

# Development of a Minimum Reporting Package for Emergency Supplementary Feeding Programmes

Project report, Sept 2011



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The Minimum Reporting Package project was implemented by the Emergency Nutrition Network (ENN) in collaboration with Save the Children UK (SC UK) under an OFDA funded grant to the ENN.

The principal researcher was Carlos Navarro Colorado, initially as an ENN consultant and from 2010, as CDC Atlanta. The IT specialist was Mark Yarmoshuk. The ENN lead was Jeremy Shoham, and Victoria Sibson was the SC UK lead. Training in Zimbabwe and Thailand was implemented respectively by Nicky Dent, ENN Consultant and Katherine Jobber, ENN Consultant.

The ENN gratefully acknowledge the work of World Vision Kenya and CARE Ethiopia who piloted the package, individuals that gave technical feedback (Yvonne Grellety), as well as the inputs of the agencies that comprised the steering committee (World Vision, SC UK, Nutrition Information in Crisis Situations (NICS), FANTA2, International Rescue Committee (IRC), World Food Programme (WFP), Nutrition Cluster, UNHCR, Concern Worldwide and Valid International) to this effort.

Produced by the ENN, September, 2011



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## 1

Introduction  
and rationale

# Introduction and rationale

In 2005-6, the Emergency Nutrition Network (ENN) and Save the Children UK (SC UK) undertook a study aimed at determining the efficacy and effectiveness of emergency supplementary feeding programmes (SFPs). The study was a retrospective analysis of emergency SFPs involving an analysis of 82 programme data sets from 22 countries undertaken by 16 international humanitarian agencies between 2002 and 2005<sup>1</sup>. A key finding of the study was that inadequate reporting standards were being followed, making it difficult to assess the efficacy of programmes without considerable re-analysis of data. Furthermore, various aspects of reporting guidelines needed modification in order to improve understanding of programme performance.

An unexpected number of information gaps, inaccuracies, statistical errors and other inappropriate uses of information and data were found in scrutinising reports to extract data and build the dataset for the study. This raised concerns over the quality of the interventions themselves, the accountability of agencies and the capacity of agencies to learn from experience. It was exceptional to find a programme document which provided comprehensive information on all the programme inputs, context, design and outputs. Furthermore, contradictions about programme activities were common and it was often difficult to follow the logical linkages between the assessments, the interventions and the results obtained. There was frequently insufficient information on programme context, design or presented data. Programme objectives were often poorly articulated and it was unclear if the SFP was supplementing a basic or general ration or not. Programme protocols were also poorly described. Data presentation also suffered from numerous weaknesses.

Given these worrying findings a key recommendation from the study was to clarify, define and implement minimum reporting standards for emergency supplementary feeding programmes.

A workshop was held at SC UK in May 2008 (hosted by ENN and SC UK) with the principal aim to advance the research agenda around treatment of moderate malnutrition in emergencies and strengthen emergency SFP reporting. Prior to the workshop, a number of research protocols were developed by ENN/SC UK (with input from various technical experts), as well as a project proposal to produce minimum reporting standards for SFPs and standardise reporting. The proposals were presented at the SC UK inter-agency meeting and further elaborated in working groups. A number of agencies present at the meeting then pledged commitment to participate in the research and in a project to develop a standard minimum reporting.

<sup>1</sup> Humanitarian Practice Network Paper: Navarro-Colorado. C, Mason. F and Shoham. J (2008): Measuring the Effectiveness of Supplementary Feeding Programmes in Emergencies. HPN Network Paper, No 63, September 2008. Available at: <http://www.ennonline.net/research/supplementary>

# 1

## Introduction and rationale

The proposed minimum reporting project involved developing and piloting guidelines and software for minimum reporting on emergency SFPs. It was hoped that agencies would adopt this standardised reporting approach. A number of agencies at the meeting committed to participating in this work and to contributing data based on the minimum reporting (World Vision, SC UK, Nutrition Information in Crisis Situations (NICS), FANTA2, International Rescue Committee (IRC), World food Programme (WFP), Nutrition Cluster, UNHCR, Concern Worldwide and Valid International).

It was expected that the development and implementation of a standardised Minimum Reporting Package (MRP) on SFPs would yield benefits at several levels:

- For the implementing agencies, it would provide a reliable way of monitoring and evaluating the performance of SFPs using approved and standard definitions. Field staff would not need to expend time in deciding which indicators to report and how to report them. The number of errors and inconsistencies would be reduced, and where these occurred they could be easily identified and corrected.
- With the information generated by the reporting package, agencies would be in a better position to identify problems and where programmes need to be adapted.
- The use of a common reporting tool for different programmes and agencies would facilitate supervision of programmes for managers, officials at agency and country level and donors. It would provide a reliable tool for direct comparison of programmes between different agencies at country level that would, in turn, facilitate decision making on where more resources or support may be needed. Communication of programme results between field staff, headquarters and donors, as well as with other agencies or local authorities, would be improved by the use of common reporting standards.
- Finally, the implementation of a common set of accepted reporting standards would be key to enhancing accountability of programming to both donors and beneficiary populations.

Following the meeting, a proposal was formulated by ENN and submitted to the US Office for Disaster Assistance (OFDA). Approval was granted for a project to begin in September 2008 and was completed in 2011.

This report describes the outputs of the project and the process of the MRP development in sequence of development, challenges and events.

## 2

Method and  
project design

# Method and project design

The project outputs were identified as three main tools:

- i)** A set of guidelines and data collection templates
- ii)** Supporting manuals and training materials
- iii)** A database application for data entry, analysis and reporting based on the guidelines, and employing user friendly software developed for this purpose.

Draft minimum reporting guidelines had already been prepared and presented at the ENN/SC UK workshop in May 2008. A small number of modifications were made based on comments received at the workshop. Furthermore, a critical mass of organisations endorsed the MRP and was willing to implement it in the field. Subsequent stages agreed under the OFDA agreement were as follows:

### *Development of final guidelines and report templates among agencies endorsing the MRP*

Agencies interested in endorsing the MRP Guidelines would form a steering committee to develop a final version, agree on the final details and develop its associated tools (templates, software, training materials).

### *Translation into a software tool by I.T. experts*

The software would allow automatic compilation of data from several centres to build programme reports, data comparison across centres, programmes or countries and extraction of data with specific criteria (queries) for comparisons of centres or periods for lessons learning.

### *Software development*

The main components of the software would be:

- Database tables of:
  - individual patients (or weeks of operation)
  - centres in a programme with their main characteristics
- Data entry forms for:
  - individual patients (or weeks of operation)
  - centres and programme characteristics
- A query tool to select patients or periods of time, so that reports for a specific period or a specific group of patients can be generated.
- A report tool, to automatically produce reports (while still allowing user interaction to decide on the period to report, the information to include, select appropriate graphs, etc.), with output in the form of a common statistical template (exportable to standard text processors).

# 2

## Method and project design

- A data extraction tool, to extract information from the data sheet to be exported to other software for specific analysis.
- A graphics tool to develop line graphs to show indicators trends over time.

A manual and training tool would be developed for the use of the MRP software.

### *Field piloting of the reporting package and guidelines*

Two agencies would commit to pilot the guidelines and associated materials in two settings. These agencies would report to the steering committee.

### *Developing final version of guidelines and software tool*

Guidelines and software would be modified on the basis of pilot study findings.

### *Training and dissemination*

Staff from steering agency headquarters and other agencies would be trained to use the package. These trained staff would then train their own agency staff and the package would then be disseminated to interested agencies. One hundred copies of the package would be produced and sent out to implementing agencies.

### *Rollout*

Other agencies would start using the tools once developed and would be in the position to submit data to a central repository held within the ENN or another agency. Once the data holding system was in place, the MRP would be extended to other locations and agencies.

## 3

Project  
implementation

# Project implementation

## Establishing management and steering groups

Once funding had been secured, the first activity was to establish the management group for the project. This comprised the ENN, SC UK and the principal consultant (Carlos Navarro-Colorado). SC UK's additional role was to coordinate the steering group of agencies. SC UK had to contact all agencies that had expressed interest in the project at the SC UK meeting in summer of 2008 and ascertain whether they wanted to be part of the steering group. A terms of reference (TOR) for steering group membership was then drawn up, which essentially stipulated that steering group members had to participate in regular meetings, comment on drafts of guidelines and consider offering SFP project sites for piloting of the package when it had been developed to a point where it was ready for piloting.

## Finalising guidelines

The next activity was to finalise the guidelines. This involved collating comments from steering group members. This process continued (as some comments came in late) up until May 2009. A range of comments were received, e.g. relating to information on food products, inclusion of data on infants and whether there was too much information to constitute a 'minimum' reporting package.

The main discussion points and changes introduced after extensive consultation with steering group members included:

- Extension of the MRP to blanket SFPs as well as targeted SFPs.
- No inclusion of reporting of community based management of acute malnutrition (CMAM) programmes, but ensuring that the format is compatible with standard CMAM reporting.
- Development of a simpler version for emergency programmes that may be unable to report on all items.
- Ensure that the package is able to follow seasonality and admission trends.
- Add a 'readmission' category on entry indicators and redefine it.
- Incorporate a means to calculate average weight gain and average duration of stay.
- Add a table to the module that allows reporting of population data emanating from surveys so that these data can be presented in parallel with performance information from centres and programmes.
- Agreement on definitions and appropriate terms for 'cured', 'transfer', 'defaulter' and 'non-cured'.
- Redefinition of a number of items included in 'Programme characteristics'.
- Need for flexibility on reporting frequency (weekly, monthly, quarterly or other).

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- Ensuring that the guidelines can be implemented in the absence of computer facilities (i.e. a paper based system).

A number of changes and additions to data collection were proposed and rejected by the majority of members in the steering group. These included the addition of indicators for presence of diarrhoea or parasites and addition of a 'relapse' category.

The debate within the steering group contributed to clarification of a number of questions, as well as improving the write up of guidelines and promoting buy-in from partners in the steering group.

A summary of the discussion is included in Annex 1.

### **Building upon UNHCR Health Information System (HIS) software**

By April 2009, ENN/SC UK had taken the decision to utilise (if permission were available) the UNHCR Health Information System (HIS) template for the software development. This would cut down the work for developing the software to accompany the guidelines and save project resources. Negotiations with UNHCR went well and permission was granted in May 2009. It was also suggested that ENN/SC UK utilise the IT specialist who had developed the UNHCR HIS to further expedite matters.

#### ***Securing IT expertise***

The principal consultant began engaging with the IT specialist (Mark Yarmoshuk) in May 2009 on software development and data base requirements.

By June 2009, ENN had received the UNHCR HIS data base reporting format to help understand how it worked and to develop a sense of how it might be adapted into a software to support the minimum reporting guidelines.

Throughout June and July 2009, there were further discussions about the software platforms. By the end of September 2009, the IT specialist had finalised the first draft of the software ahead of planned training of agencies conducting the pilots due to take place in December 2009. The principal consultant met with the IT specialist in October 2009 (in Toronto) in order to receive training and make final changes.

### **Identifying pilot countries**

The next phase of the project involved identifying pilot countries to test the minimum reporting package.

Steering group agencies were contacted and provided with a template document to help make decisions about potential pilot countries. The document explained what would be involved in piloting the package as follows:

The projects that were to pilot the MRP would have a project leader who would organise training of staff in selected locations. Ideally, more than one project site would be trained at the same time.



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During the training, the project leaders would collect existing data from the project sites (monthly reports for the previous 2 or 3 months), in order to feed the database and identify potential incompatibilities.

After the training, the pilot projects would be left to implement the MRP on their own. The pilot projects would commit to use the MRP to collect and report statistics from their SFPs for a number of months after the training (at least three or four months). Using the MRP would imply:

- Following MRP case definitions for 'success', 'defaulter', 'transfer', etc.
- Collecting the information in the format of the MRP
- Providing timely information to project leaders (both the reports and the raw database).

Each pilot project would be required to identify a suitable person in charge of the pilot, ideally the same person usually in charge of keeping statistics and reporting results, and ideally the project coordinator.

During this period, the project leaders of the MRP would need to be available through telephone and email contact, to solve potential problems. They would collect information on the experience in order to identify the points where the MRP and its software can be improved.

Using the results of the pilot projects, the MRP would be refined, and a final version proposed to the Steering Group. Once this has been agreed upon, the MRP would be progressively introduced in field operations.

All the costs related to transport and accommodation for the project leaders during training sessions and evaluation visit would be covered by the study budget. In principle, the organisations participating would cover training costs of the staff involved.

Steering group agency members were informed that the SFPs that would be considered for piloting the MRP would need to meet the following characteristics:

- Comprise a SFP (emergency or not) with more than one centre.
- Work in parallel with a CMAM programme (therapeutic care).
- Have enough staff for reporting and monitoring purposes (this could be the project coordinator or a dedicated person).
- Have at least one computer accessible at field level (or at coordination level but accessible to people in charge of reporting).
- Be able to communicate by mail or telephone with the MRP project leaders,
- Accept the need to modify their reporting system at least for the period of the pilot, and to share the performance results of the programme with people involved in the development of the MRP.

The process of selecting the study sites began in June/July 2009 and by September 2009, four sites had been selected in Ethiopia, Niger, Kenya and Somalia. Agency staff from these programmes attended the MRP training in Nairobi in December 2009 (see below).

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Project  
implementation**Training for four country programmes**

A training for the four pilot countries was held in Nairobi between 9-11th of December 2009 at the Save the Children offices. Training was conducted by the ENN. Teams from the following agencies participated Save the Children – Somalia, CARE – Niger, CARE– Ethiopia and World Vision – Kenya. The agenda for the three day training was as follows:

**Day 1:** Presentation of objectives of the pilot programmes.

- Presentation of the MRP. objectives, definitions, indicators, procedures.
- Discussion and questions.

**Day 2:** Presentation of MRP software. Computer installation of software.

- Practice using software.

**Day 3:** Practice with software.

- Development of action plans for implementation of the MRP in each country.
- Procedures of the pilot including supervision, support, reporting and evaluation.

Participants were requested to read the MRP guidelines before the start of the training and to bring to Nairobi:

- A laptop computer
- Copies of statistics of their SFP programmes
- Samples of the tools used to collect statistics in SFPs (tally sheets, etc.)
- Copies of the database or data storage currently in use in the projects (if any)
- Samples of reporting tools used in projects (tally sheets, monthly reports, etc)

**Developing software (delays)**

The first version of the software was delivered by the IT specialist in September 2009. Initial testing was done under close direction from the IT specialist and was judged satisfactory. After some minor changes, in early December 2009 it was considered fit for the first training planned for that month. However, most training participants experienced problems with the installation and basic use of the software due to configuration problems.

This occurred for the following reason. The UNHCR's HIS software was designed for field implementation only, although the tasks of installation, formatting and adaptation to a specific country are undertaken at a central level by a small number of experts (including the IT consultant himself). For the MRP, ENN had requested a tool that would not require this central support: users would need to be able to install, format and adapt the software to the needs of their programmes with no other help apart from clear guidelines. This change from the original or 'mother' HIS software involved a number of adaptations to the software that were more significant and complex than originally anticipated.

As a consequence, it was not possible to demonstrate some of the features of the software at the training. The software development work in the following months focused on installation and formatting issues, including making it adaptable to different versions of the Windows Operating System and different computer configurations. The necessary work on the development of specific features of the software and the launch of the field pilots were consequently delayed.

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implementation**Post-training software revisions and delays**

Following the training in Nairobi, comments from the trainees were compiled into a document and sent to the IT specialist in order to make revisions to the software. Most changes were completed by February 2010, when a new version of the software was delivered.

Meanwhile SC UK Somalia had to pull out of piloting the MRP at the end of January 2010 due to high levels of field insecurity and resulting pipeline problems. CARE Ethiopia had to delay piloting of the package as a result of delays in software development and subsequent staffing issues.

**Piloting the MRP through DanChurchAid partners**

At the end of 2009 and through early 2010, ENN had been holding discussions with the non-governmental organisation (NGO) DanChurchAid (DCA) regarding training of DCA partners in use of the MRP where partners were implementing SFPs. Four potential partner programmes were identified in Zimbabwe, Sudan, Thailand, and Gaza. The idea behind the trainings were threefold; i) to determine the appropriateness of the MRP tool for local NGOs, ii) to strengthen the monitoring capacity of DCA implementing partners, iii) to bring local NGO partners of DCA more into the professional mainstream of emergency nutrition.

As the DCA/Zimbabwe SFP programme was due close in April 2010, the training was brought forward as much as possible in order that the country team could practice data collection and entering for at least two months. As the ENN principal consultant for the project was not available at such short notice, he undertook training of another ENN consultant (Nicky Dent) in use of the package to undertake a training of the DCA Zimbabwe partner staff. This training took place in Bulawayo and the consultant wrote up the findings of the training (see Annex 2). A set of recommendations for software improvement were made following this training (see Annex 2a)

Although this work was not funded under the OFDA grant it was effectively the first piloting of the MRP with a local (non-international) NGO and therefore threw up interesting findings.

**Further delays in pilots (Kenya and Ethiopia)**

Following the training in Zimbabwe, it was apparent that further changes needed to be made to the software before the package was piloted in Kenya and Ethiopia. Problems noted in the Zimbabwe training needed to be addressed and the guidelines needed some revisions, especially with regard to blanket SFPs. Furthermore, important decisions still needed to be made regarding the context data to be included in the software. The pilot countries had been waiting several months for the next version of the software and there had been little contact with the agencies during this period.

In early April 2010, the principal consultant sent an email to the agencies that were scheduled to pilot the package explaining that the package was now ready for piloting and giving the reasons for the various delays. The email also explained some of the changes that had been made to the software since the initial training in December 2009

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and that there were still some changes to be made to the software but that the piloting should take place with the current 'draft' of the software and that for the time being these changes would remain 'pending'. During testing of the 'draft' software, the principal consultant would be available for direct assistance, with email support from the IT consultant. The email contained a short guideline on how to install, configure and use the software and asked for confirmation that the installation had been successful. The pilot countries were also asked to adapt the centre tally sheets to the software as appropriate and as discussed at the training in December 2009.

Shortly after this email was sent out, it became apparent that CARE Ethiopia would not be able to pilot the package in the short-term due to a number of factors. Furthermore, World Vision Kenya was having difficulties with the installation. In June 2010, a member of ENN held discussions with CARE Ethiopia in Addis Ababa and agreed to revise the timetable for the pilot to post-summer, pending funding decisions about the SFP. Furthermore, communication with WV Kenya was erratic and it was not clear whether piloting was taking place or when this might begin.

As piloting was not taking place, further progress was made on the 'pending' adaptations of the software. At the beginning of September 2010 the principal consultant agreed further changes to the software with the IT specialist. The list included the following:

- Create a configuration wizard to guide users on initial setup or an Excel template with configuration import export capability.
- Edit and present a user interface to harmonise wording with user expectations.
- Redefine and upgrade the analysis component
- Background information to be updated.
- Explore potential of having Excel sheet with a single tab (lower priority)
- Coverage and other survey data to be developed in a table and given more prominence as well as being utilisable in all reports.

### Thailand/DCA pilot

The second training under the DCA/ENN agreement took place in Bangkok, Thailand in August 2010. Due to maternity leave of the trainer for the Zimbabwe programme, a new trainer needed to be trained by the principal consultant. A report of the training is included in Annex 3. The guidelines and software were positively received by training participants and their supervisors. Main findings from the training were as follows:

- Identification of differences between the MRP and the locally used reporting systems. This mainly applied to the definition of entry and exit categories from centres and the subdivision of patients in treatment groups. Adaptation to the new MRP system involved changes at the data collection level (the centres) and re-training of centre staff.
- A significant problem with the data forms was the requirement that Thai NGOs had to report all information by gender and separate these out for refugee and resident population (this was requested by their donor agencies and UN partners). This multiplied the data entry effort by a factor of four, raising questions about the efficacy of the reporting system. According to the trainee participants, this reporting requirement negated the benefits of using an improved tool.

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- An extensive number of recommendations were made to improve user friendliness and utility of the software. The findings and recommendations from the training were compiled with those from all other pilots and trainings in order to develop a new and final version of the software.

### Kenya and Ethiopia: implementation and results of pilots

Piloting in Ethiopia and Kenya eventually began in September 2010. CARE and World Vision field staff were trained by those trained at the December 2009 event in Nairobi. First sets of data were received from World Vision in October 2010. The CARE Ethiopia report on the pilot was received by mid-December and the World Vision pilot report not until January 2011. (See Annex 4 for CARE report).

The pilot in Kenya was only able to provide feedback through telephone conversations with the principal consultant. These regular contacts extended throughout the period of the implementation of the pilot and included extensive direct guidance on installation, configuration and use of the software. After this direct guidance, World Vision nutrition managers were able to operate the software without help. The main feedback included:

- Problems with installation and formatting of software.
- A number of editing issues in the interface that could be changed to improve user-friendliness and reduce confusion.
- The problem introduced by the requirement to report all data by gender (requested by UN donors), which is not configured in the current MRP software.
- The large number of centres included in World Vision programmes and the need to be able to report groups of centres as a new category in order to allow summary of information.

The pilot implemented by CARE in Ethiopia had a more complex context given the significant differences between Ethiopia's Enhanced Outreach Strategy/Targeted Supplementary Feeding (EOS/TSF) programmes for moderate malnutrition, and the standard SFPs for which MRP was designed. Consequently, CARE engaged in extensive training of their field staff, adaptation of treatment protocols, re-definition of all data reporting tools and even community sensitisation around the changes introduced into the programme. At the same time, the programme retained the main features of Ethiopian's EOS as required by national protocols.

Overall, the feedback from CARE was positive although it was emphasised in their report that the resulting system and the number of changes introduced made it more complex than originally expected. They proposed a number of changes in the presentation and use of the software, and made specific recommendations for guidelines development and data collection tools. CARE had less problems with formatting than other agencies piloting the software since they were the last pilot to be implemented and benefited from the improvements introduced in the software after the first round of pilots. Unfortunately, the significant differences in protocol between the Ethiopian Government strategy for tackling moderate malnutrition (the TSF only provides for two rations over a six month period and children are not weighed and measured on a monthly basis) made them feel that the system could not be easily scaled up in Ethiopia, although CARE could be interested in using the MRP in other settings.

# 3

## Project implementation

Overall, most of the feedback on the guidelines and the software from the different pilots were consistent. The main problems and recommendations were reflected in feedback from a number of agencies (if not all). There were also site-specific comments that reflected the 'fit' with current reporting systems and specific adaptations that had to be made.

### Further changes to software and guidelines

Field observations and recommendations in these reports (World Vision Kenya and CARE Ethiopia) were compiled with those from the feedback obtained from Thailand and Zimbabwe (DCA) training to produce two sets of recommendations for further software adaptations:

- The first set of recommendations related to facilitating installation and formatting of the software, as well as changes to improve user friendliness, presentation of data and capacity to edit data and analysis findings. These recommendations were completed in March 2011.
- A second set of recommendations for change to the guidelines which would entail corresponding updates in the software were made much later in September 2011 (see Annexes 5a and 5b).
- Recommendations for a final set of changes related to the graphic representation of data in the reports were put on hold until all the above changes had been made.

### Roll out of MRP

In March 2011, ENN began discussions with SCUK and the European Commission Humanitarian Aid Department (ECHO) regarding roll out of the MRP with ECHO implementing partners under an ECHO grant for 2011/2012. Funding for this project was secured by SC UK in July 2011 with SCUK as the implementing partner. The ENN will contribute to as technical contributor to the project. This project started in September 2011.

# 4

## Key contacts

## Key contacts

For further information on the MRP project to Sept 2011, contact Jeremy Shoham, ENN, email: [jshoham@easynet.co.uk](mailto:jshoham@easynet.co.uk)

For further information on the MRP rollout, contact: Vicky Sibson, SC UK, email: [v.sibson@savethechildren.org.uk](mailto:v.sibson@savethechildren.org.uk)

## 5

## Annex 1

## Annexes

Annex 1: Summary of steering group discussions  
(2009)

*Italics reflect principal researcher response. Capitals reflect response of steering group individuals in the consultation.*

Where agreement was sought, options were:  
Agree? YES/NO/ Alternative: \_\_\_\_\_)

### 1. How much information to put on blanket feeding programmes (as opposed to targeted?)

*I will make it clear that MRP-guidelines are for targeted programmes. I will add a section on how to monitor blanket programmes, but this will not be part of the MRP.*

JS: YES

CP: YES

HD: YES

EH: YES

YG: YES

### 2. Terminology and categories for entry and exit

#### 2.1. Differentiate re-admission and relapse?

*The group thought it important to differentiate them, but I'm uneasy with calling it "relapse" (I'm probably wrong here), and because there is some confusion about dates to use to differentiate new and old episodes.*

**Suggestion 1:** Separate re-admission after recovery (new case) and re-admission after defaulting (old case).

JS: YES

CP: YES

HD: YES

EH: OK, although as you mention below, I expect that this could create problems of identification. Good idea to make this part of the pilot.

YG: YES. Relapse or 'rechute' en francais has no limit in time but he/she is a cured patient.



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**Suggestion 2:** Doubts remained about the ability of many programmes to correctly identify re-admissions. It proposed that this will be looked at in detail in the pilot programmes, and reconsidered for post-pilot version of MRP.

JS: YES AGREE

HD: YES

YG: Yes, but this is an important point to judge of the criteria of discharge are right – the food security situation, etc. There is a very big and important difference between a child that was malnourished [who] became fully normal and then developed a second episode of malnutrition. This has implications for follow up and general situation and that child has shown himself to be more vulnerable than a first admission child. Readmission after not being cured is a quite different thing and can be due to all the same reasons as defaulting. There is a third category here as well – readmission after being sent for SAM treatment or medical treatment. This type of readmission is also quite different and they need to be differentiated in the report.

### 2.2. Create a group 'other' for admissions and discharge?

*This is a new suggestion, as some exits do not fit in any group (e.g. 'error of admissions'). This will avoid these patients being inputted as defaulters or not accounted for.*

JS: YES

CP: YES and then allow some space for explaining what others are.

HD: YES. A typical problem for SFP, plentiful of them, errors that one finds out (or not) after admission

EH: YES

YG: YES, but there is a danger always and this has also to be carefully monitored. It has been tried – this category then got all sorts of people added to it. It must be very very clear in the instructions just what type of case can go into this category. It is not clear to those on the ground at the moment (non-cured, errors of admissions, second twin, out of age category (but appropriate for that age category), etc.

### 2.3. Which term to use: Cured/Nutritionally Recovered/Discharged Successfully

*Seems we agree in definitions, and the problem is just about words.*

*Please write here your favourite term: \_\_\_\_\_*

JS: Discharged successfully

CP: Recovered (without 'nutrition' [part of term])

HD: Cured (in line with management of SAM).

EH: Discharged successfully

YG: You have to think also in other languages and how the words will translate. In French we used 'Gueri' and in English 'cure' is also the right term so I don't know why to change to recovered but I will not use 'discharged successfully' – that just means the discharge was completed properly. A death would be 'discharged successfully'. Also, think about the form and the space that is used. You do not want a sentence at the heading of the column – cured has the advantage of being short and easy. 'Nutritionally recovered; is clumsy and inelegant and takes up a lot of space. After all, none of these words are correct in a formal sense (they would need to reach 100%

## 5

## Annex 1

for this to be justified and 'nutritionally recovered' is different from 'anthropometrically recovered', and what about anaemia, antioxidant status, etc. It is specialist jargon that is being agreed [and] has to be properly defined.

#### 2.4. Which terms to use: Loss to follow-up/Defaulter – confirmed/Unknown outcome

*We agreed that loss to follow up is no good term, but that it is a good idea to separate both outcomes.*

**Suggestion:** To call them 'Defaulter-confirmed' and 'Unknown outcome' (i.e. a defaulter that has not been confirmed as such yet)

JS: YES

CP: I would take FANTA definition: defaulter non-confirmed (unknown outcome); defaulter confirmed (known-outcome), for consistency

HD: YES - Defaulter confirmed and Unknown outcome

EH: YES - the most important part is that the package clearly describes each of the categories.

YG: YES, but why not simplify it to just 'defaulter' and 'unknown' Simple and fits easily into a reports heading.

#### 2.5. Separate transfer to medical facility and transfer to TFP?

*This was felt as needed, but risk that we end up with too many exit categories.*

**Suggestion:** To make two categories for this version (Transfer to medical facility and transfer to TFP) and evaluate its use in pilots.

JS: YES

CP: YES

EH: YES

HD: YES: Referral for medical problem - Referral for TF (SAM)

YES: YES, but actually they are quite different. Consider a child with TB, cirrhosis, cerebral palsy or even Downs Syndrome.

#### 2.6. Do entry categories work for all treatment groups (children, pregnant, TB, HIV, etc.)?

*I forgot to raise this point, sorry. I discussed this with Claudine, who raised the issue. In many programmes, TB or HIV are included in SFP regardless of their nutritional status, and therefore the entry categories do not apply. They are also discharged regardless of their evolution, so exit categories do not apply either.*

**Suggestion 1:** To add a column specific for these type of groups in admissions ('other' or 'non-nutritional admission') and discharge ('other' or 'end of nutritional support').

**Suggestion 2:** The alternative is to place these groups of patients in a different table altogether.

*Which one you prefer?*

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- JS: I prefer a separate table. The analysis of these data for these groups will have different objectives and different expected outcomes as well as difficult to predict outcomes. While these data are YES important to understand how effective the programme is for these groups, I can't see why one would have them in the same table as 'uncomplicated' moderately malnourished children
- CP: Alternative 2
- HD: Do not understand well.  
Only HIV and TB and any others are admitted to SFP because of MAM except for:
- Lactating mothers non MAM with malnourished infant below 6 months, and
  - SAM follow ups
- EH: Option 2. Since these groups do not enter or exit based on a nutritional indicator, you would not calculate a 'recovery rate' for example. Therefore, better to keep them separate.
- YG: A separate table – it would be must easier and maybe only used in those situations where they would have programmes for TB, HIV, etc. Would be confusing to be on standard report the field person may think if you put TB or HIV that they have to differentiate the MAM cases with TB or HIV from the MAM cases without. Also it should be clear that these are not MAM patients. Indeed pregnant and lactating could be put into this sheet if all are being supplemented and not just those with low MUAC (criteria not properly defined for PLW). Also the follow up of discharged SAM cases which is an important separate category admitted at >80% by definition.

### 3. Other indicators

#### 3.1. Use of 'minimum weight' and 'date of minimum weight' for calculations of weight gain.

*Some doubts on the quality of field data used to calculate weight gain, whatever the formula used. However, some considered this piece of information (weight gain) important and to be kept.*

**Suggestion:** *to continue using the standard formula (based on weight on admission, rather than minimum weight), for the moment. To evaluate the possibility of using 'minimum weight' in a small pilot, as a 'field research' idea, and reconsider (taking into account ease of collection, and potential use). This small field study could include the evaluation of fixed periods of weight gain (day 7 to day 28, for example) for all patients, rather than each patient contributing a different amount of time to the calculation. Agree?*

JS: YES

EH: YES

CP: YES, I think we also discussed that the quality of actual calculation of weight gain (with the standard formula) should be assessed.

HD: Can you include in the field test the exhaustive versus the sample? I still believe that these indicators are calculated on a sample, and not for all, e.g. in Ethiopia/Niger where you have 200+ kids to see in a day.

YG: I really think that RWG for SFP is a lot of work and often wrong. This always can be done during evaluation but we need good tools so this can be done retrospectively. But to know how many transfers to ISA is happening seems for me very important as

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## Annex 1

well as relapse or readmission after recovery. And the quality of a programme seems to be more closely related to things like defaulter rate, even if the calculations are automated it is still a lot of work to enter the data (accurately) into the computer in the field. This raises another point: who is this for? International NGOs or local NGOs and local health services? I think it would be a mistake to make the data entry and analysis so complicated that only very well resourced and focused international NGOs can possibly do it and it can never be generalised to local services because of its complexity. You found very poor reporting in your study; perhaps that was because we were asking too much before? Do not make it more complicated than it was otherwise the quality will fall. RWG can be done during audit or for a subset of subjects or during two months in the year (high and low prevalence times) for example, not month after month. Is there any evidence at all that the data that are now being collected lead to any change in practice or service delivery? I doubt it. RWG should not be in a 'minimum' package – it should be an 'optimum' [element].

### 3.2. Inclusion of other indicators.

*Several other indicators have been proposed. All of them have their own interest, but seem to take the MRP beyond the 'minimum' necessary.*

**Suggestion:** *Not to take any of them on board, but mention in an annex (together with other suggestions) for those who want to incorporate in their systems.*

*Agree?*

JS: YES – additional indicators should be added on the a basis of agency priorities/needs /objectives

CP: YES

HD: YES

EH: YES

This is the list of these indicators so far. Please write YES next to the item if you think it should be present in the MRP at this stage:

- calculation of height gain
- quality and process indicators relevant for the long term evaluation
- deworming
- health education,
- information on Essential Nutrition Actions (ENAs)
- presence of diarrhoea on admission,
- presence of micronutrients deficiency
- distance from centre
- other (feel free): \_\_\_\_\_

JS: presence of micronutrients deficiency: Possibly, but difficult due to uncertainties around case definitions and diagnostic ability.

HD: \* calculation of height gain – on sample, Yes

\* quality and process indicators relevant for the long term evaluation --no

\* deworming, – no as is routine

\* health education, – yes

\* information on ENAs – yes,

\* presence of diarrhoea on admission – no

\* presence of micronutrients deficiency– no

\* distance from centre – maybe

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YG: YES – ‘Optional extras’  
Add: Rate of weight gain (see above)

The potential list is almost endless – breastfeeding, vitamin A capsule receipt, measles vaccination, etc. We do not want a MICS survey questionnaire as a minimum report.

#### 4. MRP tools

##### 4.1. Do we need to develop specific MRP patient cards, register books, etc. or is it possible to use those existing in the field, provided they have the minimum information?

*The group agreed that most programmes (national or NGO/UN) have their own tools, and there is no need to develop new ones.*

**Suggestion:** *The guidelines will specify what are the information items necessary to fill in the statistics, so that one can assess if an existing system is compatible with the MRP. The guidelines will propose model cards and register books, for those setting a system from scratch.*

*Agree?*

JS: YES

CP: YES. However, it could be a good idea to review tools used (by asking agency HQ or by reviewing them in some emergencies at field level) to assess the potential needs for providing tools.

HD: YES – simple please and harmonized with management of SAM

EH: YES

YG: YES

##### 4.2. Does the MRP system need to recommend a specific identification system (unique identifier), or can it use the systems in place in each country?

*We didn't discuss this point.*

**Suggestion:** *The MRP does not need to impose a identification system to the users, provided there is one and that it works.*

*Agree?*

JS: YES

EH: YES

YG: YES

CP: ?

HD: YES - simple please and harmonized with management of SAM

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## Annex 2

## Annex 2: Zimbabwe MRP Training Report

### ENN Report: MRP\_SFP Training

BULAWAYO, ZIMBABWE 8/3/10 – 12/3/10

Christian Care (CC), on behalf of Dan Church Aid

Nicola Dent, Public Health Nutritionist

### 1 Country background

- Recent problems with drought, many programmes food security/drought related or HIV-related
- Existing National Guidelines (sent via UNICEF Harare office, not in CC office)
  - *Supplementary Feeding Programmes in Zimbabwe National Guidelines & Implementation Policy* Oct 2005, reprinted Jan 2008

According to UNICEF largely not used as encourages wet SFP but no other existing g'lines and SFP not covered extensively in CTC ones; previously MOH provided SFP, but stopped in 2005; currently blanket encouraged if >7% <-2 z-score (NCHS) unless aimed at HIV+ve or part of CMAM; no set reporting form in g'lines but following indicators suggested plus weight gain monitoring although most seem to be for targeted programmes:

Beneficiaries	Monitoring Indicators
Children 6 – 59 months	Attendance rate
	Defaulter rate
	Recovery rate
	Mortality rate
	Coverage of eligible population (%)
	Global Acute Malnutrition (GAM) prevalence
	Quantity of food delivered and utilized
	Quality of food delivered
	Availability of water and sanitation facilities
	Weight for age
	MUAC
	Health education sessions per month
	Pregnant and lactating women
Defaulter rate	
Low birth weight incidence	
Percentage of ante-natal coverage	
Quantity of food delivered and utilized	
Quality of food delivered	
Availability of water and sanitation facilities	
Health education sessions per month	

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- Guidelines for Management of Acute Malnutrition through Community-based Therapeutic Care (CTC) 2008  
Working draft. Largely based on the CTC Manual (Valid Int.) and Malawi g'lines. Standard OTP format. for reporting but nothing included for SFP (short chapter only). Currently around 431 sites in Zim.

## 2 Christian Care (CC) Programme background

- Lupane Under 5 Nutrition & Health Enhanced Programme (UNHEP) Lupane District, 6 out of 27 wards, funded by Dan Church Aid (DCA); World Vision is working in other wards and is planning CMAM programme in June this year

**Programme goal:** *improved health, nutrition & wellbeing of vulnerable children in Lupane Rural Districts*

**Objectives:** The food, income and nutritional requirements of under 5 year old children, pregnant women and breastfeeding mothers are met & Basic community health and knowledge on child care and rights is improved

**Egs of outputs:** 60% of pregnant women give birth to children above average weight 80% of the malnourished children have WAM > 80%

Increase in number of nutritious meals and food diversity eaten by under 5s, P&L mothers per day

- **Surveys:** CC proposal states baseline anthropometric survey but was never done. Surveys have been done by World Vision including in May 2009 but issues about release of results from MOH. One in Dec.2009 (LQAS 33x6 clusters reported wasting < -2 z-scores: 3.7% (CI 95% 0.7-6.7%); stunting: 34.4% (CI 27.4-41.4%); underweight 13.8% (CI: 8.6-18.9%). No results on numbers of severe
- **Nutrition support:** SFP was added to food security programme...
  - Initially blanket only for <5s and P&L, later tried to target more on WFP wealth ranking/food insecurity ranking, followed by WAZ or HAZ < 2 sd. Pregnant & lactating mothers from vulnerable families, no nutritional or trimester criteria; no discharge criteria just 6 months of feeding (some graduation of kids > 59 months or mums with infants > 6m but not captured) ie not Targeted SFP and more than blanket so for MRP categorising under "Individual Support" as involves nutritional entry criteria but no specific exit criteria – discharge is after completion of 3 cycles of ration distribution. Target 4500 6-59 months and 1500 P&L women
  - Distributions take place during the hunger gap for 5-6 months (November-March/April) - a dry ration of 10kg CSB every 2 months (not monthly apparently as MOH against splitting CSB sacks!)
  - Nutritional data only taken at baseline (benef.selection) and at 6 months (impact assessment), occ.growth monitoring by MOH inbetween but CC do not collect the data
  - Previously CC gave general ration but stopped due to food shortage from WFP; WV still give in neighbouring wards
  - Last programme 2008/2009 reported only 10-15% weight gain during 6 month distribution (?only 10% of cards sampled not entire beneficiary list.
  - Tools: simple register, date, names, ID, signature...no indication of attendance  
No cards

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- **Health:** only health services are one hospital St Lukes and one clinic Lupane...no health posts
  - Not necessary to bring child to SFP although CC facilitates MOH to do monthly EPI outreach and growth monitoring
  - Further weight monitoring at village level by Village Health Workers but no monitoring of these results. No access to MOH growth monitoring cards
  - No medical protocols (MOH take Vit.A, paracetamol and occ.skin ointment), not antimalarials, ORS, antibiotics or deworming
  - This week MOH reported malaria and measles outbreak in the area.

### 3 Trainees & Programme (see annex 1 for details of participants & agenda)

**Day 1:** programme discussion; review of existing data collection forms, training needs

**Day 2:** General overview of types of nutrition programmes, Minimum Reporting Package (MRP), CMAM/CTC

**Day 3-5:** Training on database, data collection forms; preliminary analysis of field data

- Day 2: trained 7 individuals including local agency working on HIV individual support and UNHCR representative
- Days 2-4: 3-4 people, all development studies background, no health or nutrition
- General training - all had huge nutritional gaps on basic definitions and terms and concepts eg GAM, SAM, kwashiorkor, measurement of oedema, z-scores, general ration, what basic illnesses cause malnutrition, why give Vit A etc....
- Aware of training content but had left raw data in the field!!!Good computer skills and all but one had no problem with database; all had some issues with accuracy of data entry
- Recent SPHERE and HAP trainings but unaware of SPHERE indicators for selective feeding
- Training agenda broadened to include overview of types of SFP, overview of MRP and brief explanation of CMAM/CTC (at request)

#### Constraints:

In summary participants had grasp of the way the database worked but main limitations were:

- **Nutritional knowledge gaps** Inaccuracies in proposal about description of malnutrition (eg Mentions 25% kwashiorkor in proposal but programme is not monitoring bilateral oedema even though it appears on initial screening form – left blank and not measured in field..... variable understanding during training of what it is, how caused and how to measure...)
- **Lack of raw data collected** (quantity and quality). Only some data from initial Nov.distribution; limited available for second distribution (Jan.) as in the field. One final distribution due ie 3 rounds of data only for 8 outreach + 2 MOH sites for whole programme). No data currently from MOH.
- Discrepancy between naming of programme (targeted) and reality – a mixture between individual support and blanket



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- Limitations between **programme objectives/outputs and programme data collection** mechanisms. No close monitoring of attendance ie absences, defaulters.....No close monitoring of deterioration of beneficiaries and use of transfer to hospital for severe malnutrition. Little flexibility to include new benefs.
- Numbers in programme much lower than target...?issues with new admissions & coverage

## 4 FEEDBACK

### 4.1 FEEDBACK FROM TEAM

Main expectations of team from training

- To be able to measure impact
- To have better idea of who to admit
- To have tool to monitor programme

A quick “SWOT” was carried out on last day for participant feedback on the SFR/MRP

Strengths, Weaknesses, Opportunities.....of MRP and potential changes to implement

(viewpoints from the field team)

Strengths	Weaknesses
<ul style="list-style-type: none"> <li>• Facilitating programming</li> <li>• Facilitating decision making</li> <li>• Facilitating meeting standards</li> <li>• Provides a quick check of “where we are and where we are going”</li> <li>• Helps accountability (numbers, rations etc)</li> <li>• Database is “simple” and “easy to use”</li> <li>• Helps increase accuracy</li> <li>• Narrative/context provides useful information</li> <li>• Helps measure impact</li> </ul>	<ul style="list-style-type: none"> <li>• Biased towards targeted indicators</li> <li>• Repetition in the configuration part</li> <li>• Setting up templates is long process – is it possible to simplify</li> <li>• Need to standardise wording as different in different places – eg for individual support = “defaulters” and in database = “drop outs”</li> </ul>
Opportunities for individual support	Threats – not discussed Possible Changes to Programme
<ul style="list-style-type: none"> <li>• Way to monitor “attendance” as an indicator for access/acceptability</li> <li>• ?measure outcomes eg death or defaulter</li> <li>• ?need other or error category</li> <li>• ?split P&amp;L beneficiary groups</li> <li>• Need way to monitor rations (distributed/extra/missing)</li> <li>• ?Impact measures eg weight increase/decrease/static</li> <li>• Way to record coverage</li> <li>• Improve validation part eg noting if end of last distribution is not same as next</li> <li>• Useful if there were standards developed for individual support eg minimum attendance</li> </ul>	<ul style="list-style-type: none"> <li>• Sensitising community to criteria and programme more</li> <li>• Add “attendance” column to register</li> <li>• Record if benefs.receive general ration</li> <li>• Better define absences ?code as defaulter/death/error of registration/double ration given</li> <li>• Add beneficiary ration card</li> <li>• Improve ration monitoring eg number given/excess/shortage</li> <li>• Add oedema checks</li> <li>• Add evidence of pregnancy</li> <li>• Monitor nutritional improvement: + / - / static</li> <li>• Look at coverage</li> <li>• Monitor admission rate – encourage new admissions</li> <li>• Start use of data collection forms post distribution</li> </ul>

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## Annex 2

Participants were particularly struck that they have information gaps on attendance and esp on defaulters and severe cases and as not measuring as go along that at 6 months too late to rectify programme.....

Also that they are not currently measuring rations in relation to number of attendees or coverage.

Also found the following M&E questions useful when applied to programme and proposal/logframe

- what were the reporting needs, and how did they meet them?
- what were the information needs from their donors/other partners and, were they satisfied?
- what other information could've been useful for the management and monitoring of the programme?
- are there ways for those information needs to be covered by the MRP and the accompanying software? how?

#### 4.2 General feedback (from consultant):

##### Global:

- Will the term "Individual Support" be included in SPHERE update and HTP revision as most documents refer to blanket or targeted only...More force/wider acceptance if SPHERE includes this?
- New SPHERE mentions non-responder I think but doesn't sub-divide re-admissions or defaulters so is this necessary for MRP...better if standardised/synchronised
- Good to strengthen links to therapeutic from start....
- Also could be advantageous to include section on MAMI (nb..just had a request to do a CMAM+IYCF DB)

##### Pre-training

- Useful to have more specific information about the programme, ie type of SFP, frequency of distribution, sample data sheets, criteria, proposal etc before coming incountry. Maybe devise a key document list.
- Also useful to know background of participants – eg here there are no nutritionists and staff generally have development backgrounds so can adapt training at correct level
- Need to emphasise the importance of bringing not only computers but also all available raw field data to training to make it more relevant
- Would be useful to maybe send more SFP programme literature in advance of training/use during training:
  - MRP Guidelines (sent)
  - HPN paper on effectiveness of SFP
  - HTN modules on SFP, definitions of malnutrition (or ref)
  - List of key abbreviations and definitions/glossary
  - Summary sheet/overview of CTC/CMAM if country is adopting this approach (so organisation understands link between SFP and therapeutic care even if conducting stand alone SFP)

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## Annex 2

**Training**

- 3-4 days should be sufficient (depending on level and degree of preparation) but additional preparation /document gathering day was extremely useful for gathering programme information and enabling adaptation of training to the level.
- Useful to have contacts of UNICEF/MOH nutrition office in case field office does not have recent documents!!
- Take strong up-to-date anti virus software!!!

**MRP Guidelines & Database Recs:** refer to separate document and to Draft Guidelines on Use of Database

**5 Summary**

Participants reported that the combination of general nutrition discussions, M&E discussions, the MRP database and analysing existing data and data collection gaps was useful for both the remainder of the current programme and future more targeted programming. They would like to be kept up-to-date with new software, especially to take advantage of the analysis parts. Staff members were fully capable of using the database although the way the programme data capturing tools have been set up and the infrequent distributions limits the amount of data that is available. A general nutrition training covering basic definitions of malnutrition, classification, entry/exit criteria etc would be beneficial for these staff and maybe those also in the food security programme.

***Annex 1 to report***

Christian Care Participants:

S/N	Name	Designation	Programme
1	<b>Ndlovu Tobias</b>	<b>Project Officer</b>	<b>UNHEP</b>
2	<b>Ncube Xolile</b>	<b>Project Assistant</b>	<b>UNHEP</b>
3	<b>Tshuma Vusa</b>	<b>Project Assistant</b>	<b>UNHEP</b>
4	<b>Sibanda Meck</b>	<b>Project Assistant</b>	<b>UNHEP</b>
5	Dilys	HIV project	
6	??	HIV project	
7	Eriick	UNHCR	UNHCR

Names in bold attended DB training too

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## Annex 2

**Agenda MRP Training Bulawayo 8/3/10 – 12/3/10**

**8/3/10 – Preparation:** Programme description, reporting forms, training needs and preparation

**9/3/10 – DAY ONE: Minimum Reporting Package Overview**

- Presentation of Participants, expectations
- Types of Nutritional Programmes/general nutrition terms
- Basic Data Collection Tools
- Performance Indicators & Interpretation of Indicators
- Context Information
- Minimum Reporting Package (MRP) Brief Overview
- CMAM/CTC Overview

**10/3/10 – DAY TWO: Database Installation, Introduction & Practice**

- Level of reporting (site): introduction of excel tally & report sheets
- Naming, Storing, Filing  
Database installation
- Practice Entering data
  - Data input / Data review / Data reports
- Creating Programme Specific Templates
  - Organisation / Zone / Treatment Centre & Treatment Group

**11/3/10 – DAY THREE: Practice with Inputting Programme Data**

- Revision of Creating Database Templates
- Data Entry & Analysis

**12/3/10 – DAY FOUR: Completion of Analysis, M&E feedback, SWOT**

- Complete Data Entry & Analysis
- Recap of Various Database Functions & Role in CC Programme
- Programme Objectives & Data Collection Gaps
- Context & Other Available Information (surveys, MOH etc)
- Discussion on Programme Data Gaps, M&E and Possible Use of MRP; SWOT Analysis
- Way Forward (key documents, refs handover)

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## Annex 2a

## Annex 2a: Report on database recommendations post Zimbabwe training

### Database recommendations

(following Zim March Training with Christian Care)

Nicky Dent 14th March 2010 for ENN

*(listing things that would be great in an ideal world....realise some below probably too much at this stage of development!! Ones **highlighted** are important)*

- Still think overall DB is too complicated especially the configuration part and there are bits & pieces in various menus which are not used that could possibly be removed
- **Overall layout** could be simplified i.e. little confusing when to use top tool bar and when to use different sections on first page....couldn't configuration part or definitely the batch import part come under the main front page of the database face so there is a logical sequence eg step 1, configuration, step 2, import data, step 3, check data, step 4, analyse data.....
- Would rename some of the stages to make them clearer e.g. enter/edit programme data.....can we not call this "enter context information" "configuration" – isn't there a simpler word?
- Also could be more logical to get summary of context information at the bottom under "Report" rather than having to go to top toolbar i.e. its one of your outputs from the database....bit lost up the top
- For **batch import**....would make sense to have the two options for all databases i.e. import one report or multiple report for all users...why need a special button to operationalise this? Then you miss out another step which simplifies the process
- When **importing data** that already exists can this overwrite existing data???? Or delete multiple sheets. We imported about 10 data sheets, found we had errors on first data forms, and then had to delete every sheet individually and re-import as re-importing same named sheet did not overwrite/update existing one
- Could **blank template** be part of initial software...not clear how to create one if someone is starting to use a DB from scratch. Previously Carlos or I provided.

#### **Configuration**

- Not sure of the advanced option here....would remove batch import completely and have that option available for all databases as said above. What are test sheets?? If for training then maybe not good idea to have it there for database itself with real data as confusing.
- Do the numbers to the left of each section mean anything? 6001 etc 1, 2, 3 more logical

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## Annex 2a

- Team found bottom blank bar (name, abbreviation) confusing as tend to type in information here and if make this mistake then have to repeat again under “add new”...not sure of the function of this bar, could it be removed?
- “**First report**” and “**Last Report**” caused confusion – one person continually typed in Last report space...often inconsistencies between this and ID page, couldn’t the info from configuration go automatically to ID page? Maybe easier to rename as “opening of centre” and “closing of centre” as team started to try to change on the ID page when updating monthly info
- Could there be a summary page with all information depicted so can do quick check...bit like screen once treatment groups are added in but also including start date and area??

**Zone**

- Could name “**Zone**” be changed to make it more generic...e.g. “programme area” as most deal with counties/districts/wards.
- Would delete the two example zones as not clear to team whether should be overwritten, left or deleted.
- Often need two levels of area: district/county then smaller unit e.g. zone/kebele/ward so could be useful to add this as useful to triage data according to this. Could two options be available?
- Way the centres are linked to zone at bottom of treatment page is confusing.... Would be clearer having zone or area appearing on the page to the right after the organisation and a place to click on this line rather than separately at bottom
- Also zone doesn’t seem to link at all to ID page so how relevant? Would be good to have pull down menu for ID page as appears for organisation .and centre name

**Treatment Centre**

- ?role of number to left,
- Adding centre fine and organisation and first report but maybe could add in zone in same place not below?
- Does last report have to be here?
- What does use as template mean?
- Similarly having bottom bar here is confusing as same info’ repeated as under “add new”
- If make a mistake and add a centre then delete it is deleted here but still appears under treatment categories

**Treatment categories:**

- Could this be separated out as step 4, danger of losing it here
- Repetitive on clicking on organisation and start date – can these steps be missed out
- Since there are only 5 or so set treatment categories can’t these automatically be part of the excel ID sheet ie don’t need to be pre-programmed...when click on excel can choose without long process of programming in at start? Again to try to miss out a stage.
- Is there a possibility of adding in different categories e.g. if blanket is for <2 or 3 years only or targeting chronic or different vulnerable group
- Lactating missing last “g”

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## Annex 2a

**ID page:**

- As above: doesn't seem to have drop down menu for "zone part" so not sure why need to configure this?
- Would help to use same terminology i.e. called zone in config .part but Region/district/village etc in ID page, zone doesn't appear.....other terminology more useful so could be changed to region/district etc
- Use of OTP/SC too specific for non CMAM/CTC programmes, eg with CC where only one hospital available,
  - maybe better to say referral for "therapeutic care"
- Very sensitive if missing start date on config.or on this page or if different. how critical is the start date?

**Review Section**

- For **Individual Centre Report**, although completed on the ID sheet the following categories appear blank ie info is not translated across: Region, District, Village, Referral OTP/SC, Referral HC
- For edit section bit confusing to have all tables even if irrelevant and blank ie targeted there even if only individual support and vice versa (works for individual report but not edit mode)
- Presentation of Individual Centre Report –removes targeted etc (unlike edit page) but could it be better centred on page so useful as a print out.
- Is there a way to delete pages not being used e.g. if only a blanket or Individual support programme remove targeted parts or maybe have separate simple database just for these types with far less sophisticated monitoring...for excel sheet and database?? Could be room for a blanket/individual support only DB?
- Validation section not currently working: comes up with "rule" and "action required" but nothing underneath even if missing data which we had in several reports. Comparing end of last distribution with start of this...would be very useful...or at least flagged up here big problem with this programme

**Report Section**

Extremely limited at the current time and doesn't warrant all the work for configuration and data entry...graphics need improving

Think need more outputs...current CTC databases have a graphic with total admissions and discharges in bar chart and total in programme as line above....clear graphic.

Pie charts good for exits.

Maybe move context information here....and some way of summarising data

Comparisons of different sets of data. Etc.etc

**Summary Report**

- Comes up with an "analysis status report" listing data inconsistencies and camps that are nothing to do with current database. Then have to push "yes" to continue with the analysis. Can this be corrected? Doesn't happen every time but enough to disconcert trainees

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## Annex 2a

- Currently adding up incorrectly if for cumulative months/from-to time period: eg

	total beginning of period	# new admissions	exits	total end of period
First round(Nov)	0	724	53	671
Second round (Jan)	740	27	72	695
Analysis Nov-Jan	740	751	125	1366

Total at end of Jan should be equal to 695 cases not 671+695

- Could be interesting to compare sets of data...is that possible here ie between totals between one year and another?

- **Indicator Analysis:**

- Page falling short ie have to lower bottom bar to find "generate" button..can this be changed. Also some of tables generated cut short names of centres.. difficult to read on left hand side
- Still refers to "camp" on page
- Re-running generate and seems to work on my machine but didn't work on any of trainees computers...wouldn't compute or produce any tables
- What is function of map? Is this GIS/GPS related?

- **Performance Indicators:**

For targeted only so not used

**Possible additional categories: Individual Support & Blanket Categories**

- **Ration Monitoring:** Extra categories for individual support/blanket ....needs to be added to tally to highlight if too many or too few rations distributed.... Not clear at moment
- Maybe categories for "old cases", "new" and "other admissions" in this programme usually spare rations were given to people on the site....not taken back and sometimes insufficient rations available and no way to capture this surplus or insufficiency
- Way to capture **attendance** for ISP/blanket...defaulter a bit late if distributions are infrequent eg here where they are every 2 months with total of 3 cycles....a defaulter wont be picked up clearly.... So non attendance or absent useful. Team wanted breakdown into defaulter/death/double ration/error/SAM referral etc but probably too detailed
- ?is compilation sheet for ISP or targeted that useful?
- **Coverage** should be in context sheet

Various commands for import/export/compact/analyse....are these all necessary?



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## Annex 2a

***Typos & Inconsistencies***

I know this might not be the priority but for professionalism would be good to change if possible. (sorry was an editor before nutrition and typos don't encourage beliefs of accuracy!!!)

- Last letters missing eg "lactatin" "ratio" not ration
- Mix of American English – program, center and English English – programme, centre, good to be consistent e.g. on context information both appear on same page  
Program on front page, and in context sheet but programme also there  
Front page has both "centre" and "center".....  
Remove word "camp" also reference to "alicante" etc appears occ.  
?change word zone and make more general and consistent with ID page....district/village
- Targetted = targeted
- Usually refer to "total at end of last period" not "total at beginning of new period" though amounts to same good to use same as appears on UNICEF/MOH forms etc
- Need to check dates...I think some appeared in American style i.e. month/date/year and some European i.e. date/month/year
- Presentation: all very small...some tables you cant see all text and some sheets/graphics opened have to be pulled down/extended to show all categories or next command (tricky if not computer literate)

Need consistency of categories and naming on excel sheets and database...think tally sheet for ISP or blanket misses number already in programme

***MRP Guidelines & Database Recommendations: refer to separate document***

- Add contents and key abbreviation list
- Add references for summary documents on SFP and CTC/CMAM
- Add glossary and put definitions of each of the 3 forms of SFP (targeted, blanket, individual support) and their associated objectives (or range of) at start or annex so jumps out at you
- Increase potential link with CMAM or therapeutic programme (would need more explanation of criteria etc)
- Increase MAMI section
- Add examples of register for blanket and individual support....not in excel annexes
- Add examples of ration card for blanket and individual support
- Ensure excel sheets consistent with database formats eg wording, columns etc....
- Usually refer to "total at end of last period" not "total at beginning of new period" though amounts to same good to use same as appears on UNICEF/MOH forms etc
- Maybe check consistency between excel sheet categories and column names and those in DB
- ? change ref to OTP/SC on ID pages...think reference to monthly distributions somewhere tho' often more or less frequently
- Too many columns for tally sheets and compilation sheet
- Missing ISP tally and compilation sheet or use same but add to title
- Flow diagram was thought too complicated by team  
(Team tend to work at level of individual child data not per centre so were having problems initially understanding that specific child data is not captured in the database and understanding concept of combining/collating and looking at the level of each centre.)

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## Annex 3

## Annex 3: Thailand MRP Training Report

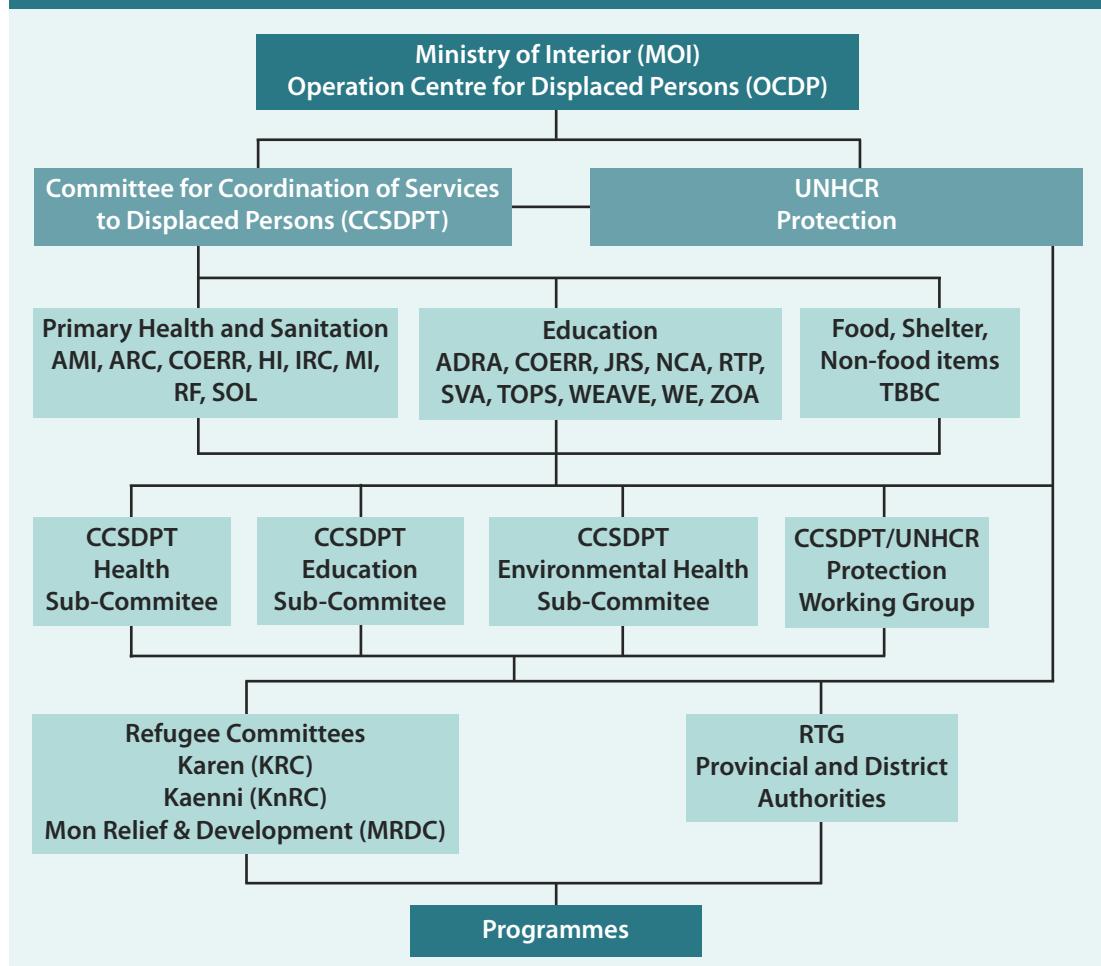
### Programme Background

#### General Background

The Thailand Burma Border Consortium (TBBC) comprises a membership of twelve international NGOs with a mandate from the Royal Thai Government (RTG) to provide food, shelter and non-food items for all the refugees along the border. TBBC also conducts research on causes of displacement and advocates on behalf of the refugees. TBBC's programs are implemented through partnerships with refugee committees, community-based organisations and local groups.

TBBC is a member of the Committee for Coordination of Services to Displaced Persons in Thailand (CCSDPT), committed to coordination of all humanitarian service and protection activities with the other 17 members of CCSDPT and the UNHCR (see Figure 1).

**Figure 1: CCSDPT/UNHCR Coordination Structure**



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## Annex 3

**Note:**

UNHCR role is principally one of monitoring and protection.

TBBC is the main provider of food.

Health agencies provide implementation support to SFP activities.

Refugee committees administer the relief programs.

Burma's longstanding political and humanitarian crisis has displaced millions of people forcing many to flee to neighbouring countries. Today about 140-150,000 refugees are living in nine camps distributed along Thailand's western border (see Annex 1: Map of Displaced Burmese June 2010).

## Food & Nutrition Programme Background

### *General Food Ration*

- General Food Ration consists of 8 food items (rice, fortified flour, fish paste, iodised salt, mung beans, oil, dry chillies and sugar) providing ~2,100 calories per person per day. There are plans for this to reduce slightly due to funding shortfalls.

### *Supplementary Feeding Program (SFP) and Therapeutic Feeding Program (TFP)*

- 2 types of SFP are currently implemented – blanket and targeted.
- 5 target groups for blanket: pregnant, lactating, chronic condition/disability, HIV/AIDS and TB
- 4 target groups for targeted: malnourished pregnant, malnourished lactating, malnourished under-5 and malnourished over-5.
- No two target groups receive the same ration except HIV/AIDS and TB groups. Items available in the SFP food basket include: blended food premix 1, blended food premix 2, oil, beans, eggs, peanuts, dry fish and tinned fish. On average each target group SFP ration consists 3 items.
- 1 SFP per camp (however in 2 camps there are 2 distribution sites per SFP)
- TFP is also on-going in the camps
- SFP and TFP activities currently under review given low GAM rates (<5%) whilst chronic rates are high (>35%), high SFP non-recovery and re-admission rates and budget constraints.

### *SFP and TFP Reporting*

- Currently health agencies report using 2 systems: TBBC (data mainly used to track food consumption) and HIS. See attachments for examples of the monthly reports and current information flow for both systems. Data requirements include disaggregation by sex and by people living within and outside of camps.  
Training
- 12 Participants. Included SFP supervisors and data inputers from 4 health agencies covering the nine camps (IRC, MI, AMI, ARC), TBBC nutritionist (Erika) and DCA Head of Humanitarian Response (Erik Johnson).

## Documents/Software Supplied

- Measuring the effectiveness of SFP in emergencies. Carlos Navarro-Colorado, Frances Mason, Jeremy Shoham HPN Network Paper 63 Sept. 2008
- Agenda

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- Presentation – Minimum Reporting Package – Training (see attachment)
- Minimum Reporting Package for Emergency SFPs Draft Guidelines May 2009
- Installing and Using Database Draft Guidelines
- SFP MRP Database – Version 23 Sept. 2010
- SFP MRP Excel data Sheets (see attachment)
- 6 months of TBBC monthly reports for data entry

## Agenda

### Day 1 (Monday 18th Oct.):

- Background / Introduction to MRP
- Introductions by participants
- Presentations of current reporting systems by each agency, including current strengths and weaknesses
- Nutrition Revision – types, causes and ways of addressing malnutrition
- MRP Guidelines – Introduction to new terminology, treatment groups and admission categories

### Day 2 (Tuesday 19th Oct.):

- Revision of topics covered day 1
- MRP Guidelines – discharge criteria, performance indicators
- Exercise – calculation of performance indicators
- Presentations by participants on what performance indicators tell us about our programmes
- Trained Erika (TBBC) on database – configuration, development of SFP template sheets, importing data and data analysis

### Day 3 (Wednesday 20th Oct.):

- Revision of topics covered day 2. Re-visiting issues remaining unclear/questions remained unanswered from day 2.
- Data entry and quality checks

### Day 4 (Thursday 21st Oct.):

- Presentation of data analysis using database
- Importance of monitoring
- MRP feedback by participants
- The Way Forward for TBBC and health agencies

### MRP Feedback\* (includes feedback from participants and myself)

\* much of this has already been shared with one/both of you but thought good to have in one place

### Minimum Reporting Requirements

Overall there were no problems in understanding the terminology/definitions used in the MRP Guidelines and there was a general acceptance that the suggested admission and exit categories were a good idea. In the main this was because health agencies already feed into 2 comprehensive reporting systems (TBBC and HIS) and much of the MRP requirements are already covered by one or both system(s). There

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## Annex 3

are the usual reporting errors and lack of clarity over which category to admit or discharge a patient. This is mainly due to high staff turnover and also confusion resulting from the use of 2 different reporting systems. This however can be addressed through regular refresher training.

- HIS system reports on TFP as well

***Main differences between TBBC reporting system and MRP***

<b>TBBC</b>	<b>MRP</b>
<b>Admission</b>	<b>Admission</b>
- New admission	- New admission
- Re-admission of cured	- Re-admission after recovery
- Re-admission of non-cured	- Re-admission (other)
- Re-admission of defaulters	
- TOTAL Admissions	- TOTAL Admissions
	- Moved in
	- TOTAL IN
<b>Discharge</b>	<b>Discharge</b>
- Cured	- Cured
- Death	- Death
- Defaulter	- Defaulter non-confirmed
	- Defaulter confirmed
- Transfer	- Non-cured
- TOTAL Discharge	- TOTAL Discharge
	- Moved out
	- Other
	- TOTAL OUT

- TBBC reports on all target groups (targeted SFP, blanket SFP and TFP) in 1 report. 'TFP follow-up' not currently a separate treatment group.
- Other indicators collected by TBBC include: % recovered, % coverage, average length of stay and average caseload.
- Currently TBBC only use 'average caseload' and a food requirements data sheet for their monitoring and donor reporting requirements. Other data isn't consistently/systematically used.

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HIS	MRP
<b>Admission</b>	<b>Admission</b>
- New admission (for various target groups and 'other')	- New admission
- Re-admission ('moderate malnutrition' and 'other')	- Re-admission after recovery
	- Re-admission (other)
- TOTAL Admissions – moderate	- TOTAL Admissions
- TOTAL Admissions - other	
	- Moved in
	- Other
	- TOTAL IN
<b>Discharge (x2 – 1st section for moderate, 2nd for other)</b>	<b>Discharge</b>
- Cured	- Cured
- Death	- Death
- Defaulter	- Defaulter non-confirmed
	- Defaulter confirmed
- Referral	- Transfer to medical facility
	- Transfer to therapeutic programme
- Non-cured	- Non-cured
- TOTAL Discharge – moderate	- TOTAL Discharge
- TOTAL Discharge – other	
	- Moved out
	- Other
	- TOTAL OUT

- Health agencies report on both blanket and targeted SFP activities in the HIS SFP section. Target groups are reported in both rows and columns. 'TFP follow-up' not currently a separate treatment group.
- Other indicators collected by HIS system include: length of stay, recovery rate, death rate, defaulter rate and referral rate for moderately malnourished under-5. Coverage rate for malnourished under-5 and P/LW is also calculated.
- Participants understood the term 'individual support' but decided not to use it. All the SFP target groups either fell under – 'targeted' or 'blanket'. 'TFP follow-up' was the only obvious group to fall under 'individual support' however it was agreed it made most sense to include 'TFP follow-up' as a separate treatment group under 'targeted' rather than have 3 separate reports.
- ? over whether possible to collect 2 types of defaulters – non-confirmed and confirmed. Some camps have the capacity to confirm defaulters, others don't.
- Re-admission 'Others' – some participants felt by incorporating all remaining categories into 'others' (except 'cured') we would be missing out on useful information such as who was re-admitted because they had defaulted and who was re-admitted because they were 'non-cured'.
- Weight gain and LOS – lack of clarity on how to calculate. Is a calculation done using weeks as opposed to days? Doesn't admission week always mean 'week 1'?
- A general consensus that the minimum reporting requirements were relevant, informative and theoretically easy to adopt. All participants agreed effective

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## Annex 3

monitoring would aid program decision-making. Participants look forward to interpreting their centres' performance and getting feedback from program managers based on the data collected. Some participants even believed a more informative monitoring system would improve staff engagement.

- Updating program/reporting protocols is always a challenge. Training program staff is time consuming and high staff turnover also affects progress. Took camp staff 6-12 months to understand the HIS system when 1st introduced.
- HIS registration books (1st step in the data collection process) will have to be adapted to include additional MRP data.

### MRP Database

Disappointment data base not ready – sections on blanket, individual support, length of stay and weight gain not ready. Section on blanket feeding would have been very useful given the number of blanket programs run by TBBC and health agencies.

#### *Excel sheets – data entry*

- For the TBBC reporting system health agencies fill in monthly SFP data into excel sheets. As a result all participants found the MRP monthly reports easy to fill in. Also there no problems with making copies from the 'blank' configured monthly report, naming and systematically filing monthly reports.
- A unanimous complaint about data entry was the need to fill in 4 data sheets per centre as currently health agencies required to disaggregate data by sex and by those persons living inside and outside a camp. This process was both lengthy and would result in more errors during data entry.

#### *Configuration*

- During configuration stage for organizations, zones, treatment centres and treatment groups, the green section with white boxes (in the 1st window that appears) does add some confusion as you tend to want enter data into them directly rather than do as the instructions say (!) and 'add new'.
- Edit/Add treatment centre. Allocation of specific 'zone'. When allocating a zone it is not obvious you were successful in doing so as the zone does not appear in the white table section alongside the treatment centre and organisation.
- Where you add treatment groups to a treatment centre need to change 'name' to 'treatment group'.
- Currently the only 'treatment groups' you can choose from are <6 months, 6-59 months, older children, ....., chronic disease. Is it possible to have the option to put in your own additional treatment groups?
- For each treatment group the database currently allows you to choose all 3 treatment options at once, although it doesn't actually work.
- On 'summary of configuration' page change 'supplemental' to 'individual support' and 'bulk' to 'blanket'.
- 'Summary of configuration'/'program configuration' page appear as a small window – I can't see any way of enlarging the window, so makes for difficult reading.

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**Configured excel sheets**

- SFP ID – there is no ‘date opened’ and ‘date closed’
- SFP ID – Is it possible to add TFP to Referral OTP/SC, as some organisations unfamiliar with CTC/CMAM
- Only 15 of the 36 centres added during the configuration of the database appeared in the configured excel sheets.
- Currently all ‘treatment groups’ selected in the database configuration stage come up as options for selection in the excel sheet for ‘targeted’, ‘IS’ and ‘blanket’. For example during database configuration I selected ‘TFP follow-up’ as the only ‘treatment group’ for ‘IS’, however in the excel sheet for ‘IS’ I have the option of selecting ‘treatment groups’ I selected for ‘targeted’ and ‘blanket’ as well.
- Currently for both ‘blanket’ and ‘IS’ the number of treatment groups that can be selected/reported on is restricted to 3. I know TBBC may be an exception but they have 5 target groups for ‘blanket’ feeding.

**Review section**

- When selecting a report for editing, in the edit data/feeding summary window only the targeted and IS data appears, there is no information on blanket feeding.

**Importing reports & Analysis**

- Database doesn’t seem to accept .xlsx version of excel sheets – can this version be accommodated for?
  - When importing reports (I did in batch mode): I got the following messages:
  - Importing for treatment group ....
  - Importing for treatment group.....
  - Data import complete
  - Total # of missing values 3
  - Files imported – list of all files imported.

I imported 4 batches of reports (i.e. 4 months) each batch had 15 centre reports. For each batch I got exactly the same messages above. Do you know what the missing values refer to? Am assuming significant as when I come to the ‘Report’ section I get lots of error messages (see below).

- Summary Report. Tried to run a summary report by month (entered specific month) on all 15 centres we entered data for (those that appeared on the configured excel sheets). Each time I got the following message:
  - Analysis status
  - Reporting period data inconsistencies:
  - UDF check running
  - UDFs are not consistent within the selected reports
  - Missing reports check running
  - Missing reports check failed
- In Thailand the messages we were getting were:
  - UDF check running
  - UDFs are not consistent within the selected reports
  - Missing reports check running



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- Missing report: UNKNOWN CAMP ID 7096 2010.10
- as above but different CAMP ID no – (same message >20x)

Not quite sure what I have done differently to get a different message????

Anyway, if I say 'yes' to continue with analysis it appears to give me a correct summary report.

- Indicator analysis. Looked at cured rate, for 6-59 month group, for 15 centres in a 1 month period. 1st time round generating the analysis I got the following message:
  - Check reporting period
  - Missing reports check running
  - Missing reports check failed

If I say 'yes' to continue with analysis I get the results table – which appears correct, however part of the table falls outside of the window (needs re-positioning). I also get another report in a separate window called 'Reporting details' which lists 'camps selected for this report' and 'camps included in this report' – all looks correct. However I also get a list of missing reports listing Alicante with various treatment groups and months (16x).

In Thailand we kept getting a 'runtime error' when trying to generate a graph, however appears to be working now.

- Performance indicators. Doesn't appear to be working – just have a graph with labelled axes but no data

## Conclusion

Whilst it was agreed nearly all the minimum reporting requirements were key to interpreting program performance and theoretically easy to adopt and that the excel sheets and database user friendly, an issue remains about how best to incorporate any/all elements of the MRP into the current reporting system.

There was a general feeling of disappointment as the expectation (pre-training) was the MRP would reduce time spent on data collection, as well as improving on the current reporting systems used.

MRP could replace much of the TBBC reporting system (except for TFP data and tracking food requirements). However, given the HIS allows data collection and reporting on population, health and nutrition data across all the camps TBBC and health agencies feel it important to continue reporting into this system. The MRP is still a 'working package' and not ready to be adopted by UNHCR so currently can't replace the nutrition tab in the HIS system. Therefore if TBBC and the health agencies were to adopt MRP they would still be left with reporting into 2 health systems.

Given there are already plans to review the SFP and TFP programs (reducing ration sizes, treatment groups, etc.) TBBC felt it made sense to

- at least start this process before making any changes to the current reporting systems.

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- b).** then look at TBBC and HIS systems cutting out any duplication of information collected - effectively reducing TBBC reporting to just TFP and food requirements data.
- c).** and finally, reconsider whether it is appropriate to introduce the MRP in this context. This will effectively mean reporting into 2 systems again (increasing staff workload) but with the advantages of a different formatting of data, a few extra indicators, feeding into a central database and using an information system that hopefully will be adopted as a standard sometime in the near future.

## Training Feedback

### Content, Structure and Delivery

Clear. Relevant. Good balance between theory/explanation, group discussions and exercises.

Mixed reviews over speed of delivery.

Mixed reviews over time spent on data entry.

Nutrition review to include more on chronic malnutrition as bigger issue than acute malnutrition in the border camps.

Trainer unclear on some of the indicator's definitions/their relevance – these points had to be re-addressed at a later point in the training.

### Training opportunities and outcomes

An opportunity to review current reporting systems, share and learn from others' experiences (more time would have been liked by some on this).

Introduction of conceptual framework of malnutrition and exercise looking at causes of malnutrition in border camps informative.

Exercises ensured theory put into practice and participants had clear understanding of concepts/theory.

Team building.

Understanding of MRP reporting requirements and MRP excel data sheets – relevant and user-friendly.

Appreciation of usefulness of program data/performance indicators and how they help inform program progress.

### Suggestions

Send all documentation (background reading material and agenda) to participants before training.

Set out training ground rules.

Discuss expectations, hopes, and fears prior to commencing training.

Add more warm-up/energiser exercises.

Allow more time for translation opportunities (by participants for participants) and include time in schedule to review each training session, this will ensure clearer understanding of topics covered.

Database should be ready before training (blanket SFP and analysis sections incomplete).

Follow-up of training to share experiences once implementation goes ahead.

MRP to be presented differently. Emphasis in training should shift from the 'Minimum Reporting Package' to looking at in 2 distinct parts – 'Minimum Reporting

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Requirements’ and ‘The database’. Argument being not all agencies may be in a position to take on the whole package but are happy to adapt the current reporting system to include all the required indicators.

Would have been better to adapt training goals early on, given fairly clear it was the wrong timing/context for introducing MRP. Such as to allow more time to review current reporting systems, share information, discuss general problems related to the program.

In future, useful to organise a separate visit to the program prior to the training. This will ensure training is best tailored to the needs of the program and will meet the expectations of those attending the training.



### Eastern Burma:

IDPs 500,000

### Thailand:

Refugees in camps 150,000

Refugees outside camps (including Shan) 200,000+

Migrant workers 2,000,000+

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Annex 4

## Annex 4: Final report from CARE for MRP pilot in Ethiopia



Figure 1: CARE Ethiopia SFP (Famix distribution)

### Final Report for Emergency Nutrition Network

**Project Name:** Supplementary Feeding Program Minimum Reporting Package (SFP MRP) Pilot

**Project Location:** Ethiopia – Oromiya Region, East Hararghe Zone

**Grant Amount:** USD \$4,000

**Funding Period:** August - December 2010

**CARE Contact:** Alix Carter [acarter@care.org.et](mailto:acarter@care.org.et)

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## Annex 4

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**Acronym List**

<b>CARE</b>	<b>Cooperative for Assistance and Relief Everywhere</b>
<b>CF</b>	<b>Community Facilitator</b>
<b>CIDA</b>	<b>Canadian International Development Agency</b>
<b>CTC</b>	<b>Community-Based Therapeutic Care</b>
<b>DPPC</b>	<b>Disaster Prevention Preparedness Commission</b>
<b>EH FO</b>	<b>East Hararghe Field Office</b>
<b>ENN</b>	<b>Emergency Nutrition Network</b>
<b>GoE</b>	<b>Government of Ethiopia</b>
<b>HEW</b>	<b>Health Extension Workers</b>
<b>MAM</b>	<b>Moderate Acute Malnutrition</b>
<b>MUAC</b>	<b>Measurement of Upper Arm Circumference</b>
<b>NGO</b>	<b>Non-Government Organization</b>
<b>OFDA</b>	<b>Office of Foreign Development Assistance</b>
<b>OTP</b>	<b>Outpatient Therapeutic Care</b>
<b>PLW</b>	<b>Pregnant and Lactating Women</b>
<b>SAM</b>	<b>Severe Acute Malnutrition</b>
<b>SC</b>	<b>Stabilization Center</b>
<b>SFP</b>	<b>Supplementary Feeding Program</b>
<b>SFP MRP</b>	<b>Supplementary Feeding Program Minimum Reporting Package</b>
<b>TFP</b>	<b>Therapeutic Feeding Program</b>
<b>TSFP</b>	<b>Targeted Supplementary Feeding Programs</b>
<b>UN</b>	<b>United Nations</b>
<b>UNICEF</b>	<b>United Nations Children’s Fund</b>
<b>WFH</b>	<b>Weight for Height</b>

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## Annex 4

## 1. Background

The Government of Ethiopia (GoE) and humanitarian actors (Non-Government Organizations (NGOs), United Nations (UN) Agencies) in Ethiopia implement Targeted Supplementary Feeding Programs (TSFP) as per the national protocols for the management of Moderate Acute Malnutrition (MAM). The Government oversees all screening to these programs through performing mass screening (Enhanced Outreach Screening) with UNICEF at set times during the year. There are not standardized protocols for monitoring and follow-up of beneficiaries admitted to SFP in order to track the improvement and exits of admitted cases. Limited reporting criteria means there is a lack of information about SFP effectiveness in general such as length of stay, average weight gain, specific defaulter data, etc.

CARE Ethiopia is a regular emergency nutrition response partner and has been implementing SFP in partnership with Government for many years. The Emergency Nutrition Network (ENN), with funding from Office of Foreign Development Assistance (OFDA), developed an SFP Minimum Reporting Package (SFP MRP) to improve the quality of SFP data and standardize tools to report SFP among different actors on a global level. ENN initiated a pilot phase to test this system in late 2009 and invited many NGO actors in different parts of Africa to participate. In the aim of improving SFP data and impact measurement, CARE agreed to participate in the SFP MRP pilot program. Two of CARE's nutrition/humanitarian staff took part in SFP MRP training in December 2009, held in Nairobi, Kenya. These staff cascaded this training to others at the CARE Ethiopia Country Office and Field Office where the pilot was implemented. CARE chose to implement the SFP pilot in one woreda in conjunction with its ongoing Canadian International Development Agency (CIDA) funded emergency nutrition project (April 1, 2009 – November 30, 2010). The program provides Community-Based Therapeutic Care (CTC) which includes: Therapeutic Feeding Program (TFP) comprised of inpatient Stabilization Center (SC) services for complex Severe Acute Malnutrition (SAM) cases of children under five and Outpatient Therapeutic Care (OTP) for SAM in children under five; and SFP for Pregnant and Lactating Women (PLW) and children under five (6-59 months) with MAM. CARE implemented the SFP MRP pilot for a two month period (October-November 2010) in six SFP sites of Kurfachelle woreda in East Hararghe Zone of Oromiya Regional State in Ethiopia.

## 2. Pilot Activities

### 2.1 Training Workshop

The SFP MRP Pilot Manager (Humanitarian Accountability Advisor) and CARE Ethiopia Nutrition Advisor based in the Country Office in Addis Ababa, traveled to the CARE Ethiopia Field Office in East Hararghe Zone on September 22, 2010 to train the CIDA Nutrition Project staff on the SFP MRP. This included presentation and explanation on the guidelines and reporting formats, practice activities, and action

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planning for the pilot. A total of 18 people participated in the training, mainly staff members employed under the CIDA project and local Government officials participated in the training (in order to familiarize them with CARE's pilot plans and build a sense of partnership).

The field office planned to have six SFP sites (Alemdrom, Arele Guda, Chefi Anene, Derme Shieck, Hula Jeneta, and Kurfachelle) in Kurfachelle woreda for the pilot with three designated SFP teams comprised of food distributors, nurses, community facilitators and Government partner staff. Each team was responsible for pilot implementation at two sites. The manager provided a field office budget for the extra costs associated with pilot implementation (above regular costs in the CIDA project). The SFP MRP Manager, Nutrition Advisor and SFP teams agreed on distribution dates and reporting dates for all data to be submitted.

## 2.2 SFP Distribution Activities

CARE EH SFP staff completed two service rounds of distribution at each of the six sites from October to November 2010 (the end of the pilot coincided with the end of the CIDA Nutrition Project). Two days before starting SFP MRP pilot, CARE staff engaged in community mobilization and government partners to inform them of pilot and increased reporting and monitoring requirements. SFP teams divided up the different tasks required for the pilot such as a measurer, data recorder, crowd controller, etc. Each team had access to one vehicle to conduct activities in each of their assigned sites. Teams reported that one vehicle was enough for their purposes due to low SFP beneficiaries (as compared to months prior) and shorter distances between sites; however more than one vehicle (for two sites) may be required in future in circumstances when the distribution sites are farther from the warehouses and if there are more beneficiaries expected at each site. This would have budget implications for the SFP nutrition response if more vehicles are required.

On service days in October and November each team traveled to their distribution site and commenced SFP screening and distribution as per the MRP guidelines. Each team took an average of two days to complete the service round for one distribution site. The team based at the main town in the woreda (Kurfachelle) and transported commodities to their respective distribution sites every morning. All members met every morning prior to departure to distribution sites to share lessons and challenges face at the SFP sites using the MRP. SFP teams also used the opportunity of SFP distribution to transfer key messages about the SFP program, proper use of Famix and oil, family planning, and healthy nutrition and child caring practices.

To give an overview of the effort required to implement SFP activities under the SFP MRP Pilot as compared to the regular method used by CARE in other SFP interventions, the following comparative summary is provided.

### **Human Resources (HR):**

- Normally (pre-pilot) screening is conducted in advance by GoE HEWs so only one food distributor, one Community Facilitator (CF) and one storekeeper is needed for the SFP distribution.



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- In order to implement the SFP MRP properly, five staff members are required on site to screen, admit, record, and distribute (one distributor, two data recorders, two measurers). This has obvious implications for implementing agency budgeting.

**Logistics:**

- Normally, only one vehicle is needed to mobilize target communities about the SFP program and there were less distribution sites. Because the screening is usually completed by GoE before service days, beneficiaries come to the CARE store/warehouse site to collect rations. This created problems with attendance and targeted beneficiaries would sometimes send other people to pick up their food and then it meant that the whole distribution could take longer.
- For this Pilot, CARE required three vehicles (one per team) to implement at six SFP sites. This extra logistics requirement also has budgetary implications for SFP implementation.

**Time:**

- Normally, it takes four to five days for distribution at one site because the sites are usually farther apart and the GoE screening and information system is limited so beneficiaries take longer to receive the information and CARE must wait for all to arrive for their rations.
- It took two days per service rounds per site for the pilot period.
- Even with the extra level of effort required, it is more efficient in terms of time for CARE to undertake both screening and distribution activities for SFP.

## 2.3 Data Entry and Reporting

On each service day, the SFP teams recorded all beneficiary data in on the patient cards and in the registration book. At the end of each service day, the team transferred the data from the registration books (separated by treatment groups) into the tally sheets (also separated by treatment groups). At the end of the service round, the SFP teams compiled all information from all treatment groups into one statistical report for each site. These reports were sent to the EH Nutrition Officer (who acted as Coordinator of the pilot at the field level) where he cross checked the data and entered into the MS Excel documents for each site. The Excel sheets, copies of the completed reporting formats, and a narrative summary of the round were sent to the SFP MRP Pilot Manager in Addis. The SFP MRP Manager reviewed all excel reports, crosschecked data with the hard copies and imported all site data into the software with program data. This process was completed twice for each of the SFP MRP rounds.

## 2.4 Closing Meeting

On December 7th, 2010, the SFP MRP Pilot Manager traveled to the EH FO to hold a closing meeting with the EH Nutrition Officer (who acted as Coordinator of the pilot at the field level) as well as five other SFP MRP pilot implementing staff who still

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remain at CARE since the close of the CIDA Nutrition Project on November 30, 2010. At the meeting, the team reviewed the completed reporting outputs (registration books, tally sheets, statistical reports) for all sites. The team also discussed different strengths and challenges associated with the SFP MRP guidelines, reporting formats, and implementation in the local Ethiopian context. The field staff forwarded recommendations which the SFP MRP Pilot Manager recorded for this report. Finally, six staff completed an evaluation of the pilot, created by the SFP MRP Pilot Manager. The results of this evaluation are summarized in the section below entitled “Evaluation Results” while Annex A provides a copy of the evaluation format.

### 3. Successes

SFP field staff reported that using the SFP MRP system led to increased accountability and supervision of program. The formats and the books were well designed (except for the different aspects outlined in recommendations. Overall, they were easy to use. The tally sheets are especially good, as CARE Ethiopia staff had not encountered such a tool before. Having one registration book was also good (usually there is a registration book and follow up sheets that are separate and there is more chance for error when transferring the data). This made the workload to compile data easier; previously they did it on paper and then transferred it.

The data collection was very successful in terms of accuracy and consistency. The field level SFP MRP Pilot teams met all deadlines as per the pilot plan. All team members were satisfied using this system; however the pilot period was very short. Ideally, this should have been a longer period, but given the limitations of time, the pilot was very successful.

Key comments provided at the closing meeting in December by the pilot implementing field staff on the strengths of the SFP MRP Pilot are summarized below.

- The MRP system is very good and an ideal format for SFP because it is a targeted program in which the targeted beneficiaries are appointed to come to an identified area and the skilled SFP staff take all the necessary screening data which minimizes inclusion and exclusion errors. Previously, the Government Health Extension Workers (HEW) are the ones responsible to screen the beneficiaries (and CARE sometimes finds inappropriate beneficiary errors as a result).
- Another aspect is that the pilot was really designed to minimize risks of beneficiaries worsening from MAM to SAM because the pilot followed a very tight schedule and allocated proper logistics. The teams received good orientation to the MRP and delivered all SFP services as per the planned schedule.
- The main advantages of using this system is that normally in SFP in Ethiopia, targeting is performed by GoE and the implementing agency receives the beneficiary lists and payment sheets. The targeting and distribution are normally very far apart (up to a month) which leads to risks. Also, the information doesn't often reach all beneficiaries and CARE had to wait up to 5 days to finish distribution in only one SFP site. There is often confusion over the beneficiaries (even mothers

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## Annex 4

forget their names given at the GoE screening). In this SFP MRP pilot, CARE performed the targeting and distribution on the same day which means there is no confusion and all beneficiaries receive food immediately when they need it.

- The pilot organized teams from different backgrounds (health, nutrition, etc) which meant that the teams were well balanced and positioned to deliver SFP services.

## 4. Challenges

### 4.1 Community Buy-In

During community mobilization for the SFP MRP Pilot, the field level SFP teams explained the pilot MRP system to all target communities and Government counterparts of Kurfachelle woreda. However, when people came to be screened and did not meet the admission criteria, they were very unhappy (because this is different than the regular GoE screening system) because they had expectations and had travelled far to the site. In the GoE system, beneficiaries are screened and admitted at a separate time, so when they arrive on distribution day, they are guaranteed to receive services. Some women would claim (without proof) that they were pregnant to try to get assistance. The Government staff also encouraged people (who were not in CARE's treatment groups) to go to the screening and distribution, but they were not admitted because they did not meet the criteria and then were displeased and distressed.

### 4.2 Long Term Sustainability

Sustainability of the SFP MRP (past a pilot into all regular SFP interventions) would be very challenging because the GoE has standardized this SFP system and performs the screening (every 3 months with all kebeles in one woreda screened on the same day) and then gives implemented NGOs payment sheets and beneficiary lists prior to distribution day (it can be up to a month between screening and distribution).

CARE makes large efforts to oversee this screening process, but it's not possible to closely oversee all screening and the organization has little control over inclusion/exclusion errors. CARE does make complaints in the case of identified inclusion/exclusion and provides lots of capacity building to GoE staff to help them target correctly.

To implement this pilot, CARE consulted with the woreda and zonal Government Health Offices and the Disaster Prevention Preparedness Commission (DPPC) office and included representatives in the SFP MRP orientation training. If a partner wants to implement this SFP MRP system at scale in future projects (more than a pilot), major negotiation and consultation (including at the regional level) would be required which may or may not be successful. Based on extensive experience operating nutrition programs, CARE EH field staff think it would be quite difficult to convince the GoE to allow this system to be implemented at scale. The humanitarian context in Ethiopia is very complex and the GoE asserts close control over NGO humanitarian projects and nutrition targeting.

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If there were no issues related to obtaining GoE permission, the system would be sustainable and the staff feel confident that they could maintain the recording and organization of data as required by the system. However, the sites would be increased (CARE only piloted in one district) and therefore extra time would be required for inputting data. This would be feasible if the donor would provide the budget required for the extra level of effort (HR, logistics) required.

## 5. Recommendations

The following are comments and recommendations on the SFP MRP guidelines, reporting formats and software.

### 5.1 SFP MRP Guidelines

- The guidelines should include the discharge/admission criteria for different patient groups. Since this is country specific, it was suggested that there be a blank page allocated for this that staff could fill in this information. This would make the book a useful reference for field level implementers.
- The guidelines should include reference for procedures for preparing SFP foods.
- The guidelines should include a Weight for Height (WFH) chart should be added for all age groups (standard median WFH).
- The guidelines should list all materials required to conduct the SFP MRP program such as weight scales, etc.
- Overall, the guidelines were very clear in terms of content and easy to refer to, self explanatory for an educated professional with a good English capacity, however CARE may face issues if the GoE staff and Community Nutrition Volunteers who do not speak English well were to use the guidelines. Staff suggest that it would require translation if the SFP MRP were to be rolled out on a mass scale
- The guidelines should provide explanation on p.10 about treatment groups in SFP – what category do PLW or children under five be recorded into if they also have a chronic disease? This should be unpacked further in the guidelines.

### 5.2 Registration Books

- The book rows and columns is far too congested and does not have enough space to record all information, this was very difficult for staff (they addressed this problem by using multiple rows for one beneficiary).
- There should be different book formats for different treatment groups PLW/Children under five (for PLW there should be a column to note how long she has been pregnant or lactating) – this could be recorded in the “notes” column, but this risks being easily overlooked.
- There should be space to note whether it is an OTP/SC transfer or medical transfer. It is too complicated to have another separate sheet for OTP transfers.
- A space to record the date in the “weeks” column should be added in addition to just the admission date
- Space should be added to specify age by year and month for children under five.

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- The “address” column should be clarified to indicate what needs to be stated (town, house #, etc).
- MUAC (Measurement of Upper Arm Circumference): there is no column in the registration books, this definitely needs to be added as most beneficiaries are admitted by MUAC
- One point raised was about Pregnant and Lactating Women – if they are admitted as pregnant and then give birth and cannot come, but are not defaulters, how should this be recorded? This should be explained in the MRP guidelines.

### 5.3 Tally Sheets

- There is no column for OTP/SC transfers. The team didn’t experience these cases because it was a very short period, but in future such a column should be created in all formats.
- For the “Location”, this should be more specific in terms of what specifically should be indicated (such as district or village).
- After one round if a beneficiary is absent, there is no space for recording that absence. This should be added since one absence is not considered as a defaulter (CARE just recorded these cases as “defaulter non-confirmed” for pilot purposes).
- The total at beginning of each service round should only be written once or it is confusing (on the current tally sheet format there are boxes to fill in the total at the beginning of each service day which led to confusion and risk of double counting). Also, the “total” at the end of service round should also be written once as well otherwise there could be mistakes in data and double counting if all boxes are added up.

### 5.4 Statistical Reports

- In the bottom table for calculating rates, there should be separation of transfer medical and transfer the TFP (OTP/SC) otherwise it does not accounting for all transfer types
- There should be a column for absences (before beneficiaries are considered defaulters) as well as a column for moved in from TFP (OTP/SC).

### 5.5 SFP MRP Software

- The software was fairly user friendly and straightforward, however the guidelines for software instruction should be clearer, especially if this is to be used by field staff without extensive expertise using computers and information technology.
- For example, the SFP MRP Manager faced issues importing excel sheets because of a simple error – the month was written in word form instead of number form. The software should have a function that actually explains the error if it cannot import a excel report, so the user is aware of the specific problem.
- It was challenging to calculate the average length of stay and weight gain especially when the percentage of cured beneficiaries is quite high. The software should include a function to calculate average weight gain and length of stay.

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## 6. Evaluation Results

A backup file of the CARE Ethiopia SFP MRP database software is provided with this report for ENN's review and reference.

The SFP MRP Pilot Manager (Alix Carter) developed an evaluation to give to EH field level implementing staff on the SFP MRP guidelines and reporting formats. Since the CIDA project closed on November 30, 2020 and the closing meeting was held on December 7th, 2010, only six of the SFP staff are still with the organization and filled the evaluation. Below are a summary of the results. For a copy of the evaluation form, please see Annex A.

- 100% of evaluation participants reported that SFP MRP pilot met the overall objectives of improving quality and organization of SFP data.

Out of a scale of 1-4 (1=Not at all; 2=Partly; 3=Mostly; and 4=Completely) evaluation participants rated agreement with the statements shown in the two tables below.

**Table 1: SFP MRP Evaluation Summary 1**

Statement	1 = Not at all	2 = Partly	3 = Mostly	4 = Completely
The introduction and explanation of the SFP MRP materials (guidelines and reporting formats) were clear:			66.66%	33.33%
The SFP MRP guidelines were easy to understand and refer to throughout the pilot period		16.66%		83.33%
The reporting formats (registration books, tally sheets, etc) were user friendly:			33.33%	66.66%
The reporting formats were appropriate for the local context.			83.33%	16.66%
I found that the SFP MRP system was useful in improving the quality of data for CARE's SFP				100%
I think that this system would be sustainable in future SFP interventions.			16.66%	83.33%
I will apply what I have learned from the SFP MRP pilot to my daily work			66.66%	33.33%
I would recommend this system to implementation partners and other humanitarian actors providing SFP.				100%

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## Annex 4

**Table 2: SFP MRP Evaluation Summary 2**

Agreement with this statement: <i>"The activity was easy to implement without any issues/challenges"</i>				
Activity	1 = Not at all	2 = Partly	3 = Mostly	4 = Completely
Informing and receiving endorsement from implementing partners (Government counterparts) about the new SFP MRP system and pilot		33.33%	16.66%	50%
Screening beneficiaries using the SFP MRP guidelines and protocols			33.33%	66.66%
Recording all required information on beneficiary cards			33.33%	66.66%
Recording all required information in the registration book		16.66%	50%	33.33%
Recording data into the tally sheets at the end of the service day			16.66%	83.33%
Recording data into the statistical report at the end of the service round			16.66%	83.33%
Following up with SFP absences/defaulters as per the SFP MRP requirements		50%		50%

## 7. Financial Expenditure

This is a draft expenditure report for the pilot period (August-December 2010). Due to CARE's financial system, the December finance report will not be finalized until early January after the month of December accounts are closed. This is a draft expenditure report based on August-November confirmed expenditure. ENN can request that CARE send a final expenditure report in January if required. The total expenditure for the pilot will not exceed the provided budget of \$4,000 USD.

**Table 3: SFP MRP Budget Expenditure, Aug-Nov 2010**

Description	Estimated Cost (USD)	Actual Expenditure
Staff Time for Humanitarian Accountability Advisor (Alix Carter)	Approximately \$300 per month for 5 months (August - December 2010) – total \$1,500 <sup>3</sup>	September: \$612.44 October: \$384.88 November: \$384.87 Tax on Salary: \$172.32 December: this will be charged at end of December (with the remaining funds in account)
Reporting materials (registration books, tally sheets, and SFP patient cards)	\$500	\$500.04
Training and Closing Workshop costs (including travel from Addis to Pilot area of SFP lead staff and meals and lodging of participants)	\$1,000	Training in Sept 2010: \$575  Closing Meeting in Dec 2010: expenses not reflected yet
Field Expenses for implementation in Oct-Nov	\$1,000	\$955
<b>Total</b>	<b>\$4,000</b>	<b>\$3,584.55</b>

<sup>3</sup> Since the funds were not transferred until September 2010, the costs for salary were dispersed and charged from Sept-Dec which also includes August costs for staff time.

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## Annex 4

### 8. Conclusion

CARE Ethiopia thanks ENN for extending the opportunity to be a part of this important initiative. The SFP MRP system is positive step to improving the data management and report quality of SFP programs which in turns leads to greater evidence of impact and accountability to our stakeholders. Please keep CARE Ethiopia informed of updates and changes to the SFP MRP as it is further refined and rolled out on a global level.



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## Annex 4


## Annex A: SFP MRP Evaluation Form

A copy of the evaluation form developed for the SFP MRP pilot is shown below for ENN's reference.

**EVALUATION OF THE SUPPLEMENTARY FEEDING PROGRAM  
MINIMUM REPORTING PACKAGE (SFP MRP) PILOT**


**East Hararghe Zone, Ethiopia. Dec 7, 2010**

Emergency Nutrition Network (ENN) is interested in having your feedback about the SFP MRP Pilot. Please take a few minutes to rate the following items.

 **SFP MRP Pilot Objective:**

**The SFP MRP pilot:**

- Successfully met the overall objectives of improving quality and organization of SFP data.
- Failed to meet the overall objectives of improving quality and organization of SFP data.

 **SFP MRP Guidelines and Reporting Formats:**

Please rate each of the following aspects of the SFP MRP orientation (training) and guidelines. Circle the number that indicates how much you agree with each statement.

1 = Not at all
2 = Partly
3 = Mostly
4 = Completely

The introduction and explanation of the SFP MRP materials (guidelines and reporting formats) were clear.	1 2 3 4
The SFP MRP guidelines were easy to understand and refer to throughout the pilot period.	1 2 3 4
The reporting formats (registration books, tally sheets, etc) were user friendly.	1 2 3 4
The reporting formats were appropriate for the local context.	1 2 3 4

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## Annex 4

 **Content**

Please rate the success on each of the following items related to pilot implementation. Circle the number that indicates how much you agree with the following statement.

1 = Not at all	2 = Partly
3 = Mostly	4 = Completely

**The activity was easy to implement, without any issues/challenges**

Informing and receiving endorsement from implementing partners (Government counterparts) about the new SFP MRP system and pilot

1	2	3	4
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Screening beneficiaries using the SFP MRP guidelines and protocols

1	2	3	4
---	---	---	---

Recording all required information on beneficiary cards

1	2	3	4
---	---	---	---

Recording all required information in the registration book

1	2	3	4
---	---	---	---

Recording data into the tally sheets at the end of the service day

1	2	3	4
---	---	---	---

Recording data into the statistical report at the end of the service round

1	2	3	4
---	---	---	---

Following up with SFP absences/defaulters as per the SFP MRP requirements

1	2	3	4
---	---	---	---

 **Future use**

Circle the number that indicates how much you agree with each statement.

1 = Not at all	2 = Partly
3 = Mostly	4 = Completely

1. I found that the SFP MRP system was useful in improving the quality of data for CARE's SFP

1	2	3	4
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2. I think that this system would be sustainable in future SFP interventions.

1	2	3	4
---	---	---	---

3. I will apply what I have learned from the SFP MRP pilot to my daily work

1	2	3	4
---	---	---	---

4. I would recommend this system to implementation partners and other humanitarian actors providing SFP.

1	2	3	4
---	---	---	---

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## Annex 4

### COMMENTS

Please give any suggestions you have for future versions of the SFP MRP guidelines and reporting formats.

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Thank you for participating in the SFP MRP Pilot and for your valuable feedback.

## **Annex B: SFP MRP Pilot Tally Sheets and Statistical Reports for CARE Ethiopia**

Please see the attached PDF sent with this report to review scanned copies of the October and November tally sheets and statistical reports for each of the six SFP sites that implemented the pilot in Kurfachelle Woreda, East Hararghe Zone.

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## Annex 5a

## Annex 5a: Second set of recommendations for change to the guidelines post pilots and trainings

*Comment boxes reflect instructions from principal consultant.*

### Programme and Context Characteristics

These are the new items for the Programme and Context characteristics. They are based in the previous ones, with some changes. The comments on the side refer to formatting.

Each section should be in a different tab (sometimes in two tabs).

The other change to Programme and Context Characteristics is that we need them 1) at the Data Enter group (where it is now, where it can be modified), and 2) at the Report group, where it should appear as a document with formatting that can be copied into a report – but not modified.

- |   |   |                |   |
|---|---|----------------|---|
| <p><b>A.</b> General programme information</p>  | ← | 20/10/11 10:00 | Comentario [2]: All these items already exist. Each of them to be 3 lines, except when noted.                                     |
| <p>1. Location</p>  | ← | 20/10/11 10:00 | Comentario [3]: Only one line – the details of this are already in the formatting of the database.                                |
| <p>2. Summary description of the crisis</p>   |   |                |   |
| <p>3. Summary description of population</p>   |   |                |   |
| <p>4. Main causes of malnutrition</p>   |   |                |   |
| <p>5. Rational and objectives</p>   | ← | 20/10/11 10:00 | Comentario [4]: Leave on 4 lines.   |
| <p>6. Funding sources</p>   | ← | 20/10/11 10:00 | Comentario [5]: Only one line.  |
| <p><b>B.</b> Activities</p> <p>Note to user: Enter here only relevant information, preceded by the date. When updating information, please precede each change by the date in which it happened and order events in inverse order (newer events first).</p> | ← | 20/10/11 10:00 | Comentario [6]: Each of these to be 3 lines. 11 to 13 to be 5 lines – This means that they may need to be set in a different tab. |

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## Annex 5a

7. Summary description of General ration
8. Summary description of other nutrition interventions
9. Summary description of health programmes
10. Summary description of livelihood programmes
11. Major events – with dates
12. Main problems faced by the programme – with dates
13. Summary of main threats to performance

## C. Protocols

14. Criteria for admission and discharge – table ← 20/10/11 10:00  
Comentario [7]: See table 1., below.

15. Criteria for admission and discharge – comments ← 20/10/11 10:00  
Comentario [8]: 3 lines

16. Frequency of distributions (Wet/Dry) ← 20/10/11 10:00  
Comentario [9]: One line.

17. Summary description of medical protocols ← 20/10/11 10:00  
Comentario [10]: Four lines.

18. Basic description of programme procedures (registration, community mobilisation, health education and cooking demonstrations, home visiting and defaulter follow up, integration with health centre or other activities, etc.). ← 20/10/11 10:00  
Comentario [11]: 6 lines.

D. Products distributed ← 20/10/11 10:00  
Comentario [12]: See Table 2.

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## Annex 5a

**Table 1. Admission criteria for Targeted SFP and Individual Nutritional support.**

Treatment group	Criteria 1		Criteria 2		Criteria 3	
	Indicator	Threshold	Indicator	Threshold	Indicator	Threshold

**Table 2. Products distributed. (If all treatment groups receive the same products, write the product only once).**

Product	Programme type	Treatment group	Amount per distribution	Amount per day	Manufacturer	Supplier	Premixed (Y/N)*

\* TSFP, INS or BF.

\*Mark those products that are mixed together with a similar number (1, 2, etc.)

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## Annex 5b

## Annex 5b: Additional tables: part of second set of recommendations for change to the guidelines

Mortality surveys												
Description						Results						
Date	Country	Region	Area covered	Sampling	Total sample	Clusters	CMR	CMR CI	U5MR	U5MR CI	U5MR CI	Comments
1												
2												
3												
4												

Nutrition surveys															
Description						WHZ			MUAC						
Date	Country	Region	Area covered	Sampling	Total sample	Clusters	MAM Rate	CI	SAM Rate	CI	MAM Rate	CI	SAM Rate	CI	Comments
1															
2															
3															
4															

Coverage surveys								
Description								
Date	Country	Region	Area covered	Sampling	Total sample	SFP programme	Point coverage (%)	Period coverage (%)
1								
2								
3								
4								











