per day).
- Always offer the child plenty of clean water to drink while he or she is eating the balamrutham+.
- Continue breastfeeding for young children. Offer breast milk first before every balamrutham+ feed.
- Caregiver should wash her and the child's hands with soap before feeding if possible.
- Never mix the balamrutham+ with other foods and follow the instructions on the packet for any doubt. If other foods are given they should be given at a separate time from the balamrutham+.
- Explain that for the first week or two the child will probably not finish all the balamrutham+ given. But as the child recovers his/her appetite will improve so that all the diet will be taken later on in recovery.

During follow up Visit:

- Balamrutham+ is a medicinal food for children with acute malnutrition only. It should not be shared with siblings and other family members.
- Sick children often don't like to eat. Give small regular meals of balamrutham+ and encourage the child to eat often.
- Continue breastfeeding for young children. Offer breast milk first before every balamrutham+ feed.
- Never mix the balamrutham+ with other foods. If other foods are given they should be given at a separate time.
- Caregiver should wash her and the child's hands and face with soap before feeding if possible.
- Keep balamrutham+ clean and covered in airtight container.
- When a child has diarrhea, never stop feeding. Give extra feed and extra clean water.
- Care giver should have an attentive, caring attitude while feeding the baby; talk, sing and play with the child to stimulate appetite and development.

STEP 6:

Medication

No other nutrient supplementation is required. Balamrutham+ already contains all the nutrients required to treat the malnourished child (provided that the caretaker gives sufficient balamrutham+ to the child – the need to give sufficient to the child and not to share the balamrutham+ needs to be emphasised to the caretaker at admission to the programme).

- Additional potassium, magnesium or zinc should not be given to the patients. Such a "double dose", one coming from the diet and the other prescribed, is potentially toxic.
- For children with diarrhea on balamrutham+, there is no need to give additional zinc.

1.Antibiotics (Amoxicillin):

The body's defence system (immune function) does not work properly in children with SAM. As a result, the usual signs of infection such as fever are often absent and infections remain hidden. The important principle of community based management of SAM is that all children should be given oral amoxicillin. Amoxicillin is also effective in reducing overgrowth of bacteria in the Gastrointestinal (GI) tract which is commonly associated with severe acute malnutrition. The dose of amoxicillin given to children with SAM is given in Table 9.

2.Albendazole:

Albendazole is best absorbed after reconditioning of the GI tract with broad spectrum antibiotic. Albendazole is actively absorbed from the intestine and is more effective when the GI tract is free of other infections. It is therefore given on the second visit (Table 8).

3.Diarrhea without dehydration

- If the child has loose watery stools, give ORS after every loose stool.
- The frontline worker should teach the mothers how to wash hands before preparing the ORS/ feed of the child. Hygiene is very important to prevent any further episodes of illnesses.

Table 9: Routine medication for SSFP				
Drug**	**When**	**Age/ weight**	**Prescription**	**Required amount**
Amoxicillin DT (125 mg)	First dose on enrolment and then for home (two times daily for five days)	4.0 - 6.9 kg	1 tab twice daily for 5 days	10 tablets
		7.0 - 9.9 kg	1.5 tabs twice daily for 5 days	15 tablets
		10.0 - 12.9 kg	2 tabs twice daily for 5 days	20 tablets
		13.0 - 15.9 kg	2.5 tabs twice daily for 5 days	25 tablets
		16.0 - 18.9 kg	2.5 tabs twice daily for 5 days	25 tablets
Albendazole1 (5ml = 200mg)	Second visit	< 1 year		None
		12 - 23 months	Do not give	5ml
		≥ 2 years	5ml	10ml
Folic Acid	First dose on enrollment	6 - 59 months	10ml	1 tablet
Vitamin A	One dose on admission if not given during last 1 month and also if there is next biannual round of vitamin A upcoming with next1 month	6 - 12 months	5mg on day 1	1 lakh IU/1ml
		>1 year		2 lakh IU/2ml

Note: Balamrutham+ to be given to children with SAM in SSFP programme. Iron syrups have to be given as per the guidelines of Anemia Mukt Bharat. For any other problem send the child to nearest PHC.

EXERCISE 5

Calculate the dose of Amoxicillin for the following children on enrolment?
What are the total numbers of tablets required for five days?

Name	Weight (Kg)	Prescription on Amoxicillin (12mg) for 5 days	Total number of tablets Amoxicillin
Sushma	4.2	1 tablet twice a day	10
Ravi	7.8	1.5 tablets twice a day	15
Mohan	9.4	2 tablets twice a day	20

STEP 7:

Health education

It is essential to educate mothers and caregivers. This step is critical in preventing relapse and occurrence of malnutrition in other children of the family.

A. Health education at AWC and home visits:

The SSFP programme provides a good opportunity for health education. The aim of treatment is not only to treat the child but also to empower mothers and caregivers so that they are able to maintain the child's nutritional status after discharge from the programme and also prevent malnutrition in their other children.

During first visit

When the child is first enrolled in the programme information about the need of augmented THR foods, how to give, need and method of giving medicine at home, basic hygiene is required. No other health education messages should be given on the first visit to avoid overloading the caregiver with new information. At the end of the first visit, it is vital to check whether caregivers have understood the instructions given by the health worker by asking some simple questions before they leave.

B. Health education during follow-up visits at SSFP sessions

Additional health, nutrition and hygiene messages need to be provided during follow-up visits each week, as part of an extended health and nutrition education programme.

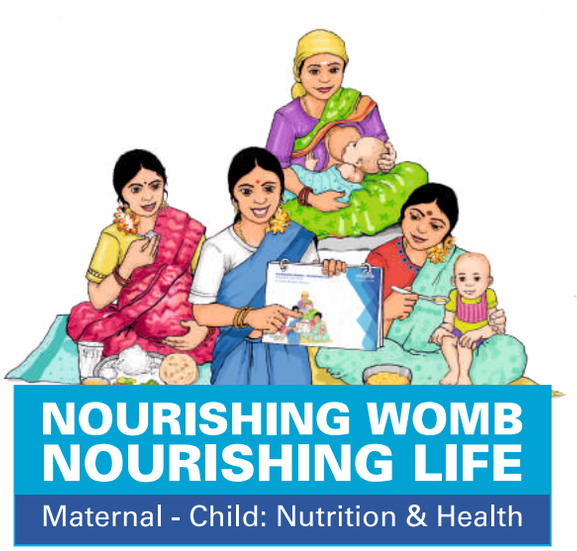
It is essential that messages be reinforced by practice. Example: Hand washing with soap.

One reason for poor brain growth is malnutrition, the brain need more food to grow well. To help the child with SAM recover physiologically, metabolically, immunologically and emotionally, along with the therapeutic foods, antibiotics and other medicines, the child also needs care, responsiveness and stimulation. Eye to eye contact, talking, singing, holding and playing with the child will help the child recover. The visits of the mothers and caregivers to the SSFP session/clinic should be optimally utilised for promotion of early child development activities through one-to-one or group counselling.

- An illustrated guide for SSFP developed in form of flip book is available. State can use this flip book by translating it in their local language.

Counselling toolkit for health workers

Structured counselling tool can be used during follow up visits in SSFP programme



- The illustrated guide can be used to counsel mothers, caregivers and community members about nutrition practices essential for optimal health and growth of children.
- It is important that, before starting the counselling, counsellor be fully acquainted with contents of the guide.
- During counselling, ensure that the place of counselling is clean and comfortable.
- Greet mothers and listen to them carefully, throughout the counselling session, and respect their point of view.
- It is necessary to use good and clear communication.
- During counselling, hold the illustration side of the flip guide facing the group, making sure that it is held straight and not slanting or that your hands are not covering the picture.
- Do not forget to summarise the key message at the end of each session.

What is required during counselling?

Good and clear communication skills, patient listening, and familiarity with local terminologies, and friendly approach are effective in gaining mother's confidence. For effective communication of messages, following skills are useful:

1) Encourage mothers to speak, listen patiently and praise what the mother (or caregiver) is doing correctly and reinforce the good practices.

2) Give relevant advice in simple language.

3) During the session, ask questions to ensure understanding of group. Before discharge, children enrolled in the SSFP programme should begin to transition to appropriate high-energy, nutrient-rich home foods. Workers should ensure that the mother/caregiver knows:

- What foods can be given to the child;
- How to enrich home foods by adding locally available and culturally acceptable foods and by addition of oil/ghee;
- How often and frequently to feed the child before the child leaves the SSFP programme. This will also help the child to adjust slowly from eating mostly balamrutham+ to eating mostly local foods.

Key messages on various topics

A. Role of nutrition during life cycle

- Age appropriate immunization, prompt and adequate care during sickness, good hygiene and sanitation practices are important during pregnancy, at birth and neonatal period, infancy and young childhood, preschool and school years adolescence.
- Healthy Child Makes a Healthy Community
- Impact of Malnutrition During Life Cycle

B. Identification of children with SAM & MAM

Children with SAM and children with MAM can be identified by WHZ and edema.

C. Sanitation and hygiene

- Use of sanitary latrine, Safe disposal of all faeces – both human and animal – is the single most important action to prevent the spread of germs by people or flies.
- Safe disposal of all household refuse helps to keep the living environment clean and healthy. It is also important to avoid activities which increases indoor pollution like smoking, cooking inside living room and avoid cooking on wood if possible. Most importantly keep all pesticides, drugs outreach of children.

Safe drinking water: Families can store drinking water in a clean, covered container.

-Use long handled ladle to take out water from container and clean the container frequently.

-Washing hands with soap and water, working up lather and cleaning palm, finger nails and space between the fingers removes germs of diseases.

-Must wash hands with soap before preparing food and feeding the child after using toilet and cleaning baby's bottom after handling animals.

D. Nutrition during adolescence, pregnancy and lactation

-Good nutrition during adolescence ensures better learning ability and healthy adulthood.

-Boys and girls require an equal balanced diet.

-In addition, weekly iron folic acid supplementation and bi-annual de-worming should be administered.

-Use of iodised salt in food preparation. Iodised salt should be stored in air tight containers and kept away from heat. Storing salt in open or exposure to sun or moisture results in loss of iodine.

- A pregnant and lactating woman needs extra food every day to meet the needs of the baby and her own well being.
- She should take one additional meal. She needs variety of foods available at home
- She should take prescribed iron folic acid (IFA) tablets.180 tablets of IFA is being provided during pregnancy and lactation through AWC, as per NIPI guidelines

E. Complementary feeding

After 6 months, breastmilk alone is not sufficient to maintain growth, so baby needs other food or liquids in addition to the breastfeeds which is known as Complementary Feeding.

Discuss these points one by one:

- Risk of starting Complementary Feeding before 6 months (Too Soon)
- Delaying Complementary feeding beyond 6 months (Too late)
- Appropriate Consistency
- Food Diversity of Complementary Foods
- Responsive Feeding
- Hygienic Preparation and Storage of Food
- Food Items To Be Avoided
- How to Enhance Nutritive Value of Food items?

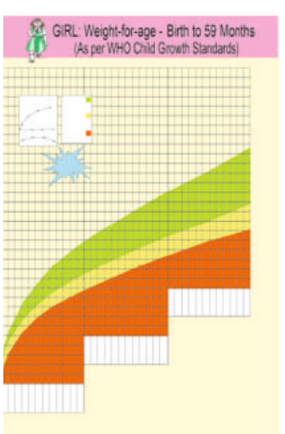
F. Breastfeeding

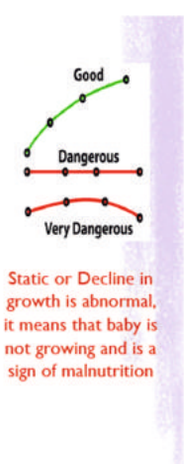
Lead a discussion with mothers on the following topics. Listen their views and then give key messages.

- Early Initiation of Breastfeeding within 1 hour of birth
- Dangers of Pre-lacteal Feeds
- Advantages of Colostrum
- Explain benefits of breastfeeding for the baby, mother and for family and community.
- How to know that Baby is Getting Enough Milk?
- Risk of Starting any other Feed before Six Months
- Factors Affecting Milk Production
- Factors Responsible for Successful Breastfeeding
- How to know that Baby wants to breastfeed?
- Exclusive Breastfeeding for First 6 Months (180 Days)

G. Growth monitoring

- Weight gain is the most important sign which shows that a child is growing and developing well. Infants and children should be weighed at least once every month during first 5 years of life.
- Every child should have a growth chart / MCP chart on which weight should be recorded.





H. Care of sick child

For nutrition for a sick child, please consider the following points (Image 17)

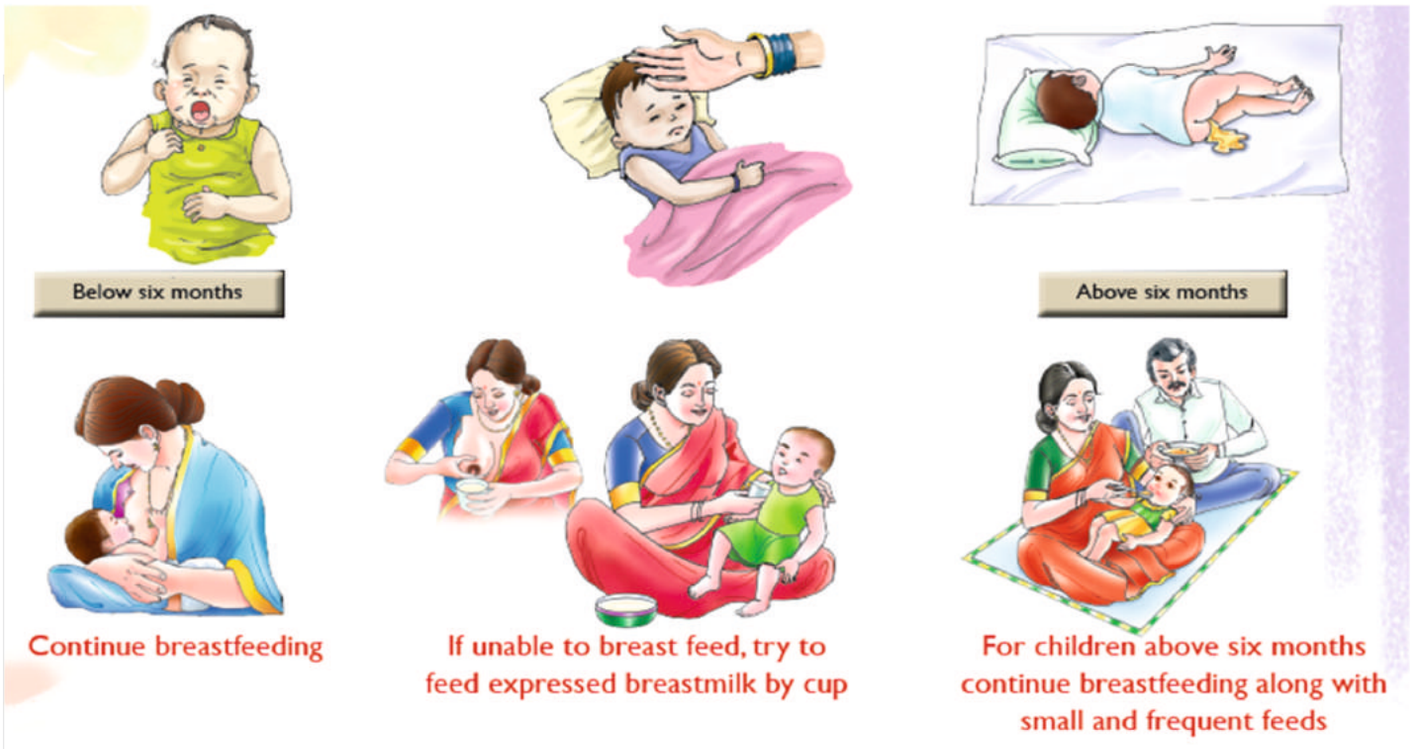


Image 17: Care of sick child

I. What to do if child develops loose motions (Diarrhoea)

Following steps need to be taken care of while managing child with Diarrhoea (Image 18)

Image 18: Diarrhea management

J. Identifying sick child for early referral

- If a sick child is identified and taken to the health facility immediately, his/her life can be saved (Image 19).

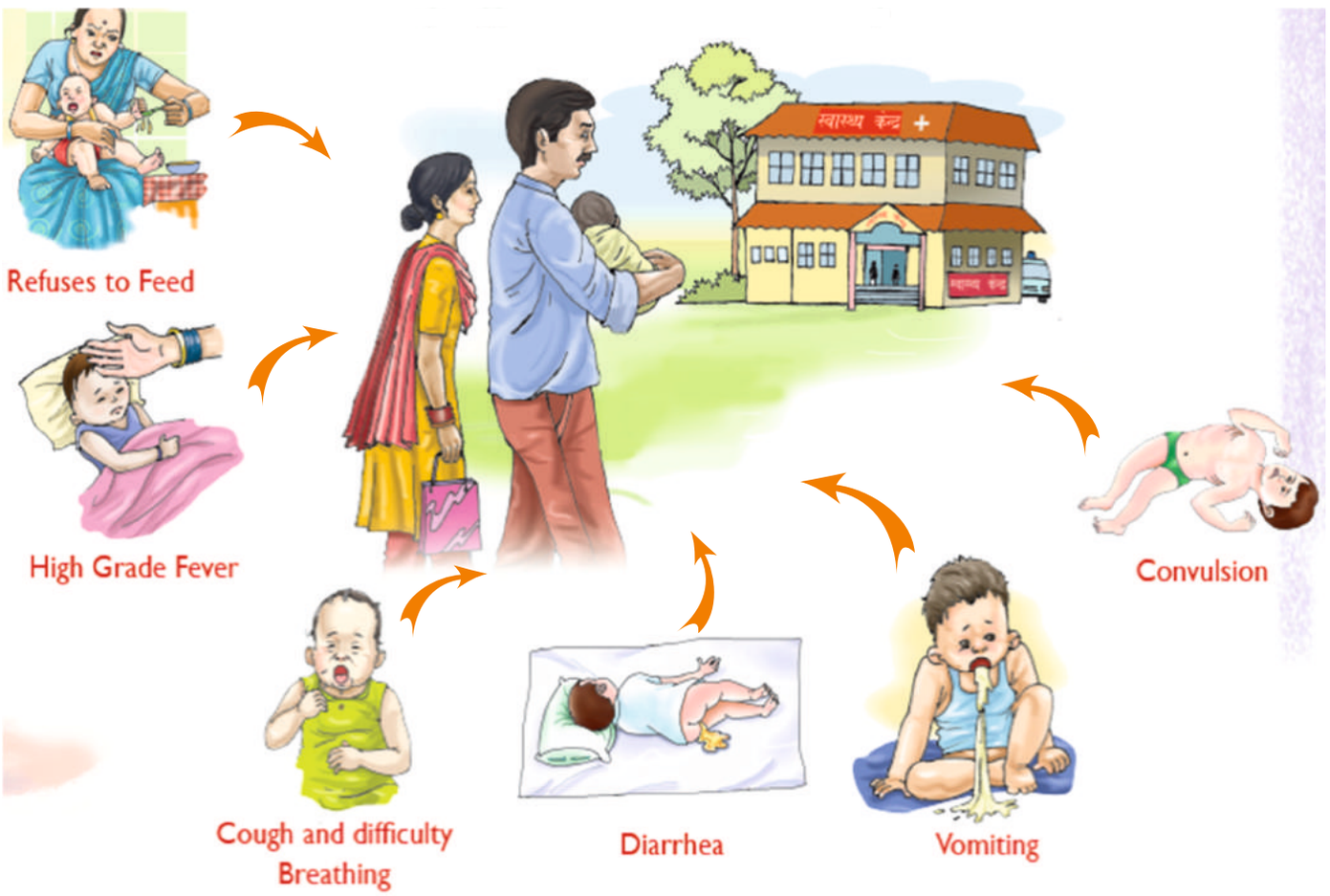


Image 19: Danger signs for early referral

K. Relationship between family size and malnutrition (Image 20)

- Large family size with limited income causes food scarcity, limited money is available for children's education and care during illnesses.
- Food scarcity, poor hygiene and frequent illness predispose these children for malnutrition.

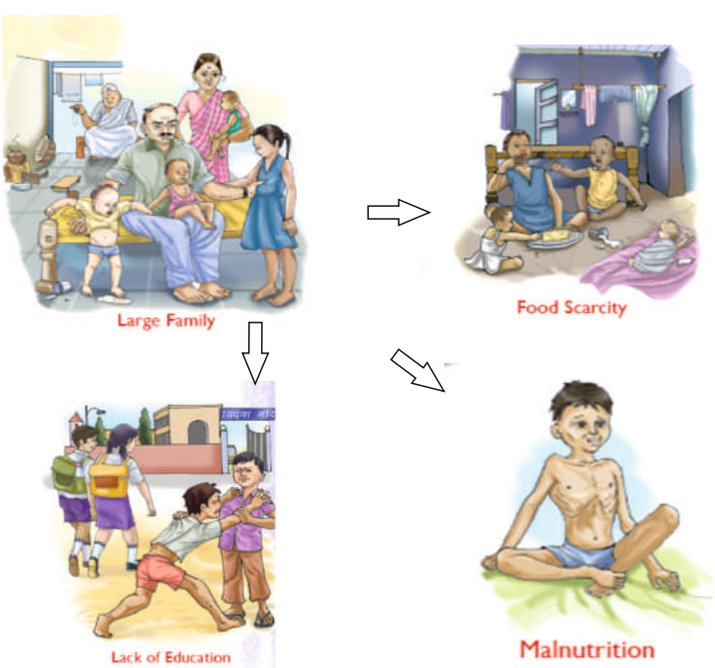


Image 20: Relationship b/w family size and malnutrition

L. Discuss with mother for family planning

Discuss the following options available for family planning (Image 21)

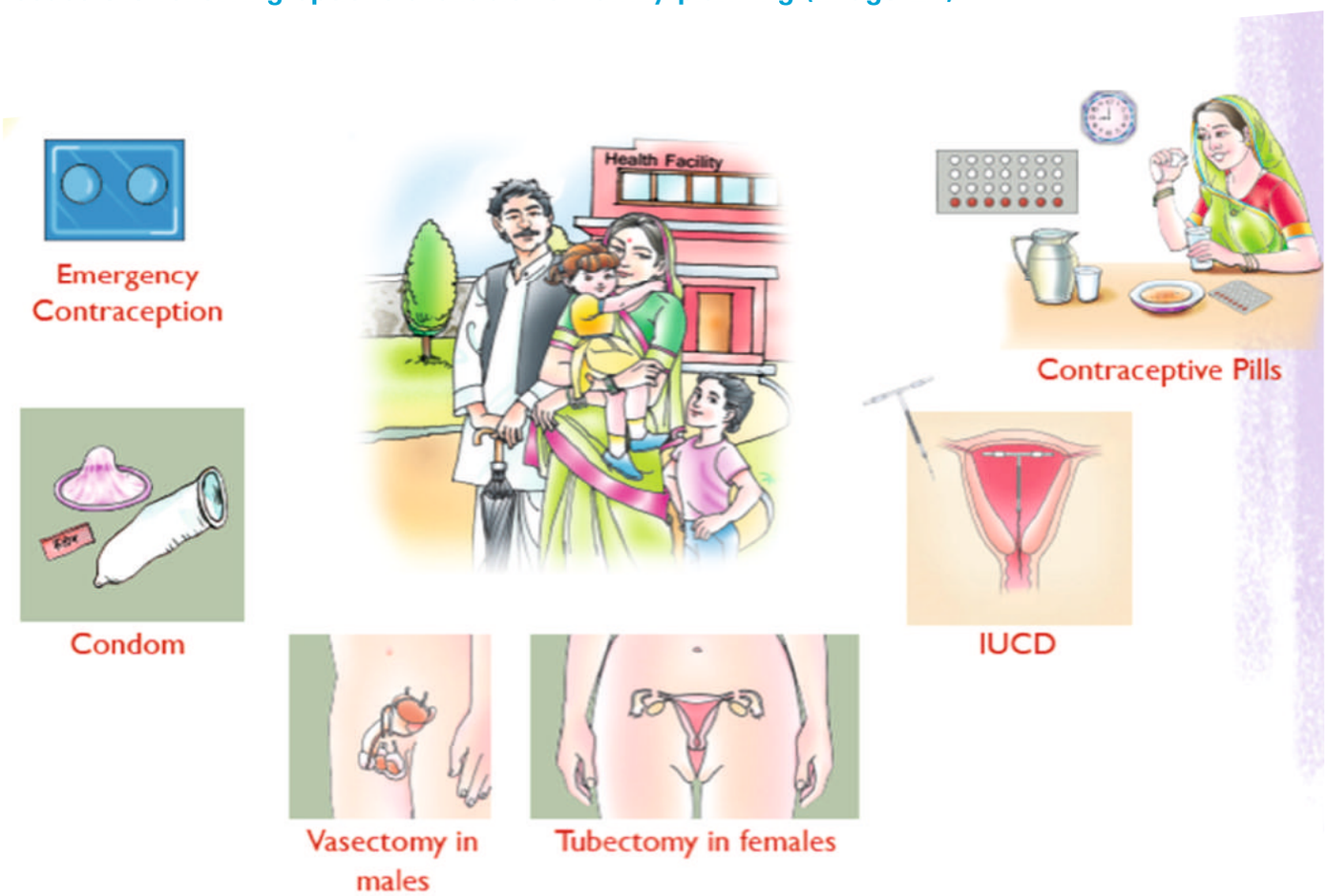


Image 21: Family planning - what choices are available

STEP 8:

Follow up while in the programme

Child's progress is monitored regularly at the AWC and is recorded in SAM/MAM Card until s/he is discharged from the programme.

Follow-up visit for Children with SAM:

- For first four weeks: Weekly follow-up by AWT.
- From the fifth week of enrollment till the completion of treatment: Fortnightly follow-up will be done at AWC.
- Follow-up visit for Children with MAM:

  From the first week of enrollment till the completion of treatment: Fortnightly follow-up will be done at AWC

A. Activities undertaken during follow-up visit (Table 10)

- Weight, height measurements and assessment for edema are taken during every follow-up visit.
- Medical checkup and medical history (illness in the previous week) at every follow up visit; determine if there are complications, if there is a need to refer to inpatient care or if follow up by a AWT/ASHA or a community volunteer is needed at home.

- The patient receives drugs and balamrutham+ supplies for the week.
- All children who has attained WHZ > -2SD in two consecutive follow-up visits, will be done exit assessment and discharge.
- All children will continue receiving balamrutham+ till discharge.
- Individual counselling and health and nutrition education in groups will also be provided during these visits.

Clean water for hand washing and for drinking should be available at the AWC. So that mothers can wash hands. It is important to organise a smooth flow of patients which limits waiting time and ensures that all patients are seen and properly looked after. At 7th (MAM)/16thweek (SAM)/ successful discharge, assess whether the family is getting benefits from PDS. If family is not getting PDS benefits, take help from CDPOs & district official to link the family with PDS scheme.

Table 10: Activities to be carried out during follow up at SSFP clinic/session

Activity	Frequency
Weight and height measurements	Every visit
Check for edema	Every visit
Complications	Every visit
Assessment of appetite	VHND
Home visit	Only when needed
Vaccinations	According to immunization schedule
Health/Nutrition education	Every visit
Evaluation of balamrutham+ consumption each week	Every visit
Provision of balamrutham+	Every visit

Home visits to be prioritized for children with SAM across AWCs

Children with SAM - 10% of cases enrolled in the, home visits will be done by AWT as a part of Intintiki anganwadi campaign

Children with MAM - 5% cases home visit to be done by AWT as a part of Intintki anganwadi campaign

AWT should closely monitor following children through home visits:

- The care giver has refused admission of the child to the NRC
- Cases in the first two weeks after transfer from the NRC
- For all defaulters/absences from the SSFP, it is important to gain an understanding of the reason for absence and to encourage return
- Check the child who has been transferred from NRC to the SSFP is recovering from recent illness (if any)
- A child who has not come to the SSFP for weekly check-up and replenishment of balamrutham+
- Child showing weight stagnation or weight decline

The following aspects should be assessed:

- Caregiver's understanding of the messages received in the centre
- Compliance with the treatment (SSFP and medications)
- Reasons for non-compliance with treatment, absence or defaulting
- Availability & accessibility of water and sanitation facilities and hygiene practices
- Health and hygiene and food safety practices and general household food security

The AWT should:

- Where possible provide support for any problem identified
- Encourage the continuation of the treatment
- Give health and nutrition education and recommend good infant feeding practices

C. Tools for individual follow up

In order to ensure quality and continuity of care during the management of SAM cases, following documents should be used:

- SAM Card & MAM Card (Annexure 1&2) :- Stays with the mother/family and contains all information regarding the child's condition at admission and discharge and his/her evaluation during treatment.
- Referral Slip (Pink Color- (Annexure 3) :- To be filled by AWT while sending him to NRC, if child has developed some medical complication during SSFP program.
- Transfer slips (green coloured- (Annexure 4) :- Sent with the caregiver to allow tracking of information about the child's condition and evaluation during movements between services (NRC to SSFP session).

Linkages with facility based care at NRC

SSFP programme will have linkages with the nearest NRC for referral of children with SAM having any medical complication or who develop complications during the treatment (See referral Slip from SSFP clinic to NRC in Annexure 3. Similarly, children transferred from NRC after initial stabilization will be enrolled in SSFP Clinic/Program and continued on therapeutic feeding (without anti-biotic) till their discharge.

SSFP to NRC	NRC to SSFP
- Development of oedema or other medical complications like diarrhea with dehydration or fast breathing - Lack of appetite to consume balamrutham+ at home. - Decline in weight in two consecutive visits - No change in weight for three consecutive weighing - Child has fever and is not alert - Children who have not graduated from <-3SD WHZ, even after four months of treatment at SSFP	- Medical treatment completed - Child has a good appetite (consuming at least 75% of F100 or 75% of TF) - Edema resolved - The child is gaining 5g/kg/day for three consecutive days - The immunization of the child is up-to-date

EXERCISE 6

Sunder's 10 months old male, belongs to ---------- village of Maldakal mandal of Gadwal District. His admission weight was 5.2 kg, during the first follow-up visit his weight was 5.4 kg and his WHZ remained at <-3SD. During the second follow-up on 12/04/17 he was bought to AWC by her mother Meera, he was weighed again and his weight was 5.3 kg and WHZ <-3SD. No visible complications were found.

1. What action should be taken?
2. If referral is needed, fill the referral slip.

STEP 9:

Discharge criteria for SSFP programme

The discharge criteria from the community based programme are:

Clinically well and WHZ > -2SD

Maximum duration in SSFP Program:

- For SAM – up to 16 Weeks
- For MAM –up to 8 weeks
- It may be highlighted that average duration for successful discharge from the programme is usually 2-3 months; therefore, it is mandatory that once admitted, the children will be enrolled till the child meets the discharge criteria.

- If the child does not attain WHZ > -2SD even after 16 weeks for SAM and 8 weeks for MAM, s/he should be referred to the nearest NRC/health facility for detailed evaluation and referred as non-respondent. If any secondary cause for malnutrition is detected, the child has to be treated appropriately, and if the child is found to have no medical complications. S/he should be classified as Discharged – Non-recovered.

At the time of discharge of the child from the SSFP program, ANM and AWT should again counsel the mothers that the child should get age appropriate quantity, frequency, variety and consistency of complimentary feeding as laid down in Chapter 2 & 3 and also under Step-7 of the SSFP Management in this chapter. They should also be counselled on child caring practices and also to maintain hygiene and cleanliness in the surroundings to avoid any bacterial growth. Mothers/caregivers should be made understand that, if they don't follow the above practices, there is a high chance that the child will again fall into the cycle of malnutrition.

STEP 10:

Follow-up after discharge from SSFP programme

Children discharged from the SSFP programme will be enrolled in the Supplementary Nutrition Programme (SNP) of the ICDS and their growth will be monitored every month during the first 6 months after discharge; children who have not recovered (not met the discharge criteria) in the programme will be referred to NRC for medical examination and a detailed workup before being sent to the SNP and classified as Discharged not recovered.

WHO - The AWT will mainly be responsible for this activity and will be supported by the ANM/ ASHA.

WHERE - AWC at VHND

WHEN - Schedule for follow-up visits:

Every child discharged from the programme must be followed up monthly in the first six months after discharge from the programme.

WHAT - Actions to be taken during each follow-up visit

1. Measuring weight and height/length and assess SD score
2. Recording medical history (any illness between the intervening period from the last visit)
3. Reinforcing key messages on nutrition and child care
4. To check the SSFP card and add information regarding relapse.
5. If weight loss or static weight, counsel the mother for improving feeding practices.
6. If any child comes under SAM and MAM category within three months from the discharge date, s/he will be readmitted and given the same SAM and MAM numbers.
7. If any child comes under SAM and MAM category after three months from the discharge date, s/he will be admitted in the SSFP programme as a new admission and given a new SAM numbers.
8. It may be noted that after 16 weeks/successful discharge child will stop receiving balamrutham+, however monthly follow ups till the end of six months will be continued.
9. At the 3rd month of follow-up also assess whether the family is getting benefits from PDS. If family is not getting PDS benefits, take help from CDPOs & District official to link the family with PDS scheme

   During every post discharge follow up visits, ANM and AWT should counsel the mothers that, the child should get age appropriate quantity, frequency, variety and consistency of complimentary feeding, as laid down in Chapter 2 and Chapter 3 and also under Step-7 of the SSFP Management in this chapter. They should also be counselled on child caring practices and water, sanitation and hygiene practices during every follow up visits. During every follow up visit, mothers/caregivers should be made understand that, if they don't follow the above practices, there is a high chance that the child relapse and again fall into the cycle of malnutrition.

Table 11: SSFP indicators	
ADMISSIONS	**DEFINITION**
New admissions [1]	New cases that comply with admission criteria.
Other new admissions	Cases that require admission but do not fulfil age or anthropometric criteria for admission. Note: for twins where one twin is not malnourished - the second twin is given an admission card but not recorded as an admission.
From NRC	Returned from inpatient care - cases that were transferred to inpatient care, and are returning to continue their treatment or those cases that arrived directly to inpatient and have now been discharged to complete treatment in AWC
Returned after default	Returned defaulters who, on return, have not yet reached programme discharge criteria.
From another AWC site	Children moved from another AWC to continue their treatment.
EXITS [2]	
Discharged - cured	Cases meeting programme discharge criteria.
Died	Cases who die while registered in the programme.
Returned after default	Cases are classified as defaulter on their third absence. This provides time for follow-up after the first absence to encourage return.
Referral to NRC	This is used for children who deteriorate in the AWC and need to be transferred to inpatient care, or for those who are registered in the AWC but are immediately transferred to inpatient care on admission
Non-responder	Cases who do not meet discharge criteria after four months when all investigation and transfer options have been carried out. Or medical referrals who do not return.

[1] 'New Admissions' Includes: children presenting to the AWC site who are transferred immediately to inpatient care; all children refusing transfer to inpatient care on presentation; all children transferred from AWC due to deterioration in their condition; Direct admissions to inpatient care are recorded in "From NRC" when they arrive in the AWC because they will already have been recorded as new cases of malnutrition by the hospital that is managing the inpatient care.

[2] Transfers from AWC are recoded as exits. Medical referral from AWC to a hospital or medical facility other than inpatient care for medical treatment or investigation are not recorded as exits. However if they fail to return they are recoded as non cured.

4.3 TAKE HOME MESSAGES

- All children with SAM detected during screening (WHZ <-3SD) should undergo assessment for bilateral pitting edema, appetite test and assessment for medical complications to decide the level of care (SSFP programme/NRC)
- Management in SSFP programme comprises 10 steps
- Balamrutham+ is a medicinal food for SAM children. child should be offered plenty of clean water to drink while s/he is eating balamrutham+
- Balamrutham+ should not be shared with any sibling or any other family members.
- The discharge criteria from the SSFP programme is WHZ > -2SD and no edema (for two consecutive visits) and clinically well
- All children after discharge from SSFP programme if not enrolled, must be enrolled in SNP, ICDS.
- All enrolled SAM children will be followed weekly for the first one month for monitoring progress, followed by biweekly follow up till 16 weeks or discharge.
- All enrolled MAM children will be followed biweekly till 8 weeks or discharge
- After the child gets discharge from the program, the child should get age appropriate quantity, frequency, varieties and consistency of food items
- Mothers/caregivers should also be counselled on child caring pratices and WASH practices to avoid the child falling again into the cycle of malnutrition

SESSION 5
Record keeping, monitoring and reporting

Session Plan		
S. No	**Details**	**Methodology**
5.1	What is monitoring? Levels of monitoring in the programme	Discussion, presentation, role play and reading
5.2	Reporting and reporting flow - Monthly reporting - CSSFP program center - Reporting flow	Discussion
5.3	Supportive supervision	Discussion
5.4	Summary: Take home message	Discussion

LEARNING OBJECTIVES

By the end of the session, participants will be able to:

- Describe what type of data they have to collate and will also learn how to record this data
- Monitor the programme using SSFP card and SSFP register and various other formats
- Understand the flow and frequency of reporting in order to submit timely reports

Record keeping, monitoring and reporting

5.1 What is monitoring?

Monitoring is a continuous and essential process. It helps us identify the areas of improvement, progress and impact of the programme and enables us to make the required improvements. Monitoring is not done for finding fault; instead it is done to ensure that all activities are going as per plan. It helps in tracking the child through the SSFP programme components, ensure the follow up of defaulters, and monitor the effectiveness of the programme, identifying problem areas, finding immediate solutions to the problems and to provide timely constructive feedback to the workers for making course corrections and learning.

What does monitoring do?

It will help project staff to know how things are going, as well as give early warning of possible problems and difficulties.

- It reveals if timely and appropriate services have been delivered to the individual patients.
- It highlights areas for improvement in project implementation.

  For effective implementation of the programme, it is important that data and records are maintained regularly. For the management of SAM and MAM at the community level, it is important that appropriate data is maintained. Records used in the programme are listed below in
- It highlights areas for improvement in project implementation.

  For effective implementation of the programme, it is important that data and records are maintained regularly. For the management of SAM and MAM at the community level, it is important that appropriate data is maintained. Records used in the programme are listed below in table 12.

Table 12: Records to be maintained in SSFP Programme

S. No	Record Name	To be filled by	Sent To	Time
1	SAM & MAM card (Annexure 1&2)	AWT	Patient	During follow up visit
2	Referral slip for referral to NRC: Pink in color (Annexure 3)	AWT, ANM	NRC	SSFP session/clinic
3	Transfer slip for transfer from NRC to AWC: Green in color (Annexure 4)	NRC	AWT	During discharge from NRC

Monitoring will be done at two levels:

1. Monitoring of the programme
2. Monitoring of the individual child

1. Monitoring of the programme

The Supervisors and CDPOs will monitor the following indicators to assess the quality of services being provided.

- No. of new admissions each month
- No. of children referred to NRC
- No. of children cured and discharged
- No. of children died
- No. of children defaulted
- No. of children not recovered over 4 months periodfor SAM
- Regular and timely supply of drugs and balamrutham +
- Frequency at which follow up sessions are organised
- Transfer between different programmes (SSFP programme and NRC)
- Admission & exit criteria for the SSFP program is given in table 10

2. Monitoring of the individual child

Children move between the components (SSFP at AWC and inpatient care at the NRC) as their condition improves or deteriorates. It is important to be able to track children between the programme components and programme sites. To allow this, there must be strong links between the SSFP (at AWC) and NRCs and information have to be well managed between the different components.

Regular monitoring of the progress of individual child should be done during the treatment of children with SAM in SSFP programme. For this weekly/fortnightly sessions will be organised.

What is to be monitored?

If the child is not gaining weight in the first week, home visit by AWT should be ensured and they should monitor:

Monitoring Indicators of Individual Child

- Increase in weight and height measurements
- Appetite status
- General condition of the child

- Whether the child is being fed adequately or not
- Frequency of feeds (at least 6 to 8 times/day active feeding)
- Does the child vomit after taking feed?
- Whether feed is being shared by siblings
- Hygiene practices
- Any history of illness in the previous week- Availability of clean drinking water

If there are discrepancies in any of the above practices, teach the mother the correct practices (correct amount of feed to be given, frequency of feeds and active feeding, clean drinking water, do not share feed with other siblings, correct method of washing of hands etc)

If after all corrective steps have been taken, the child is still not gaining weight for three consecutive weeks; the child should be referred to the NRC.

5.2 Reporting and reporting flow

Reporting enables the gathered information to be used in making decisions for improving project performance. The report should provide a monthly summary of quantitative information from the SSFP programme at AWC. The report should mention the following information:

Monthly reporting

- Number of children between 6-59 months screened during monthly passive screening
- Number of children between 6-59 months with WHZ < -3SD, and bilateral pitting edema identified
- Number of new cases (children) registered (by age-group, caste and gender) at the SSFP
- No. of SSFP follow up sessions held
- No. of children attended the SSFP Session held in the month
– Total referrals (outgoing) to NRCs/inpatient health facility in the month
– Number of children discharged from SSFP program

Reporting flow

- Data will be recorded and collated at AWC level by AWT regularly
- NIN team will compile the report at district level to be shared with District officials, WCD and Health State officials and UNICEF
- Regular review of program at State level under the chairmanship of director DWCD and at district level under chairmanship of district collector

To monitor the programme, the following indicators will be used:

Performance Indicators

- Recovery (cure) rates
- Mortality rates
- Defaulter rates
- Relapse rates
- Non-responder rates

Output indicators

- Number of AWCs established as SSFP sites
- Number and percentage of children under 5 screened
- Number and percentage of children under 5 with SAM identified and referred for treatment
- Number and percentage of children under 5 with MAM identified and referred for treatment
- Number of children with SAM admitted to SSFP
- Number of children with MAM admitted to SSFP
- Number of children with SAM referred to NRC
- Number or percentage of frontline workers trained in SAM case management
- Number and percentage of children completing the three follow-ups after discharge
- Relapse rate among children treated in the program
- Number and percentage of children who died within 6 months of discharge

5.3 Supportive supervision

- Good and effective service delivery requires that trained and motivated workers are in place and have the supplies, equipment, transportation and supervision to do their job well.

District and Block Level Supervisory staff from the Health, ICDS and other related departments should provide supportive supervision to the AWT and ANM (Table 13).

Table 13: Roles of the supervisors/CDPO for SSFP:	
Activity	**Supportive supervision responsibility (CDPO/Supervisor)**
Supervision and support for monitoring SSFP sites	Atleast 25% of AWCs should be visited every month for supportive supervision. Primary responsibility would be of supervisor in coordination with CDPO
Supervision and support for Community Sensitization and Mobilization during VHND meeting	Primary responsibility would be of CDPO in coordination with the Block Medical Officer.
Checking of screening of SAM and MAM child	Closely monitor screening of SAM/MAM children. Primary responsibility would be of supervisor of the respective sites
Checking of case selection	Atleast 10% of the cases selected should be checked. Primary responsibility would be of supervisor
Checking of quality of care	Primary responsibility would be of CDPO of the respective sites and block medical officer
Checking of cards and registers	Atleast 20% of cards and registers should be checked every month. Primary responsibility would be of supervisor of the respective sites
Compilation and dissemination of monthly and monitoring reports	Primary responsibility would be of AWT
Coordination and problem solving	Primary responsibility would be of supervisor and CDPO
Interaction and feedback from the community	Primary responsibility would be of supervisor

5.4 TAKE HOME MESSAGES

- For any programme to be successful, it is very important to maintain the documents of the programme
- In this programme, primarily SSFP register, SSFP Card, referral slip, transfer, monthly reporting format and tally sheet have to be filled
- Reports from all blocks will be compiled at the district level every month and sent to the state programme officials

SESSION 6

Inter personal communication

S. No	Details	Methodology
6.1	**Introduction** What is Inter-personal communication? - Features of interpersonal communication - Inter-personal - Communication skills - Counselling process	Discussion and brainstorming game
6.2	Summary: Take home message	Discussion

LEARNING OBJECTIVES

By the end of the session, participants will be able to:

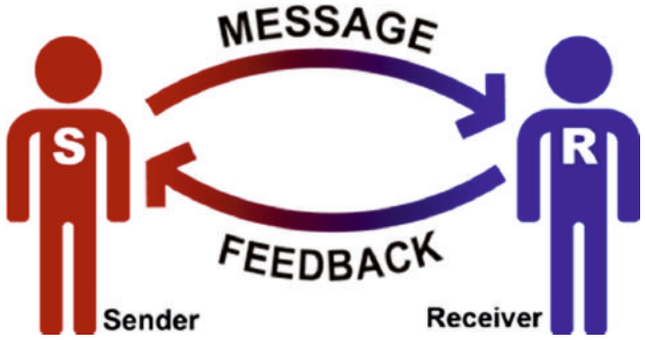
- Define Inter-personal communication and its importance.
- Demonstrate Inter-personal communication (IPC) skills.
- Understand the importance of IPC in successful implementation of the programme.
- Demonstrate the steps of counselling (GATHER).
- Demonstrate how to conduct group counselling sessions.
- Enlist key messages to be given to mothers/caregivers of children with SAM

6.1 Introduction:

For effective communication, we need to possess several types of communication skill. Counselling is not only giving information or advice but it is a process through which beneficiaries learn how to make decisions and adapt a new way of behaving, feeling and thinking.

What is Inter personal communication?

Interpersonal Communication is a person to person, two ways, verbal and non verbal interaction that includes the sharing of information and feelings between individual or in the small groups, that establishes trusting relationships.



Features of inter personal communication

Following are the features of Inter personal communication (Figure 7):

- **Understanding the problems of community members and barriers to behavior change**
- **Addressing doubts and queries of members regarding a health service or practice**
- Clarifying existing myths and misconceptions about specific health behaviors
- Helping the mothers /family members in adoption of new health behaviors or behavior change
- Establishing trust and credibility among the community at large
- **Identifying gaps in the knowledge of community members and filling them**

Figure 7: Features of Inter personal communication

Interpersonal communication skills

For effective communication, workers need to possess several types of communication skills. These are given in figure 8:

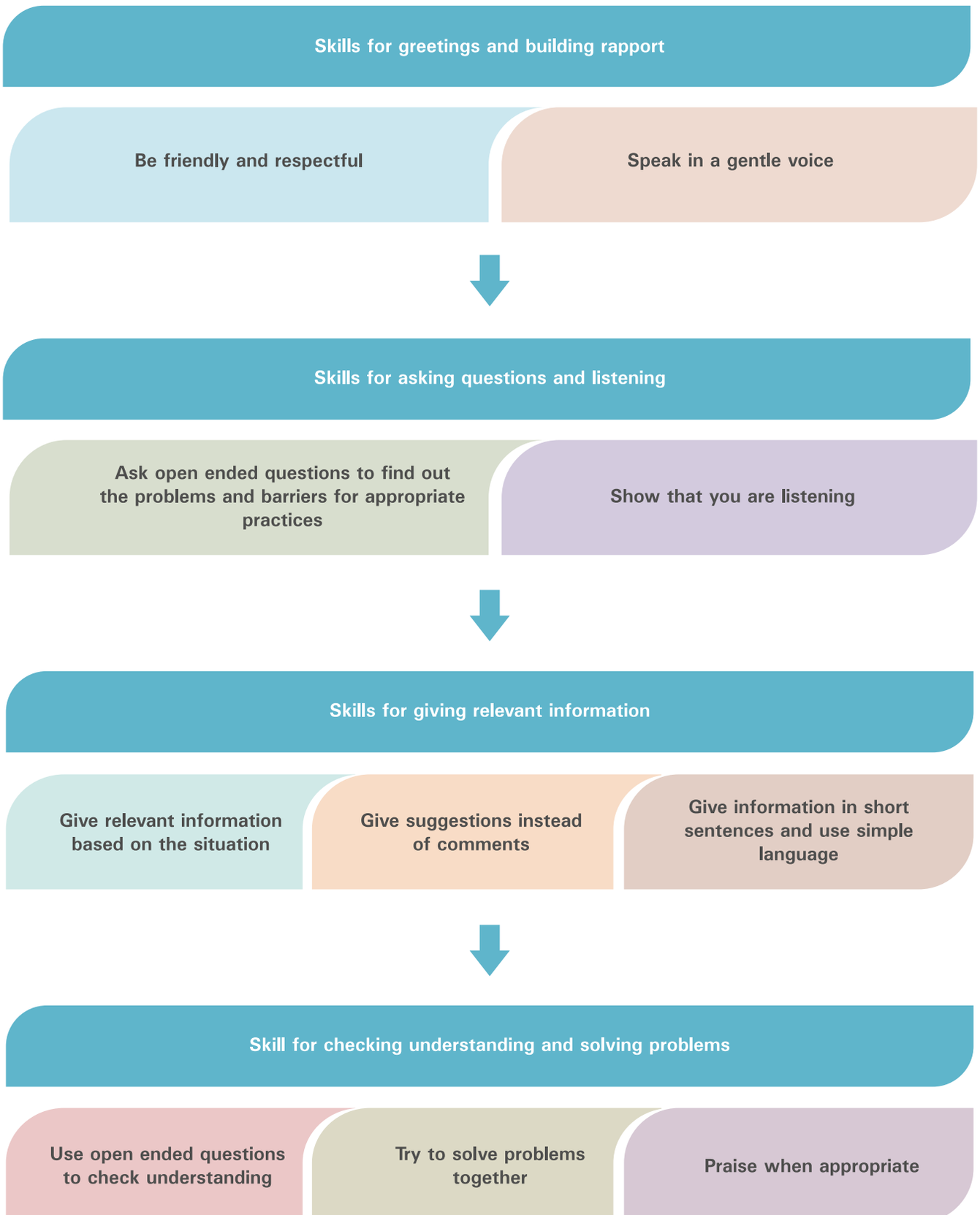


Figure 8: Types of communication skills

Counselling process

For effective communication, volunteers/ workers need to possess several types of communication skills. There are six steps to the counselling process that we will discuss and this is known as GATHER (Figure 9).

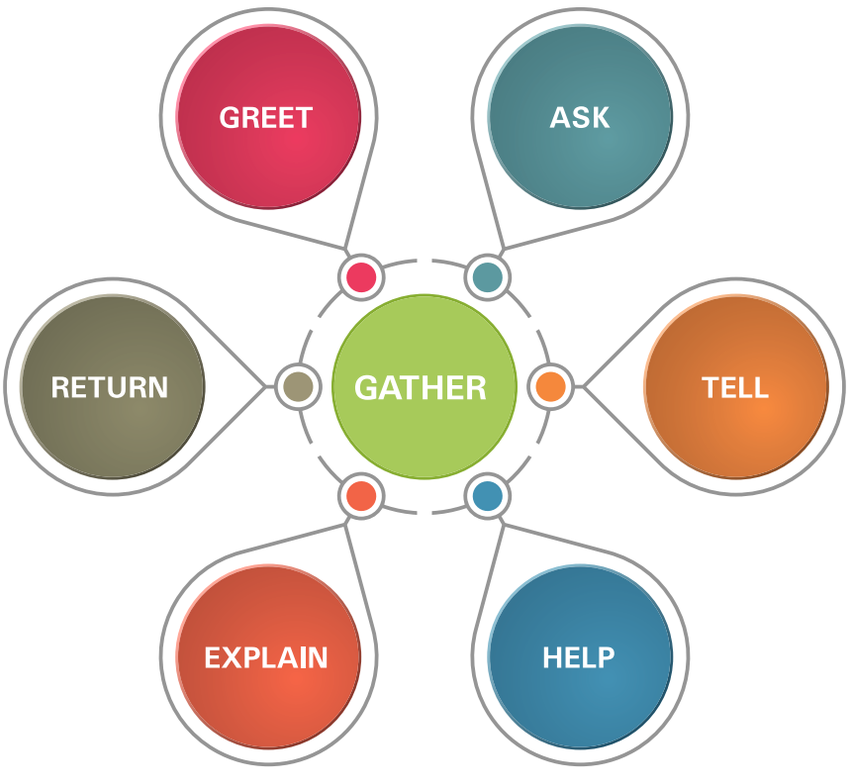


Figure 9: GATHER chart

a) G (GREET) – Greeting the beneficiary

Always greet senior family members and build rapport with them. The greeting should be specific to the age of the person you are talking to. It could be done verbally or through non-verbal communication such as a smile. This helps in building rapport with the community members. Enquiring about general well-being and initiating discussion with the mother/caregiver of a child to understand the situation or a problem.

b) A (ASK) –

When you are talking to mothers/family members, if you use following skills in your communications it will be more effective.

Skills of asking open ended questions.

SITUATION 1: CLOSE ENDED QUESTIONS

HW: Good morning (name). I am (name),

Health Worker of your village. Is your child well?

Mother: Yes.

HW: Is he eating his food properly?

Mother: Yes.

HW: Is he having any difficulties?

Mother: No.

HW: Do you have food items at home?

Mother: Yes.

SITUATION 2: OPEN ENDED QUESTIONS

HW: Good morning (name). I am (name), Health Worker of your village. How is your child feeling today?

Mother: He is well but he has very poor appetite.

HW: Tell me, what have you been giving him/her to eat?

Mother: I gave him/her some mashed dal and rice in the morning. I'm not sure what I will give him/her later on.

HW: What sort of food do you have at home?

Mother: I have rice, pulses, potatoes and some green leafy vegetables at home.

In the first situation, most of the questions that the HW asked were answered in "Yes" or "No" by the mother. In the second situation, the mother has answered it with some additional information. When you ask questions in which mother gives information rather than reply in Yes or No is known as asking open ended questions. Asking open ended questions let the beneficiaries express their viewpoints and emotions freely. That is why workers should ask open ended questions to the beneficiaries so that they have full idea about the present situation.

Show that you are listening

- Use body language to show that you are listening.
- Avoid words that sound judgmental.

- Use body language to show that you are listening

You can show that you are listening even without saying anything by: Sitting opposite to the person you are listening to at same head level and appropriate distance; demonstrate interest in what s/he is saying; maintaining appropriate eye contact; looking relaxed and open. Show that you are not rushing or acting as if you are in a hurry and using gestures like nodding, smiling or saying hmm and touching inappropriately.

- Do not use judgmental words

Most of the questions asked by people have judgmental words. Words that can be perceived as judgmental include: Right, wrong, good, bad, well, badly, enough, properly

For example: Avoid questions such as "Does your baby eat well?" Instead, you can ask: "How is the baby eating?"

- Empathize

Show that you understand what the person feels by putting yourself in his/her place and thinking of how he/she is feeling in that situation and support him/her. Empathy builds trust. Mother and family members come out with the queries when the counselor uses empathy.

c. T (Tell) –

Provide information as per the requirement of the beneficiary. Based on the information emerging from the discussion, the worker should analyse the situation and conclude in her mind the factors responsible for the situation. The factors identified could be lack of information to mothers, incorrect feeding, poor support from elders or lack of time. Based on the analysis of the situation, counselling should be conducted and give appropriate guidance given.

Give relevant information

Example: For mother who has 2 months old baby information about exclusive breastfeeding is relevant. Information regarding complementary feeding is not relevant for that mother.

GIVE SUGGESTIONS INSTEAD OF COMMANDS IN SHORT SENTENCES USING SIMPLE LANGUAGE. Do not use technical words, if not commonly used. Use local words and language.

d. H (Help)

Give possible options to the caregiver and help in decision making. Counsellor should be aware of the rationale supporting each message that is being imparted. The information delivered should be simple and supported with the rationale to convince the caregivers to follow the practice.

Praise the mother and family members whenever they are doing something well or have understood instructions correctly. This will build their confidence. However, be sure that praise is genuine. You can always find something to praise. Praise can be given throughout the counselling process when appropriate.

e. E (Explain)

Provide complete information related to the decision made and addresses queries. The caregivers might have certain questions/doubts/ misconceptions, may be facing some barriers like being forced by the mother-in law, poor support from elders or lack of time. So take time, negotiate with family members and try to solve problems by suggesting practical solutions.

Check understanding

Ask the mother/caregiver to repeat what needs to be done in her own words. This will give you feedback - what she has understood and what she remembers. This is very important to ensure that she has understood what needs to be done.

If possible, repeat your message in a different way.

Example: "How many times and what do you will feed your child?" What is most important factor for milk production?

f. R (Return)

Many a time behavioral changes take follow-up visits. Follow-up is required to check whether the person is able to practice desired behavior or not? Ask questions to assess whether your message has been correctly understood, whether the caregiver is convinced and is following the advice given. Repeat key messages and action points. Ensure assistance in case any difficulty arises.

The Importance of negotiation

'Families/communities' views on child feeding/maternal nutrition/adolescent nutrition are often influenced by local beliefs and experiences. They are also affected by local situations/availability of food items/social customs/myths. Families often lack basic information on preventive care for pregnant women, lactating mothers and newborns. This can explain why beliefs and practices differ from or even contradict the behaviors that health workers want to promote.

When talking with mothers and their families, it is better to move away from simply telling them to do something but rather to go through a process of negotiation and get them to agree to try the desired behavior/activity.

Negotiation is a process, based on dialogue, reflection, problem solving, mutual respect, and support to engage people through a joint search for solutions. Negotiation has been shown to be an effective way to encourage people to try new behaviors. The process represents an important shift from external imposition or a prescriptive approach to mutual understanding for the attainment of common goals (i.e. healthy mothers and babies). Case studies/Stories of people's experiences can help to motivate families, such as those who practice optimal practices are protected from diseases. Early referral has better outcome while delay in seeking proper treatment increased complications and even resulted in the death.

For example,

- What was the behavior you were told to do?
- Who told you to try the new behavior?
- What was the reason they gave you for trying this behavior?
- How did you feel about the behavior and the person telling you to do it?
- Did the person telling you to do it provide you with support?
- What were the main reasons you agreed to try the recommended behavior?

Providing people with correct information is necessary, but this alone is not usually enough to change behavior. As a HW, they can communicate best with people by listening, understanding and negotiating so that the women/families will try the new behavior and then adopt it.

Some of the healthy practices being promoted may be uncommon in their communities. There may be many reasons why people do not want to practice what the volunteer/ CHW is suggesting. In fact, CHWs should anticipate barriers to practicing healthy behaviors and help women to identify ways to overcome these barriers. Explain that as a CHW they will need to talk with a woman about her individual situation and make her feel that she is respected. It is important to share information with mothers/ their families, encourage them to talk about why they are or are not able or willing to try a practice. It is extremely important to listen patiently to families and their challenges/problems and work together to find solutions.

Explain that healthy behaviors will often need to be negotiated.

Key points to remember when negotiating with family:

Involve key decision-makers in the family in the negotiation process, such as the husband/partner, mothers-in-law, and other elder women.

- Share information about any support services available in their community that could help the family in complying. The latter can be improved further by community mobilization and convincing of key leaders.
- Come up with options that both sides can benefit from and negotiate the desired behavior. To do so, remember to respect culture, and harmless traditional practices.

6.2 TAKE HOME MESSAGES

- Inter-personal communication is a two-way communication process that enhances people-provider interactions
- Effective listening skills, observation skills, questioning skills, relation building skills are important IPC skills
- The six important steps of GATHER enhance effective counselling

SESSION 7

Roles and responsibilities of workers in SSFP programme

S. No	Details	Methodology
7.1	Roles and responsibilities of ANM in SSFP programme	Game, discussion and brainstorming
7.2	Roles and responsibilities of AWT in SSFP programme	Game, discussion and brainstorming
7.3	Roles and responsibilities of ASHA in SSFP programme	Game, discussion and brainstorming
7.4	Roles and responsibilities of lady supervisor	Game, discussion and brainstorming

LEARNING OBJECTIVES

By the end of the session, participants will be able to:

- Enumerate their roles and responsibilities in community based management of children with SAM and MAM.

7.1. Roles and responsibilities of ANM in SSFP programme

A. Conduct SSFP clinic at Anganwadi Centre (AWC) on VHND every month.

B. During SSFP clinic, assess and confirm nutrition status of children identified by AWT or ASHA during screening in the last one month or self referral.

C. Measuring weight, height, WHZ and check for bilateral pitting edema and identify children with SAM and MAM

D. Assess for medical complications by taking medical history, identification of danger signs and by performing physical examination.

E. Decide whether the child has to be enrolled in the SSFP programme or referred to NRC.

F. Start medical treatment for all children enrolled in the SSFP programme.

G. Complete the admission details of the patient in the SSFP card and SSFP register.

L. Enroll and start treatment of all children with SAM and MAM who are diagnosed in between VHNDs and brought to SSFP clinic by AWTs.
M. Sensitize community about SSFP programme. Counsel mothers regarding IYCF practices, immunization and basic hygiene and safe drinking water etc.

7.2.Roles and responsibilities of AWT in SSFP programme

At SSFP programme level

A. Responsible for overall management of children with SAM and MAM.
B. Measure, weight and height/length at AWC and support ANM in taking, weight and height of children on VHND for screening of children with SAM and MAM.
- Organise monthly VHND sessions at AWC and ensure the following:
- Weigh, measure height/length of every child who has come for follow-up.
- Examine SAM children for danger signs, fill the enrolment form and refer to NRC if any complication is present.
- Record medical history.
- Perform appetite test.
- Calculate balamrutham+ & validate Lady supervisor.
- Distribute balamrutham+ and replenish the stock.
- Maintain the SSFP card and SSFP register.
- Enrol children transferred from the NRC.
- Administer Amoxicillin to the newly admitted children with SAM after consulting with the ANM.
- Organise health and nutrition individual/group counselling sessions of caregivers at the SSFP session.
- Refer children according to the situation which also includes filling of referral slip.
- Maintain records/registers and support ANM in preparing the monthly reports.

At village level

A. Conduct home visits for children who are defaulters (do not attend the SSFP clinics after enrolment), are not gaining weight or have any medical condition that requires follow-up.
B. Organize activities (group meetings, mother's meeting etc.) for community mobilization regarding identification of children with SAM.
C. Provide health and nutrition education to mothers of MAM and SAM children and demonstrate feeding with the support ASHA.

7.3.Roles and responsibilities of ASHA in SSFP programme

A. Support AWT in active screening of children and in enlisting these children
B. Mobilize community, caregivers and children with WHZ <-3SD to visit SSFP clinic for initial assessment and enrolment by ANM/AWT in the SSFP programme.
C. Mobilize and accompany caregivers for their first visit to the SSFP sessions.
D. Assist AWT in organizing the SSFP session/clinic
at AWC.
E. Support AWT in conducting home visits for children whenever required.
F. Support ANM/AWT in conducting follow-up visits for all children that exit the community based programme.

7.4.Responsibilities of lady supervisors

To ensure quality in service delivery and smooth functioning of the programme, Lady Supervisors will visit the various community based therapeutic care sites (SSFP sessions). They will provide oversight and onsite support to the service providers (ANM, AWT) for proper management of cases at the community level.

Lady supervisors will observe the following:

A. Review the case load

B. Review whether the staff has been trained on the standard operating procedures

C. Availability of supplies of therapeutic food

D. Review the outcomes (especially defaults, deaths and non-responders)

E. Review record maintenance

F. Review transfers or up-referrals

G. Review availability of tools and equipment

H. Observe the skills of the AWT and ANM on assessment, conducting appetite test,

triaging and counseling

I. Discuss performance and management with the service provider

J. Undertake exit interviews (at 10% of cases)

What to feed a child (0-5 years)?

Age	Amount (for breastfed child)	Frequency	Texture of food	Examples
6-8 months	Start with 2-3 table spoons per feed and gradually increase to ½ cup of a 250 ml cup or bowl along with breastfeeding	2-3 meals per day plus breastfeeding	Soft mashed food items	Properly mashed fruits and vegetables; soft dalia
9-11 months	½ of 250 ml cup or bowl and gradually increase to ¾ cups or bowl along with breastfeeding	3-4 meals per day plus breastfeeding	Finger foods which child can pick herself and eat	Long cut pieces of fruits and pieces of chapatti
12-24 months	¾ th one 250 ml cup or bowl and gradually increase to 1 cup or bowl along with breastfeeding	3-4 meals plus breastfeeding and depending upon child's appetite 1-2 snacks to be offered	Finger foods which child can pick herself and eat	Long cut pieces of fruits and pieces of chapatti
2-5 years	Family meals	3 with 1-2 snacks depending on appetite	Child can enjoy all different textures of food	Rice/chapatti, pulses, vegetables, seasonal fruits, milk & milk products and animal foods (egg, fish, and meat).

Balamrutham + Recipe

1. Wash your hands before preparing balamrutham +. Make sure bowl and cups used in preparation are thoroughly cleansed
2. Store balamrutham+ in a clean air tight container.
3. Take clean drinking water for mixing
4. Add recommended quantity of balamrutham + in a bowl and mix it while adding equal quantity of water.
5. Stir until the smooth paste is prepared and feed immediately using a clean spoon.
6. It is recommended that a fresh feed is prepared for child at every meal time.

Remember- Mother should always wash her own and child's hand before feeding.

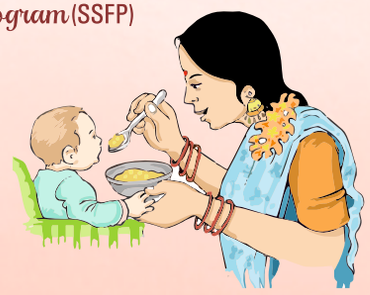
Cleanliness should be endured in and around child and while preparing and storing food.

How to enhance nutritive value of meal for children?

- Young children have small stomach size. They can eat limited quantity at a time. It is important to make it energy dense.
- Cook cereals in milk for eg porridge in milk
- Add butter/ghee/oil or jaggery from top to increase energy and enhance the taste
- Add peanut powder to meals
- Try to include variety of seasonal vegetable and fruits in your child's diet
- Include fermented food items in the meal eg- idli, dosa
- Grains can be sprouted, roasted and then dried. A powder can be made out of these dried grains which can be added into food items.

Follow up after discharge

Follow up Schedule	One month	Second month	Third month	Fourth month	Fifth month	Sixth month
Anthropometry and clinical sign						
Edema (y/n)						
Weight (kg)						
Height (cm)						
WHZ						
MUAC (cm)						
History and Examination						
Any complaint (Loose motion/vomiting/ cough/ anyother)						
Remarks (absence due to migration, referred to NRC)						
Referral required either to NRC or SSFP (Yes/NO)						



Supervised Supplementary Feeding Program (SSFP)

SAM Card

Basic Information

Name of Child _____ Mother's Name _____

Name of the AWC/Code _____ Mother's Adhaar No. _____

District _____ DOB _____ Sex ☐ Male/Female ☐

Date of admission in SSFP _____ Age (months) at time of admission _____

Anganwadi Teacher Name _____ ANM Name _____

Anganwadi Teacher Contact No. _____ ANM contact No. _____

SSFP visits schedule (to be filled by AWT)

	1st month				2nd month		3rd month		4th month	
	Registration visits (W1)	W2 weekly	W3 weekly	W4 weekly	W6 fortnightly	W8 fortnightly	W10 fortnightly	W12 fortnightly	W14 fortnightly	W16 fortnightly
Date										
Anthropometric Assessment										
Weight (kg)										
Height (cm)										
WHZ (put a tick mark in appropriate color box)										
MUAC (cm)										
Any Complications										
Edema (Y/N)										
Loose motion (Y/N)										
Vomiting (Y/N)										
Cough (Y/N)										
Fever (Y/N)										
Any other (please specify)										
Appetite observation at AWC on follow up visits										
Appetite present (Y/N)										
Micronutrient Supplementation & Deworming										
Bi- weekly IFA supplementation (put tick mark for dose received)										
Vitamin A supplementation given(Y/N)										
Deworming done (Y/N)										
Antibiotic given (Y/N)										
Remarks (absence due to migration, referred to NRC)										
Date of discharge from program										

SSFP feed schedule for SAM child

(Please indicate no. of scoops child had in a day)

Month	Week	Child Weight (Kg)	Packets given	Scoops recommended per feed	*Feeds given per day (Recommended feed four times in a day) Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
1st month	Week 1										
	Week 2										
	Week 3										
	Week 4										
2nd month	Week 5										
	Week 6										
	Week 7										
	Week 8										
3rd month	Week 9										
	Week 10										
	Week 11										
	Week 12										
4th month	Week 13										
	Week 14										
	Week 15										
	Week 16										

* To be filled by care giver everyday

Note: week in which mother is required to visit AWC for follow up visit are highlighted in blue

Things to ponder

What can be done to prevent malnutrition to set in child?

- Good nutrition during pregnancy and lactation will be help mother to nurture the baby better
- Good hygiene and sanitation protects from infection
- Practice exclusive breastfeeding for first 6 months as it provides optimal nutrition and protects from infection
- Age appropriate immunization protects children from common illness
- After 6 months, age appropriate complementary feeds along with continued breastfeeding, two years or beyond.
- Ensure regular growth monitoring at AWC for child
- Prompt treatment and continued feeding during illness helps baby to recover sooner.

How can family support in management of malnourished child?

- Family members can support mother during exclusive breastfeeding and child care by sharing in household responsibilities with mothers
- Can support mothers in ensuring provisions of healthy diet and timely visits to health facility, as required
- Care and support provided by husband and mother in law gives emotional support and confidence in child bearing

How to feed a child?

- Young baby should be fed directly and older children should be assisted while eating. Both boy and girl can equal quantity of food.
- Feed slowly and patiently and encourage the child to eat, but do not force feed them
- While feeding, talk and engage with child by telling them stories. Maintain an eye contact with them. Make feeding time for them something which they look forward too.

What things should be kept in mind for management of malnourished child?

- Should take the child to AWC for regular follow up visits.
- Ensure that child is weighed regularly at AWC. Weight gain is the most important sign indicating child is growing well.
- Child should have normal appetite.
- Feed the balamrutham+ regularly to child as suggested by AWT. It should not be shared with others in home.
- Try to feed the child more frequently and more nutrient-dense meal
- Ensure all timely vaccination and supplementation (vitamin A and Iron) is provided for them
- In case of any severe health problems or lack of appetite, take the child immediately to AWT/ANM
- Hygeine is maintained in child's surrounding
- Clean drinking water is available

What to feed a child (0-5 years)?

Age	Amount (for breastfed child)	Frequency	Texture of food	Examples
6-8 months	Start with 2-3 table spoons per feed and gradually increase to ½ cup of a 250 ml cup or bowl along with breastfeeding	2-3 meals per day plus breastfeeding	Soft mashed food items	Properly mashed fruits and vegetables; soft dalia
9-11 months	½ of 250 ml cup or bowl and gradually increase to ¾ cups or bowl along with breastfeeding	3-4 meals per day plus breastfeeding	Finger foods which child can pick herself and eat	Long cut pieces of fruits and pieces of chapatti
12-24 months	¾ th one 250 ml cup or bowl and gradually increase to 1 cup or bowl along with breastfeeding	3-4 meals plus breastfeeding and depending upon child's appetite 1-2 snacks to be offered	Finger foods which child can pick herself and eat	Long cut pieces of fruits and pieces of chapatti
2-5 years	Family meals	3 with 1-2 snacks depending on appetite	Child can enjoy all different textures of food	Rice/chapatti, pulses, vegetables, seasonal fruits, milk & milk products and animal foods (egg, fish, and meat).

Balamrutham + Recipe

1. Wash your hands before preparing balamrutham +. Make sure bowl and cups used in preparation are thoroughly cleansed
2. Store balamrutham+ in a clean air tight container.
3. Take clean drinking water for mixing
4. Add recommended quantity of balamrutham + in a bowl and mix it while adding equal quantity of water.
5. Stir until the smooth paste is prepared and feed immediately using a clean spoon.
6. It is recommended that a fresh feed is prepared for child at every meal time.

Remember- Mother should always wash her own and child's hand before feeding.

Cleanliness should be endured in and around child and while preparing and storing food.

How to enhance nutritive value of meal for children?

- Young children have small stomach size. They can eat limited quantity at a time. It is important to make it energy dense.
- Cook cereals in milk for eg porridge in milk
- Add butter/ghee/oil or jaggery from top to increase energy and enhance the taste
- Add peanut powder to meals
- Try to include variety of seasonal vegetable and fruits in your child's diet
- Include fermented food items in the meal eg- idli, dosa
- Grains can be sprouted, roasted and then dried. A powder can be made out of these dried grains which can be added into food items.

Follow up after discharge

Follow up Schedule	One month	Second month	Third month	Fourth month	Fifth month	Sixth month
Anthropometry and clinical sign						
Edema (y/n)						
Weight (kg)						
Height (cm)						
WHZ						
MUAC (cm)						
History and Examination						
Any complaint (Loose motion/vomiting/ cough/ anyother)						
Remarks (absence due to migration, referred to NRC)						
Referral required either to NRC or SSFP (Yes/NO)						

Supervised Supplementary Feeding Program (SSFP)

MAM Card

Basic Information

Name of Child _____ Mother's Name _____

Name of the AWC/Code _____ Mother's Adhaar No. _____

District _____ DOB _____ Sex ☐Male/Female ☐

Date of admission in SSFP _____ Age (months) at time of admission _____

Anganwadi Teacher Name _____ ANM Name _____

Anganwadi Teacher Contact No. _____ ANM contact No. _____

SSFP visit schedule for MAM child (To be filled by AWT):

	1st Month		2nd Month	
	1st week (Registration visit)	3rd week (Fortnightly visit)	5th week (Fortnightly visit)	7th week (Fortnightly visit)
Date				
Anthropometric Assessment				
Weight (kg)				
Height (cm)				
WHZ (put a tick mark in appropriate color box)				
MUAC (cm)				
Complications				
Edema (Y/N)				
Loose motion (Y/N)				
Vomiting (Y/N)				
Cough (Y/N)				
Fever (Y/N)				
Any other (please specify)				
Micronutrient Supplementation & Deworming				
Bi- weekly IFA supplementation (put tick mark for dose received)				
Vitamin A supplementation given(Y/N)				
Deworming done (Y/N)				
Remarks (absence due to migration, referred to NRC)				
Date of discharge from program				

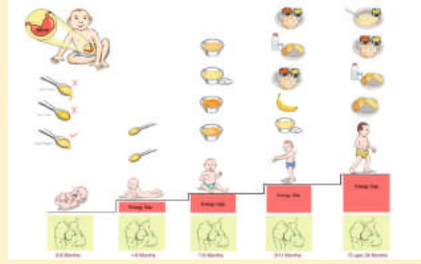
SSFP Feed schedule for MAM child:

(Please indicate no. of scoops child had in a day)

Month	Week	Child Weight (Kg)	Packets given	Scoops recommended per feed	*Feeds given per day (Recommended feed two times in a day)						
					Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
1st month	Week 1										
	Week 2										
	Week 3										
	Week 4										
2nd month	Week 5										
	Week 6										
	Week 7										
	Week 8										

* To be filled by care giver everyday

Note: week in which mother is required to visit AWC for follow up visit are highlighted in blue



Feeding child less than two years

Things to ponder

What can be done to prevent malnutrition to set in child?

- Good nutrition during pregnancy and lactation will be help mother to nurture the baby better
- Good hygiene and sanitation protects from infection
- Practice exclusive breastfeeding for first 6 months as it provides optimal nutrition and protects from infection
- Age appropriate immunization protects children from common illness
- After 6 months, age appropriate complementary feeds along with continued breastfeeding, two years or beyond.
- Ensure regular growth monitoring at AWC for child
- Prompt treatment and continued feeding during illness helps baby to recover sooner.

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How to feed a child?

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- While feeding, talk and engage with child by telling them stories. Maintain an eye contact with them. Make feeding time for them something which they look forward too.

What things should be kept in mind for management of malnourished child?

- Should take the child to AWC for regular follow up visits.
- Ensure that child is weighed regularly at AWC. Weight gain is the most important sign indicating child is growing well.
- Child should have normal appetite.
- Feed the balamrutham+ regularly to child as suggested by AWT. It should not be shared with others in home.
- Try to feed the child more frequently and more nutrient-dense meal
- Ensure all timely vaccination and supplementation (vitamin A and Iron) is provided for them
- In case of any severe health problems or lack of appetite, take the child immediately to AWT/ANM
- Hygeine is maintained in child's surrounding
- Clean drinking water is available

ANNEXURE 3: REFERRAL SLIP

Referral Slip

Name: ..... Age (in months): ..... Sex: Male ☐ / Female ☐

Mother's Name: ..... Village: .....

Mother's Adhar No. ..... Block: ..... District: .....

Date of admission to SSFP
(for already enrolled patients):

Anthropometry at Admission: .....

Edema : Yes ☐ / No ☐

Weight (kg) : .....

Height (cm) : .....

SD Score : .....

MUAC (mm) : .....

Date of referral: ☐☐ ☐☐ ☐☐☐☐

Anthropometry at the time of Referral: .....

Edema : Yes ☐ / No ☐

Weight (kg) : .....

Height (cm) : .....

SD Score : .....

MUAC (mm): .....

Transfer from: ..... (Name of AWT)

Transfer to : ..... (Name of NRC)

Reason for referral (mark the box):

Medical Complications _____ ☐

Poor appetite _____ ☐

Edema _____ ☐

No weight gain for 3 consecutive visits _____ ☐

Weight loss for 2 consecutive visits _____ ☐

Others _____ ☐

Treatment given: .....

Transferred by:

ANM's Name: ..... AWT's Name: .....

Contact No.: ☐☐☐☐☐☐☐☐☐☐ Contact No.: ☐☐☐☐☐☐☐☐☐☐

Signature: ..... Signature: .....

ANNEXURE 4: TRANSFER SLIP

TRANSFER SLIP NRC TO SSFP PROGRAM AT AWC

NRC No: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name: ..... Age (in months): ..... Sex: Male ☐ / Female ☐

Mother's Name: ..... Village: .....

Mother's Adhar No. ..... Block: ..... District: .....

Date of admission in NRC: ☐☐☐☐☐☐☐☐	Date of transfer to AWC: ☐☐☐☐☐☐☐☐
At admission:	At transfer : .....
Weight (kg) :	Weight (kg) : .....
Height (cm) :	Height (cm) : .....
SD Score :	SD Score : .....
MUAC (mm) :	MUAC (mm): .....
Edema : Yes ☐ / No ☐	Edema : Yes ☐ / No ☐

Transfer from: ..... (Name of NRC)

Transfer to : ..... (Name of AWC)

Complication Resolved : Yes ☐ / No ☐

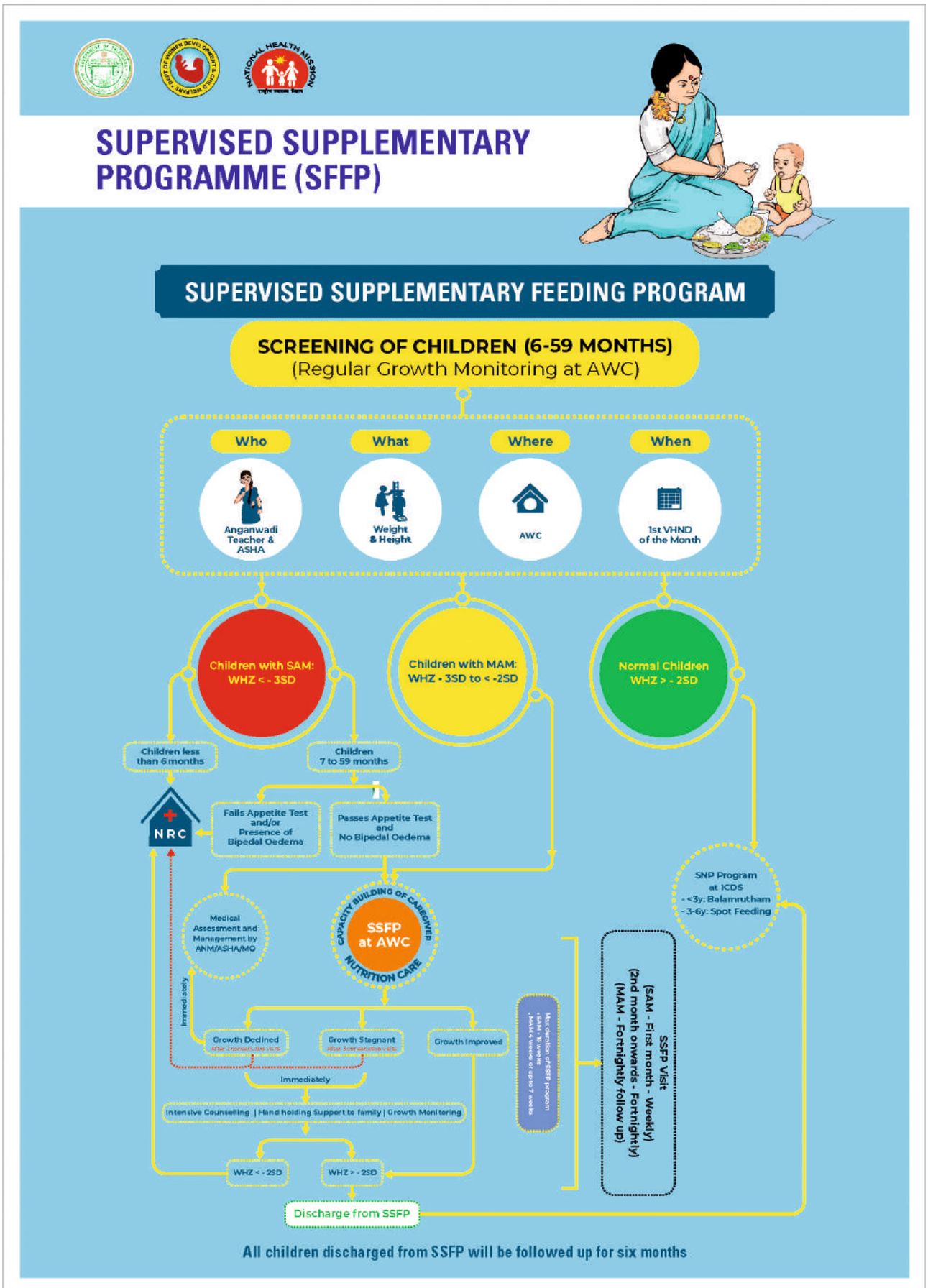
If no why, specify reason : .....

Any other Remark (for ANM/AWT) : .....

.....

Doctor's Name:	Nurse's Name: .....
Contact No.: ☐☐☐☐☐☐☐☐☐☐	Contact No.: ☐☐☐☐☐☐☐☐☐☐
Signature:	Signature: .....

ANNEXURE 5: SSFP PROTOCOL



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