Process Review of the Community Therapeutic Care (CTC) Advisory Services (CAS)

February 2006 - January 2007

Concern Worldwide Malawi

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Nutrition Policy and Practice

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Photo: Concern Worldwide: CAS Learning Forum 2 on referral networks: Observing registration during site visit to an OTP site

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Acronyms

CTC	Community Therapeutic Care	OFDA	Office of Foreign Disaster Assistance
CAS	CTC Advisory Services	OTP	Outpatient Therapeutic Program
DHO	District Health Office	POA	Plan of Action
HDMT	District Health Management Team	PD	Positive Deviance
EHP	Essential Health Package	QECH	Queen Elizabeth Central Hospital (Blantyre)
GMP	Growth Monitoring and Promotion		
HBC	Home Based Care	RUTF	Ready to Use Therapeutic Food
HMIS	Health Management Information System	SAM	Severe Acute Malnutrition
HSA	Health Surveillance Assistant	SC	Stabilization Center
HTC	HIV Testing and Counseling	SWap	Sector Wide Approach
IMCI	Integrated Management of Childhood Illness	SFP	Supplementary Feeding Program
		ToT	Training of Trainers
NRU	Nutrition Rehabilitation Unit	TFC	Therapeutic Feeding Center
MSF	Medicins sans Frontières	WHO	World Health Organization
MSH	Management Sciences for Health	WFH	Weight for Height
MoH	Ministry of Health	WFP	World Food Program
MUAC	Mid Upper Arm Circumference		

Summary

Concern Worldwide (CWW) consultant, Caroline Tanner, visited Malawi from March 19 to March 31, 2007. The purpose of the visit was to conduct a process review of the Community Therapeutic Care (CTC) Advisory Services (CAS). The review team included representation from the Ministry of Health (MoH) and Valid International. The objectives of the review were to: Look at the performance of CAS in the first phase (February 2006-January 2007); highlight issues and identify gaps and to make actionable recommendations on how CAS should move forward in the next phase.

In 2006 the MoH in Malawi adopted CTC as a national strategy for managing acute malnutrition, and initiated a scale up plan for CTC. The scale up of CTC in Malawi created a demand for technical support and the need for standardized guidelines, protocols, training and tools. CAS was formed in early 2006 to attempt to respond to these demands and needs. CAS is a joint Concern Worldwide and MoH project. The first year of CAS was funded by USAID/OFDA. The purpose of CAS is to provide technical support for scaling up CTC in Malawi over a five year period. CAS aims to build capacity of policy makers, health service providers and communities to effectively treat severe malnutrition. CAS has four Intermediate Results (IRs); Training and technical support; partnership development and mentoring; documentation of best practice and policy and analysis. CAS has faced some significant challenges in the operating and policy environment including; a lack of skilled health staff; high staff turnover and the erratic availability and high cost of Ready to Use Therapeutic Food (RUTF). Furthermore, the implementation of CTC in non-emergency settings and integration into existing health services is a new experience. There is limited documented experience and a dearth of appropriate tools and materials. To this extent, CAS is on the cutting edge and as such, the first year of CAS was has been a sharp learning curve. CAS has needed to test the waters and get its feet wet.

Progress made by CAS in the first year is somewhat difficult to align with the original objectives. Strategic Objectives and IRs are not clearly defined or easily measurable. In order to determine progress it was necessary to rely primarily on anecdotal reports. CAS made substantial progress in 2006 in training and support for districts in the planning process for the District Implementation Plans (DIPs). CAS provided initial or refresher training for 420 health staff in 13 districts thus exceeding original target of training support to 8 districts. In collaboration with the MOH, CAS identified and initiated training for 25 staff as national trainers in CTC. CAS has not yet developed a means of measuring the impact of training. Thus the extent to which the provision of CAS technical support and training is directly or indirectly affecting the quality of CTC programming is difficult to quantify. Anecdotal evidence from NGO partners and DHO's suggest that the training and support from CAS has translated into better quality CTC programming. However, DHO staff noted that while the training provided by CAS was beneficial, support from CAS needed to be continued over time with a period of sustained mentoring following set up of CTC.

CAS has developed a set of draft training materials. In addition to the training course materials, there is a need to develop a package of tools. The training materials and tool package will need to be reviewed by relevant stakeholders and pilot tested.

CAS has provided technical support to DHO's in the planning process for the DIPs. During the review this support from CAS was frequently noted as highly useful, timely and relevant. Of particular note was support provided by CAS on the DIP budgets to incorporate operational costs for CTC (including RUTF procurement) under the Sector Wide Approach (SWap).

CAS has been instrumental in the drafting of the interim national guidelines for the management of acute malnutrition through community based care. Wide dissemination of the interim national guidelines will enable CAS to harmonize and standardize the use of criteria and protocols for CTC and this should make training much easier.

CAS has established relationships with five NGO partners and two DHO partners. In theory, TORs and organizational plans are established with the partners. However, this is not systematic, making planning difficult. There is a need for CAS to develop a package of services

and a template for operational agreements with partners. Some DHO's interviewed during the review were unclear about the role of CAS and what services CAS provided.

CAS has succeeded in raising awareness. CAS facilitated exchange visits for DHO and NGO staff from districts preparing to start CTC to districts where CTC has been ongoing for some time. These on-site visits afforded DHO staff the opportunity to learn directly from their counterparts. CAS initiated the CTC Learning Forum. The Learning Forum takes place quarterly and aims to present and discuss developments in CTC. The Learning Forums are well attended. During the review, many of those interviewed cited the Learning Forum as a good way of bringing together key stakeholders to share experiences, to learn about relevant research, recent international policy and current best practice and lessons learned. To date four Forums have taken place.

Key issues and gaps include:

- Lack of clarity regarding the role and mandate of CAS including the role of the CTC Steering Committee. At present the CTC Steering Committee is tasked with management oversight of CAS but is not active.

- CAS has no strategic plan making planning difficult and progress against objectives difficult to track.

- Staffing gaps have made it difficult to provide technical support in some areas, notably monitoring and evaluation. The CAS program manager will be leaving in August 2007 leaving a significant gap.

- Gaps in the provision of technical support. There is a significant unmet need for technical support for streamlining data collection at health center level and in data collection and analysis at district level. This was not initially planned in the first year of the CAS project, and has been included in the proposal for 2007-08.

- Gaps in policy and advocacy include the need to harmonize various national nutrition and child health policies and indicators to align them with interim national guidelines and the need to test and document linkages between CTC and the Integrated Management of Childhood Illness (IMCI); Essential Nutrition Actions (ENA), HIV services, and prevention services such as Growth Monitoring and Promotion (GMP) and Positive Deviance/Hearth.

- Research is not a comparative advantage of CAS and is not an effective use of resources. Rather than carry out detailed research studies, CAS should pilot test and document the experience of integrating CTC into routine health services, highlight grey areas that may require research and use current and available research for practical purposes such as revising protocols, adapting the guidelines and informing training materials.

- Documentation in general is a weak area. CAS has not yet taken the opportunity to make the Learning Forum reports more widely available through publishing in practitioner and/or peer reviewed journals

The review team strongly supports the continuation and strengthening of CAS. Following the first year of operations, CAS is well placed to develop a three year strategic plan. Specifically CAS should:

- Clearly define its role and mandate. CAS is intended to be a technical arm of the MoH. CAS should be physically located within the MoH. This will facilitate joint work plans, meetings and operations. CWW will continue to support CAS administratively and financially. CAS should develop a revised brochure clearly outlining its mandate, purpose, package of services offered and how services can be accessed.

- Diversify the external donor funding base. Support should be sought from donors with an interest in funding CAS as a multi-year project. A proposal for funding should be developed

(following development of the strategic plan). This will allow CAS and the MoH to plan effectively over three years. External funding will be channeled through CWW.

- In collaboration with the MOH, stakeholders and the Clinton Foundation, develop a Plan of Action (POA). The POA will include: mapping ongoing and planned CTC programs; a roll out plan for CTC including the roll out of RUTF emphasizing a phased approach; planning for crisis situations and how the MoH will respond if DHO capacity to implement CTC as part of routine health services is exceeded. This will include the role of CAS in crisis situations.

- Develop a strategic plan for CAS. The strategic plan should lay out areas of focus for CAS and include specific objectives and immediate results aligned with measurable indicators. The strategic plan should detail activities for the first year under the strategic plan (2007-8) and provide a detailed outline for activities planned beyond that (2008-10). This will allow CAS to plan effectively, measure progress against objectives and will provide the basis for proposals and reports to prospective donors.

- The roles and responsibilities of the CTC Steering Committee must be defined. The CTC Steering Committee should oversee the mandate and operations of CAS (including the CAS strategic plan) and determine and delineate roles and responsibilities in the scale up of CTC.

- Staffing issues must be immediately addressed including the recruitment of a new Programme Manager for CAS. The composition of the CAS team must be re-thought to fit the key focal areas under the strategic plan. This will involve shifting responsibilities within the team according to skills and expertise.

- Finalize package of tools and pilot test their use. The package will include: a template for the DIP, guidelines for budgeting CTC activities under the DIP; examples of how to calculate estimated numbers of beneficiaries and RUTF needs; supervisory checklist for use in integrated supervisory visits and standard reporting formats.

- Strengthen documentation and dissemination. The outcomes and reports from the Learning Forums should be published in practitioner journals such as Field Exchange. The experience of integrating CTC into the existing health system and direct implementation of CTC with DHOs should be written up.

- Organize a workshop/technical meeting in late 2007 on the theme of direct MoH implementation of CTC. The workshop will include MoH representation from Ethiopia, Kenya, and Zambia where attempts to integrate CTC into existing health systems are ongoing. The outcomes of the workshop should influence the global agenda on the management of severe acute malnutrition including the development of training materials, tools and the second edition of the international CTC manual.

- Produce 2-3 page progress/update reports every quarter which clearly present what has been done to date and how it has been measured. This should be presented at coordination (TNP) and Steering Committee meetings and used for donors and other stakeholders.

- A full external evaluation of CAS should take place in 2008.

1. Introduction

Concern Worldwide (CWW) consultant, Caroline Tanner, visited Malawi from March 19-31 March, 2007. The purpose of the visit was to conduct a process review of the Community Therapeutic Care (CTC) Advisory Services (CAS). The objectives of the review were to:

- Assess the performance of CAS in the first phase (February 2006 -January 2007).
- Highlight issues and identify gaps.
- Make actionable recommendations on how CAS should move forward in the next phase.

During the 12 day visit, meetings were held with the CAS team, Concern Worldwide staff, Ministry of Health (MoH), Office of President and Cabinet/Nutrition, HIV and AIDS (OPC), UNICEF, WFP, Baylor Clinic, the College of Medicine, Valid International, Valid Nutrition, Clinton/Hunter Foundation and USAID. Meetings were also held with NGOs and with District Health Offices (DHOs), District Health Management Teams (DHMT) and implementing partners who have received training and/or support from CAS including: Management Sciences for Health (MSH), Concern Worldwide, GOAL, Concern Universal, Lilongwe DHO, Dowa DHO, Blantyre DHO, Machinga DHO and Dedza DHO. Site visits were made to Area 25/Lilongwe health center to visit an outpatient therapeutic program (OTP), Dowa District Hospital NRU and to Moyo House NRU (Queen Elizabeth Central Hospital).

The itinerary and list of key contacts can be found in Annex 1.

During the review partners and stakeholders were canvassed (through discussion and interview) to determine the progress CAS has made to date. This report notes the key findings from the review. Specifically it notes progress made by CAS during the first phase (year one), highlights issues and gaps and outlines recommendations for the next phase (3 years). The report is organized around the following areas:

- Background and operating context
- Progress against objectives
- Key issues and gaps
- Recommendations for the next phase

The review was intended to be participatory and to include participation of the Ministry of Health and Valid International. Emmanuel Mandalazi from Valid International participated in several of the meetings during the review. Sylvester Kathumba, District Nutritionist from Dowa represented the Ministry of Health and participated in the visit to Blantyre. Their inputs are represented in this report. Due to limited time and availability of staff, it did not prove possible to see the CAS team providing training or technical support in action.

Several debriefings were held with USAID, major stakeholders, the CAS team and CAS partners.

2. Background

Concern Worldwide and Valid International in collaboration with the Ministry of Health began piloting the community-based therapeutic care (CTC) approach in Malawi in Dowa and Nkhotakota districts in 2002. CTC is comprised of four components; Supplementary feeding for children with acute moderate malnutrition without complications; Outpatient therapeutic program (OTP) for severe acute malnutrition (SAM) without complications; inpatient care (also known as Stabilization Centers) for acute malnutrition with complications and community mobilization and outreach. The majority of severely malnourished children can be successfully treated at home in the CTC approach. This differs markedly from the traditional standard of care in Malawi in the Nutrition Rehabilitation Unit (NRU). Traditionally all severely malnourished children, irrespective of whether they had complications, were kept in an NRU as inpatients for the course of treatment. This resulted in poor access, low coverage, high default and high mortality rates.

CTC proved to be very successful in Malawi resulting in much better access and coverage, low mortality rates and far fewer dropouts than the standard of care in the NRU. CTC is complementary to the existing NRU system. Severely acutely malnourished children without complications are treated at home in the OTP, while severely acutely malnourished children with complications are treated as inpatients in the NRU.[1]

The gap between the number of acutely severely malnourished children in need of treatment and the provision of services in the 95 NRUs in Malawi was stark. In 2005, UNICEF estimated 42,365 children with SAM were in need of treatment with less than 12,000 children accessing treatment in the NRUs. Thus there was a clear need to scale up CTC in Malawi and integrate the outpatient treatment of severe acute malnutrition into routine health services in an attempt to address the large gap in treatment and care for severely malnourished children. CTC began to be taken up by additional NGO partners in Malawi in 2004/5. When CAS was established at the beginning of 2006, CTC implementation was ongoing in 2 districts, and had been recently started in a further 7 districts. Several NGOs initiated CTC programs as a result of the 2005/6 food crisis.

Table 1: CAS baseline: CTC implementation in Malawi (February 2006)

District	Organization
Balaka, Mzimba, Salima	MSH*
Dowa**, Nkhotakota**, Nsanje, Lilongwe	CWW
Dedza	Save the Children (US)
Mangochi	Save the Children (US)

* Piloting 1 center per district
** CWW-supported CTC programs started in 2002

In 2006, the MoH in Malawi adopted the CTC approach as a national strategy to managing severe acute malnutrition and spearheaded the scale up of CTC throughout Malawi. CTC is currently being implemented in 12 districts.[2] Seven districts are planning to scale up CTC in 2007.[3] These districts were chosen for scale up based on prevalence of acute malnutrition, vulnerability, capacity to respond and the presence of a supporting NGO partners. Two districts (Karonga and Machinga) were targeted by the MoH for direct DHO implementation (without the support of an NGO). These districts were chosen because of their capacity to successfully implement other programs such as EPI and TB control. In districts where there is no NGO support, the DHMT will be responsible for the overall management of the CTC program including the procurement and distribution of RUTF. The management of acute malnutrition has been included in the Essential Health Package (EHP) in Malawi. The EHP is a basic package of free health services. In theory, this allows components of CTC to be incorporated into routine health services. This is also referred to as 'institutionalization of CTC'.

[1] WHO, UNICEF and SCN. Informal consultation on the community based management of severe malnutrition in children. Food and Nutrition Bulletin. Vol 27, No 3 (supplement). 2006.
[2] Districts currently implementing CTC: Nsanje, Lilongwe, Dowa, Nkhotakota, Mzimba, Salima, Mulanje, Balaka, Chikwawa, Thyolo, Dedza, Mangochi,
[3] District planning to start CTC: Machinga, Karonga, Neno, Mwanza, Chitipa, Chiradzulu, Blantyre

The scale up of CTC in Malawi created a demand for technical support, a need for standardized guidelines, protocols training and tools. CAS was formed in early 2006 to attempt to respond to these demands and needs. CAS is a joint Concern Worldwide and MoH project. Phase one of CAS was funded by USAID/OFDA.[4] A proposal for the second phase (Year 2: 2007-8) has been submitted to USAID for continued technical support for scaling up CTC, and additional funding is being sought from UNICEF for monitoring and evaluation activities.[5] Since CAS is supported by external donors, CAS services are free to NGO partners and DHOs.

The purpose of CAS is to provide technical support for scaling up CTC in Malawi over a five year period. CAS aims to build capacity of policy makers, health service providers and communities to effectively treat severe malnutrition. CAS has four Intermediate Results (IRs) as shown in Table 2.

Table 2: Strategic objective and intermediate results for CAS

Purpose: Reduction in mortality and morbidity due to severe acute malnutrition
Strategic Objective (SO): Improve effectiveness and quality of CTC implementation through provision of technical support
Intermediate Results (IRs) 1. Provision of training and development of training materials 2. Partnership support and mentoring 3. Documentation of best practice and lessons learned 4. Policy analysis and development 5. Research and development*

* The research component was included in the cost-extension proposal to USAID, but not in the original TOR with Ministry of Health

According to the Terms of Reference (TOR) agreed with the Ministry of Health CAS is mandated to: Develop a scale up plan for CTC; coordinate CTC activities; provide training and mentoring support to DHO's and other agencies starting new CTC programs in priority districts; develop standardized training materials and management tools for CTC programs and to support districts in their use; advocate for greater inclusion of CTC activities into routine health care services; provide network support, documentation and dissemination of best practices and lessons learned and support monitoring and evaluation. [6]

CAS has faced some significant challenges in the operating and policy environment including; a lack of skilled health staff; high staff turnover and the erratic availability and high cost of Ready to Use Therapeutic Foods (RUTF). [7] Furthermore, the implementation of CTC in non-emergency settings and integration into existing health services is a new experience and there is limited documented experience and a dearth of appropriate tools and materials.[8] To this extent, CAS is on the cutting edge and as such, the first year of CAS was has been a sharp learning curve and CAS has needed to test the waters.

[4] Concern Worldwide. CTC Advisory Services Malawi. Program proposal January-June 2006. Submitted to USAID/OFDA; Concern Worldwide/CTC Advisory Services. Application for a 5 months cost extension (August 1-December 31). Submitted to USAID/OFDA; Total OFDA budget $316,617 for year one (2006).
[5] Concern Worldwide. Support for scale up of CTC in Malawi through the CTC Advisory Service. Program proposal. February 2007-Janaury 2008. Submitted to USAID/OFDA. Total budget $ 421,130 plus $19.265 from UNICEF to cover an M and E position in CAS
[6] Terms of Reference for CTC Advisory Services Program, Concern Malawi. Ministry of Health, 7 February, 2006.
[7] RUTF is currently produced by Project Peanut Butter (a Nutriset Franchise) in Blantyre and Valid Nutrition in Lilongwe.
[8] CWW and Valid International are pilot testing direct district implementation of CTC in Ethiopia and Zambia

3. Progress of CAS in the first phase

Progress made by CAS in the first year is somewhat difficult to align with the original IRs. Strategic Objectives and IRs are not clearly defined or easily measurable. There are no clearly defined impact indicators for the IRs making it difficult to determine impact in concrete terms. In addition, CAS has responded to needs and requests outside of the original objectives. This includes training on Positive Deviance (PD/Hearth). At the same time, additional components, such as research were added under the cost extension. This component was not included in the TOR with the MOH. Clear progress reports and documentation of activities were difficult to access during the review and where available, progress against objectives was unclear. An attempt was made to align the Intermediate Results for CAS against outputs for the first phase of CAS. These are noted below and summarized in Annex 2.

CAS start up was delayed by late recruitment of key staff. The Technical Advisor joined CAS in September 2006. The need for a monitoring and evaluation specialist has been identified and is not yet filled. CAS currently has nine staff. See staff organagram in Annex 3.

Despite some setbacks and challenges, CAS has made significant progress in the first year. CAS has completed some activities ahead of schedule including the completion of the interim national guidelines and development of training materials.

3.1. Training and development of training materials

CAS made substantial progress in 2006 in training NGO partners and DHOs. CAS has conducted Training of Trainers (ToT) and provided direct training support on site for health workers and volunteers in 13 districts thus exceeding original targets of providing training support to 8 districts. CAS has provided training to 5 NGO partners and two DHOs. In collaboration with the MOH, CAS identified and initiated training for 25 staff from various districts as national trainers in CTC. The training is being conducted in phases. Phases I and 2 are complete. Phase 3, the ToT will be conducted following completion of the training materials.

CAS has supported initial and refresher trainings for 420 health staff involved in direct implementation of CTC at health center level in Thyolo, Blantyre, Dedza, Chiradzulu, Mzimba, Salima, Balaka, Mulanje, Chikwawa, Karonga, Nsanje and Lilongwe. CAS reportedly has provided mentoring support following initial training. In practice this appears to be ad hoc. Some on the job training has been provided where problems were identified. However this is not documented and is difficult to substantiate.

The impact of the training provided is hard to assess. A pre-training and post-training test is given to determine knowledge acquired during training. The results of the post-training test are reportedly good suggesting that the training itself is appropriate and good quality.[9] However, CAS has not yet developed a routine system of follow up or means of measuring the impact of training. Thus the extent to which CAS technical support and training is directly or indirectly impacting on the quality of CTC programming is difficult to substantiate. However, anecdotal evidence from NGO partners and DHO staff suggest that the training and support from CAS has translated into better quality and more effective CTC programming.[10] In Dedza, the DHMT noted that CAS support resulted in improved program quality and CAS advice on community mobilization had translated into far fewer drop outs and better coverage. Similarly the technical support provided by CAS allowed the DHO in Dedza to expand the number of health centers offering OTP services. [11]

On the whole, DHO and NGO staff noted that while the training provided by CAS was extremely beneficial, support from CAS needed to be continued over time with a period of sustained mentoring following set up of CTC. Several DHO's noted that the gap between the training provided by CAS and set up of CTC activities was significant and resulted in the need for

[9] Interview with CAS training team, March 30, 2007
[10] Personal communication: Margaret Khonje, Management Sciences for Health; Burton Twisa, Concern Worldwide Dowa;.
[11] Personal communication Harry Phiri, Nutrition Coordinator, DHMT, Dedza and Laurence Chakholomba, Concern Universal

repeated training at the time of set up thus wasting time and resources. This is partly attributed to the delay in RUTF availability from Clinton/Hunter Foundation.

CAS has developed a set of draft training materials. CAS experience in training during the first year has highlighted the need for training materials to be adapted for different audiences with varying skill levels and roles and responsibilities. CAS has therefore identified a need for different training package for Training of Trainers (TOT); clinicians and nurses; HSAs, community volunteers and policy makers. The training materials have been developed from the CTC manual and are under constant revision as CAS adapts materials to the context and the needs of the target audience. In addition to the training course materials, there is an urgent need to develop a package of tools. The training materials and tool package will need to be reviewed by relevant stakeholders and pilot tested. There is little experience to date of direct implementation of CTC at district level (without an NGO) and thus the development of training materials and practical tools and templates developed by CAS can be used both within and outside of Malawi.

3.2. Partnership support and mentoring

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CAS has established partnerships with five NGO partners (GOAL, Concern Universal, CWW; MSF-B; Save the Children (US), and Management Sciences for Health (MSH) and two direct DHO partners in Karonga and Machinga. However the basis and terms of these partnerships appears to be somewhat vague. CAS has finalized Terms of Reference (TORs) with two organizations (MSF and Concern Universal). An example TOR can be found in Annex 4. Operational plans have been developed with 3 organizations. The TORs and the organizational plans are not systematic. This makes planning for the provision of CAS services to partners difficult. To date CAS has been reactive rather than proactive in responding to requests for training and troubleshooting and support. This has resulted in gaps between training and CTC implementation, and in insufficient mentoring and follow up. During the review, some DHOs were quite unclear about the role of CAS and what services could be provided. There is a clear need for CAS to develop a package of services and a template for operational agreements and work-plans with partners. This will enable better planning for CAS technical support services and clear idea of outputs that can be measured and documented. The package of services will vary according to the partner/client.

CAS has facilitated exchange visits for DHO and NGO staff from districts preparing to start CTC to districts where CTC has been ongoing for some time. Examples include; Dedza DHO and Concern Universal to Nkhotakota to learn about the community aspects of CTC; Blantyre DHO and GOAL to Dowa district and Mangochi DHO and Save the Children to Dowa district. These on-site exchange visits were reported to be highly successful and afforded DHO staff the opportunity to learn from their counterparts.

3.3. Network support, documentation of best practices and lessons learned

CAS initially intended to develop a CAS Management Committee, made up of the MoH, UN Agencies, and NGOs, to guide implementation of the CAS project. In discussion with the MoH, the formation of the Management Committee was canceled, and the CTC Steering Committee was established instead, in line with MoH recommendations. The Steering Committee is chaired by the MoH and is comprised of members from UNICEF, WHO, USAID, WFP, Valid International and Concern Worldwide. The CTC Steering Committee is expected to support and oversee CAS. However this does not appear to be the case in practice. In theory the CTC Steering Committee has an essential role to play in ensuring the scale up of CTC is a smooth process and in clearly delineating roles and responsibilities. CAS has reportedly played a key role in the CTC working group which is sub-group of the Targeted Nutrition Program (TNP) meeting which takes place every month under the auspices of the Ministry of Health, Nutrition Unit.

CAS has been highly successful in disseminating information and raising awareness around key issues through the CTC Learning Forum. The Learning Forum takes place quarterly and aims to present and discuss developments in CTC. The Learning Forums are very well attended. During the review, many of those interviewed cited the Learning Forum as a very good way of bringing together key stakeholders to share experiences, to learn about relevant research, recent

international policy and current best practice and lessons learned. To date four forums have taken place on the following themes:

1. Registration of beneficiaries;
2. Referral networks;
3. Integrating HIV services with CTC;
4. The DIP process.

To date, only one Learning Forum report (referral networks) has been produced and disseminated.[12] The report can be found in Annex 5. CAS has not yet taken the opportunity to make the Learning Forum reports more widely available through publishing in practitioner and/or peer reviewed journals. CAS played a lead role in facilitating the CTC review workshop held in April 2006 and documenting and disseminating the report . [13]

3.4. Policy analysis and development (integrating CTC)

CAS has been instrumental in the drafting of the interim national guidelines for the management of acute malnutrition through community based care. [14] During the first year, CAS encountered some difficulties during training because health staff and NGO staff had adopted many different interpretations of the CTC protocols. This is due in part to the numerous adaptations to CTC protocols over the years and in part to confusion regarding roles of various MOH staff (HSAs, nurses, clinical officers) in CTC implementation. The interim national guidelines will enable CAS to harmonize and standardize the use of criteria and protocols for CTC and this should make training much easier. The national guidelines should be finalized and launched as soon as possible.

CAS has played a role in ensuring the inclusion of CTC in the National Nutrition Policy.[15] However there is a need to advocate for harmonization of various national nutrition guidelines and policies to be in line with the new national guidelines for severe acute malnutrition. CAS is well placed to address this. CAS has identified key advocacy issues for integration of CTC into routine health services. Specifically this has included;

- Incorporating costs for CTC within district budgets (SWap)
- Ensuring adequate staffing of health facilities and recruitment of more district nutritionists
- Procurement and distribution of RUTF through the Central Medical Store

The extent to which CAS has been successful in terms of advocacy to date is unclear. However there is additional funding support at district level. According to the MOH, the number of District Nutritionists will increase from 7 to 16 in 2007/8. Thus districts are well placed to begin to incorporate costs for CTC interventions into their District Implementation Plans (DIPs). Efforts to procure and distribute locally produced RUTF supported by the Clinton/Hunter Foundation are underway.

CAS has been instrumental in providing technical support to DHO staff in the planning process for the District Implementation Plans (DIPs). During the review this support from CAS was frequently noted as highly useful, timely and relevant. Of particular note was support provided by CAS on the DIP budgets to incorporate operational costs for CTC (including RUTF procurement) under the SWap. It should be noted that this activity was initiated ahead of schedule, and was not planned for the first year of the CAS project.

DHO's noted that a template/format on how to include costs associated with CTC in the DIP has not yet been produced by CAS. [16] In districts where CTC is being phased in and there is no

[12] CTC Learning Forum report (September 2006). Referral networks, January 2007
[13] Concern Worldwide and CAS. The rationale for scale-up in Malawi, October 2006
[14] Ministry of Health, Malawi. Interim guidelines for the management of acute malnutrition through community based care, March 2007.
[15] Office of the President and Cabinet. National Nutrition Policy for the department of nutrition HIV and AIDS. February 2006.
[16] Personal communication; Aaron Mhango, Acting DHO, Blantyre and James Bunn, Associate Professor Pediatrics/Community health.

NGO support such as Machinga, there is some confusion between what should be included in the DIP and what may be provided by UNICEF.[17] Other DHOs such as Dedza have included all costs for CTC (training, procurement of RUTF, transport) into the current DIP planning cycle. If the DIP is approved, they will procure RUTF from Valid International and distribute it themselves from July this year.

DHO's noted that support for incorporating costing of RUTF in the DIP must simultaneously include guidance on a ceiling level for RUTF from national level (HQ). DHOs see an important role for CAS in advocating for this. While decentralization has allowed DHOs to set priorities for their own health budget, there are ceilings and competing priorities. Thus, in order for procurement of RUTF to be sustainable over the long term, the MOH must raise the ceiling and specify a certain amount of the budget can be used for RUTF procurement.[18] For example, Dowa district estimates that costs of RUTF represent 20-30% of the total budget for the district. It is therefore important for CAS to play an advocacy role to ensure that there is a higher ceiling in district budgets for RUTF procurement..

3.5 Research

CAS added a research component under the cost extension proposal to USAID. To date CAS has been involved in two pieces of research:

- An audit of identification and classification of oedema by CTC implementers.[19]
- A retrospective study on antibiotic resistance.[20]

Neither of these studies has been published. In the case of the antibiotic study, this was taken up by other individuals and organizations who, for the most part are much better placed than CAS to conduct detailed research. During the review, several stakeholders noted that the comparative advantage of CAS is not to conduct detailed research. CAS should;

- Not engage directly in research
- Highlight grey areas that may require research and advocate for others to conduct the research
- Use relevant research for practical purposes such as revising protocols, adapting the guidelines and informing training materials.
- Pilot test and document the experience of integrating CTC into routine health services.

[17] Personal communication; Eggrey Kasiya, Nutrition Coordinator, DHMT, Machinga
[18] Personal communication; Sylvester Kathumba, District Nutritionist, Dowa
[19] CAS report on oedema verification study: The case of Lilongwe, November 2006
[20] Chilima, B. et al. Retrospective study of antibiotic sensitivity of bacterial isolates in malnourished children in Malawi

4. Issues and gaps

During the review, several issues and gaps have emerged. In part these weaknesses are associated with the current policy and programming climate CAS is operating within and in part due to the relatively short time frame that CAS has been operational.

4.1. Mandate, purpose and management oversight of CAS is unclear

- Despite the production of a brochure outlining the purpose of CAS,[21] there is a great deal of confusion regarding the mandate of CAS, what services are provided by CAS and how they are accessed. Despite the confusion, partners and stakeholders agree fully on the importance of CAS and would like to see CAS as a technical support unit within the MOH with a clear mandate and purpose.

- CAS does not have a strategic plan. It is therefore not surprising that there is confusion regarding the role of CAS, when CAS itself has no strategic plan. A coherent strategic plan should allow CAS to be more effective in planning training and support.

- There is no clear roll-out plan for CTC. In order for the strategic plan for CAS to be directed and effective, a Plan of Action for CTC must also be simultaneously developed.

- The CTC Steering Committee is chaired by the MOH and comprises of; WHO, UNICEF, WFP, EU, Concern Worldwide and Valid International. The committee is mandated to oversee the national roll out of CTC. However the Steering Committee has met just once during the first year of CAS. CAS is supposed to submit quarterly and annual reports to the Committee. This has not been done, partly because the members are not active.

4.2. Gaps in technical support provided by CAS

- CAS does not have verifiable indicators against which to measure impact and performance. Clear progress reports are not available. Currently it is not possible to determine the impact of CAS except anecdotally and through observation.

- In general documentation is a weak area of CAS both in terms of what CAS has achieved to date and in terms of documenting best practice.

- Support and capacity building for the MoH on monitoring and evaluation has been minimal. In part this is attributed to the lack of a CAS staff member with experience in M and E. Support in data collection and analysis is a critical unmet need at district level. There is a key role for CAS in streamlining data collection and reporting at health centers where there is an OTP in order to reduce paperwork and workload.

- CAS has an important role to play in determining appropriate use of data and indicators when CTC is integrated into the Essential Health Package (EHP). CAS is well placed to investigate the blockages in reporting at health center and district level and seek to find practical solutions to reporting obstacles and constraints. During the review, DHOs/DHMTs noted that it would be very useful for CAS to develop appropriate supervisory checklists and to advocate for inclusion of CTC into the integrated supervision process. A supervision checklist has already been developed and will be released in the national CTC guidelines.

- CAS has not provided training on the inpatient management of severe acute malnutrition. CAS emphasizes the referral mechanisms and links between the outpatient and inpatient components in the integrated management of SAM. There is currently good capacity in Malawi for managing and training on inpatient care. The College of Medicine has plans to build a national training facility linked to the NRU (Moyo House). Thus, there will be opportunities for CAS to link to the training on inpatient management. CAS will need to

[21] CAS brochure: Community based therapeutic care in Malawi: Technical support for scaling up CTC throughout the country

determine whether to include inpatient management of severe acute malnutrition in the CAS training course.

4.3. Gaps in policy, advocacy and integration of CTC

- CAS aims to support integration of CTC into existing health services. Emphasis has been placed on integrating IMCI, Essential Nutrition Actions (ENA) and other child health services (accelerated child survival) and HIV services with CTC. In practice while referral mechanisms at health center level are noticeably improved, the links with IMCI, ENA, HIV and other services are tenuous at best. CAS should be fully involved in the drafting of the revised IMCI guidelines and testing this in practice alongside ongoing OTP services.[22] CAS aims to support the MOH and UNICEF to conduct a TOT in ENA in all districts currently implementing CTC. To date there is little linkage between the CTC program for children and the HIV/RUTF program for malnourished adults.

- CAS has responded to requests for training on PD/Hearth in an attempt to respond to donor and other pressure to address the preventative aspects of nutrition programming. There is a need to test links in practice between programs aimed at prevention such as PD/Hearth and CTC and to effectively document the findings.

- CAS is well placed to advocate for harmonization of various national nutrition policies and guidelines to be in line with the new national guidelines for severe acute malnutrition. This includes the national nutrition policy, infant and young child feeding guidelines, interim guidelines on the management of acute malnutrition in adolescents and adults[23] and IMCI guidelines. At the moment there is discordance in the various guidelines which use different indicators and terminology. [24]

4.4. Research is not the comparative advantage of CAS

Conducting detailed research is not a comparative advantage of CAS and is not an effective use of resources. CAS should not directly conduct detailed research, rather CAS should highlight grey areas that may require detailed research and advocate for others to conduct the research. CAS is well placed to use current relevant research for practical purposes such as revising protocols, adapting the guidelines and informing training materials and pilot test and document the experience of integrating CTC into routine health services.

4.5 CAS gaps in staffing

The current CAS project manager will be leaving in August 2007. A replacement should be recruited as soon as possible to allow for a period of handover and to avoid a critical gap in the management of CAS. CAS urgently needs to recruit a monitoring and evaluation specialist.

[22] Draft IMCI guidelines including management of severe malnutrition with and without complications.
[23] Ministry of Health and UNICEF. Interim guidelines for the management of acute malnutrition in adolescents and adults, March 2006.
Ministry of Health. Infant and young child nutrition policy and guidelines 2005-10.
[24] Government of Malawi. Impact and output indicators for agriculture, food security and nutrition projects in Malawi. April 2006

5. Recommendations for phase 2

In its first year, CAS has been successful in building relationships with partners, providing training and identifying and addressing some of the challenges associated with scaling up CTC. CAS is now well placed to develop a coherent strategy for the next three years. The review team strongly supports the continuation and strengthening of CAS. The recommendations noted below are intended to be actionable recommendations which should be initiated within the next year:

1. Clearly define mandate and role for CAS

CAS is intended to be a technical arm of the MoH. To this end, CAS should be physically located within the MoH. This will facilitate joint work plans, meetings and operations. Concern Worldwide will continue to support CAS. CAS must develop a revised brochure clearly outlining its mandate, purpose, package of services offered and how these services should be accessed. The brochure should be made widely available through the MOH and at Learning Forums. The brochure should include:

- A clear overview of the mandate of CAS noting that CAS is a technical arm of the Ministry of Health mandated to provide technical support for scaling up CTC in Malawi.
- What services are provided (package of services).
- How to access CAS support through the MoH Nutrition Unit including contract names and information.
- Recognition of external donors.

A flow chart for CAS is shown in Annex 6.

2. Diversify external donor funding base for CAS

- CAS received funding from USAID/OFDA for the first year. It is likely that USAID will continue to provide funding for another year (2007-8). It is essential that the funding base for CAS is diversified. Support should be sought from donors with an interest in funding CAS as a multi-year project. A proposal for three year funding should be developed (following development of the three year strategic plan). This will allow CAS and the MoH to plan effectively over three years.

- External funding will be channeled through CWW. Using current budget levels as a basis, CAS should cost approximately US $1.5- 2 million for 3 years. This should be an attractive investment to donors interested in supporting CTC scale up activities.

3. Develop a roll out plan (Plan of Action) for CTC with MOH, key stakeholders and the Clinton /Hunter Foundation.

CAS should work with the MoH to develop a POA for roll out of CTC in Malawi over the next 3 years. At a minimum the POA should include:

- Mapping ongoing and planned CTC programs.
- Mapping other initiatives and interventions (including HIV services, IMCI and ENA) and other initiatives to strengthen the health system where components of CTC may fit in.
- A roll-out plan for CTC emphasizing a phased approach. A phased approach will allow CAS to plan effectively so that they are not overstretched in attempting to cover too many districts at once.
- The phased roll-out plan should include the roll-out of RUTF. This is essential in order to ensure that districts do not receive RUTF until district capacity to implement CTC has been assessed and CAS is able to provide support. Districts receiving RUTF and CAS support should aim to be self sustaining (i.e. incorporated all costs for CTC into their DIPs) within three years. The provision of RUTF from the Clinton/Hunter Foundations will act as a buffer and ensure that all the districts planning CTC activities have time to incorporate all costs under SWAp in their DIP.

- The roll out plan should also include planning for emergency/crisis situations and how the MOH will respond if DHO/current capacity to implement CTC interventions as part of routine health services is exceeded. This will include the role of CAS.

4. Develop a three year strategic plan for CAS.

- CAS is now very well placed to develop a strategic plan. CAS should develop a three year strategic plan which clearly lays out areas of focus for CAS, specific objectives and immediate results aligned with measurable indicators. The strategic plan should detail activities for the first year under the strategic plan (2007-8) and provide a detailed outline for activities planned beyond that (2008-10).The strategic plan will allow CAS to plan effectively, measure progress against objectives and will provide the basis for proposals and reports to donors.

- Each focal area under the strategic plan should serve to strengthen and complement the other areas. CAS should not be overly ambitious. Emphasis should be given to: developing materials for training, direct support to district in DIP planning and training; addressing gaps in monitoring and evaluation; developing a package of tools; pilot testing and documenting the experience of integrating CTC into routine health services and policy and advocacy. Under the strategic plan CAS must determine its role regarding training on inpatient care. Suggested focal areas for CAS under the strategic plan are shown in Table 3.

- CAS should not engage in detailed research. CAS should develop partnerships with research organizations such as Valid International and the College of Medicine and identify areas that may require further research that could be followed up by these partner organizations. CAS should use relevant research for practical purposes such as revising protocols, adapting the national guidelines and informing training materials.

5. Define roles and responsibilities of the CTC Steering and CAS Management Committees

- The roles and responsibilities of the CTC Steering Committee must be defined. The CTC Steering Committee should play an essential role in overseeing the mandate and operations of CAS (including the CAS strategic plan) and in delineating roles and responsibilities in the scale up of CTC.

- The Steering Committee should be chaired by the MOH. Meetings should be held quarterly or every six months if this is more feasible and will ensure good attendance. Meetings should be held at the same time as the Learning Forums take place. Senior representatives in decision making positions should participate. The Office of President and Cabinet, Office of Nutrition and HIV and AIDS should be a member of the CTC Steering Committee. The Clinton/Hunter Foundation should also be a member because they are funding the procurement of RUTF. USAID should be included as principal donor to date. The members of the CTC Steering Committee will then comprise of MOH (Chair), OPC (Nutrition), WHO, UNICEF, WFP, USAID, Valid International, Clinton Hunter Foundation and Concern Worldwide.

6. Immediately address staffing issues

- A replacement for the current CAS Project Manager will need to be recruited by June 2007 to allow for a period of handover. The CAS manager must have strong strategic and managerial skills and excellent relationships with the MOH and stakeholders. Technical understanding of the issues is also essential. Ideally the candidate should come from within Malawi. If this proves difficult, Concern Worldwide should consider recruitment of an expatriate to avoid a gap in the management of CAS.

- The composition of the CAS team must be re-thought to fit the key focal areas under the strategic plan. This will involve shifting roles and responsibilities within the team according to skills and expertise. Some current team members may need to be let go while others with specific skills such as a monitoring and evaluation will need to be recruited. This should be guided by the CTC roll out strategy and CAS strategic plan after they are developed.

- The role of CAS staff in overall Concern administration will need to be clarified when CAS moves to the MOH. At present, six staff of CAS will move to MOH until further space can be found. The CTC Program Manager should remain at the Concern office to deal with administrative and managerial issues and will move back and forth between Concern offices and the MOH.

- The secondment of staff from Valid International to CAS will need to be clarified. In the first months of the project, CAS retained several days a month of time from the Valid Program Manager in Malawi. This arrangement is no longer active. CAS should continue to benefit from inputs from Valid International. This would allow CAS to make the best use of current technical expertise and experience in the country. This will need to be fully discussed with Valid International.

7. Develop a package of services, operational agreements and timelines with partners

CAS should develop a basic package of services available to DHOs. While the basic package of services will be similar for all partner organizations and DHOs using CAS support, there will be some variation according to the needs of the partner. The package will include:

- Initial capacity assessment
- Initial training (for different audiences)
- Follow up training and mentoring (on site set up)
- Ongoing mentoring
- Support in supervisory visits
- Support in DIP planning and budgets
- Support for data collection and analysis at health center and district level
- Refresher training
- Facilitate coverage surveys (optional)
- Conduct review/evaluation (after at least 12 months)

- CAS should develop operational agreements with partners receiving support from CAS. As part of the operational agreement, CAS must develop a joint work-plan and timeline with the partners based on the package of service. See a template example in Annex 7.

Table 3: Suggested key activities and focal areas for CAS under the 3 year Strategic Plan

Training and mentoring (technical support):
▪ Develop and pilot test a training package with modules that can be configured for different audiences (TOT, clinicians and nurses, HSAs and community volunteers and policy makers). ▪ Ensure compliance with national guidelines ▪ Provide initial and refresher training, mentoring and follow up support for up to a year for districts starting CTC ▪ Ensure linkages and harmonization between training on inpatient management of severe acute malnutrition and community based management. ▪ Provide support during integrated supervisory visits.
Collection of data, monitoring reporting and supervision:
▪ Identify and document issues, obstacles and constraints in data collection and reporting at health center and district level ▪ Streamline data and information collection at the health centers where OTP is implemented ▪ Pilot test use of the health passport instead of OTP cards at health centers ▪ Provide direct support to districts on data management (including use of data base) and analysis for effective feedback on programs ▪ Pilot test the use of key indicators on severe acute malnutrition in the Health management Information System (HMIS) ▪ Develop and pilot test (with key stakeholders such as UNICEF) a standard database for compilation of CTC data at national level. ▪ Determine mechanisms to include participation and reports from districts implementing CTC (with no NGO support) in TNP meetings.
Integration of CTC into existing health services—planning for sustainability
▪ Develop and pilot test a package of templates, and step by step procedures for DHOS/DHMTs in planning and budgeting CTC activities using SWap funds under the DIP ▪ Simplify data and information needs to allow for easier referral within the health center ▪ Pilot test use of the revised IMCI guidelines and ENA in health centers with ongoing OTPs ▪ Support districts, UNICEF and the MOH in planning supply needs for RUTF, F100 and F75
Policy and advocacy
▪ Document issues in CTC implementation in Malawi, and update and revise CTC protocols and the current interim national guidelines to reflect experience and changes at global level. ▪ Advocate for harmonizing CTC guidelines with other national policies and guidelines. ▪ Advocate for an increased ceiling for RUTF procurement to allow districts to procure RUTF under the DIP ▪ Advocate for inclusion of CTC in training curricula and pre-service training of doctors and nurses
Learning, documentation and dissemination
▪ Document experiences of direct district implementation of CTC highlighting the key issues and how they can be overcome. ▪ Document experiences of integrating CTC into the EHP including IMCI and ENA and HIV services and HIV testing and counseling (HTC) ▪ Publish reports of the Learning Forums in Practitioner and Peer reviewed journals in order to reach a wide audience outside of Malawi. ▪ Develop partnerships with research organizations such as Valid International and College of Medicine and identify areas that may require further research that could be followed up by these partner organizations. ▪ Use relevant research for practical purposes such as revising protocols, adapting the guidelines and informing training materials. ▪ Organize a workshop/technical meeting in 2007 for MOH and key stakeholders from other countries such as Ethiopia, Zambia where attempts to integrate CTC into existing health systems are ongoing.

8. Develop a package of tools for use by DHOs

CAS should develop a package of tools and pilot test their use. CAS should make use of technical expertise in Malawi to help with the development of tools. For example Management Sciences for Health have expertise in health systems and the DIP process. The package will initially include:

- A template for the DIP.
- Step by step guide/procedure for budgeting CTC activities using SWap funds under the DIP.
- Simple clear examples of how to calculate estimated numbers of beneficiaries and RUTF needs.
- Supervisory checklist and quality checklist for use in integrated supervisory visits.

9. Develop simple methods and assessment tools to determine the impact of training and CAS support

- CAS should develop tools and methods to measure the impact of training and support. Specific tools and methods are needed to measure the impact of training. CAS should develop a quality checklist that can be used 3-6 months after training in order to determine the impact of the training and support provided by CAS.

- CAS will need to finalize and test a capacity assessment tool for initial assessment of districts on the CTC roll out plan (identified by the MOH for scale up). This will be used to determine the feasibility of roll out and to determine the appropriate package of services prior to setting up the operational agreement and timelines.

10. Focus on pilot testing materials, tools and concepts to improve quality of CTC and sustainability

Examples include:
- Develop and pilot test training package for different audiences.
- Pilot test the use of the health passport instead of OTP cards at health centers.
- Develop and pilot test a supervisory checklist for use in integrated supervisory visits.
- Pilot test use of the revised IMCI guidelines and ENA in health centers with OTP.
- Pilot test use of MUAC only from 6 months and appropriate discharge criteria (based on length of stay and weight gain).

11. Strengthen documentation and dissemination

- The outcomes and reports from the Learning Forums should be published in practitioner journals such as Field Exchange. CAS might consider combining the Forum reports into a Special Supplement of the Field Exchange. CAS experience of integrating CTC into the existing health system and direct implementation of CTC with DHOs should be well documented and written up as a policy and practice paper.

- CAS should organize a workshop/technical meeting in late 2007 on the theme of direct MoH implementation of CTC. The workshop will include MoH representation from Ethiopia, Kenya, and Zambia where attempts to integrate CTC into existing health systems are ongoing. The outcomes of the workshop should influence the global agenda on the management of severe acute malnutrition including the development of training materials, tools and the second edition of the CTC manual.

- CAS comparative strength is providing support for CTC scale up in Malawi given the close relationship with the MoH. However once CAS is fully established and operational in the MoH, CAS Malawi may be well positioned to assist the establishment of similar technical bodies in other countries (satellite CAS).

- CAS should produce 2-3 page progress/update reports every quarter which clearly present what has been done to date and how it has been measured. This should be presented at TNP and Steering Committee meetings and used for donors and other stakeholders.

- A full external evaluation of CAS should take place in 2008.

Annex 1: Itinerary and key contacts

Key contacts

Name	Affiliation
Fiona Edwards	Country Director, Concern Worldwide
Shahnewaz Khan	Deputy Country Director, Concern Worldwide
Stanley Mwase	Program Manager, CTC Advisory Services
Gwyneth Hogley Cotes	Health and Nutrition Advisor, CTC Advisory Services
Itayi Nkhono	Research Officer, CTC Advisory Services
Austin Kachipeya	Information Officer, CTC Advisory Services
Lillian Chirwa	Project Officer, CTC Advisory Services
Alice Gandiwa	Project Officer- Quality of Care, CTC Advisory Services
Alice Nkoroi	CTC Program Manager, Concern Worldwide
Dr. Maria Kim	Pediatric AIDS Physician, Baylor College of Medicine, Children's Center of Excellence
Dr. Mary Shawa	Principal Secretary for Nutrition and HIV/AIDS, Office of President and Cabinet (OPC)
Catherine Mkangama	Head, Nutrition Unit, Ministry of Health
Felix Phiri	Nutrition Unit, Ministry of Health
Margaret Khonje	Management Sciences for Health, Nutritionist
Rudi Thetard	Management Sciences for Health, Chief of Party
Roger Mathisen	UNICEF, Clinical Nutritionist
Lazarus Gonani	WFP Program Officer (Nutrition)
Sophie Weirich	Deputy Director for Health, Clinton Hunter Foundation
Penjani Kamudoni	Clinton Hunter Foundation, Nutritionist
Burton Twisa	Concern, Dowa, Area Program Manager
Ronald Chirwa	Concern, Dowa, CTC Program Advisor
Sylvester Kathumba	District Nutritionist, Dowa
Mrs Kamfose	District Health Officer, Dowa
Emmanuel Mandalazi	Valid International Community Development Advisor
Angela Mtimuni	Valid International, Research Officer
Gertude Nyirenda	Valid International, CTC Program Manager
Maggie Nayeja	Valid International, Research Nurse
Happy Botha	Valid Nutrition, Production and Marketing Manager
Aaron Mhango	Acting DHO, Blantyre
Pauline Mwasigala	Senior Nursing Officer (DHMT), Blantyre
Phyllis Oyugi	Nutrition Coordinator, GOAL, Blantyre
Marion Matundu	Program Manager, GOAL
Dr. James Bunn	Professor Pediatrics and Community Medicine, College of Medicine
Dr. Marko Kerac	Pediatrician, Queen Elizabeth Hospital/Valid International
Eggrey Kasiya	Nutrition Coordinator, Dedza District Health Management Team (DHMT)
David Chimwaza	IMCI Coordinator, DHMT, Machinga
Mr Mwanmadi	MCH Coordinator, DHMT, Machinga
Laurence Chakholomba	Nutrition Coordinator, Concern Universal, Dedza
Harry Phiri	Nutrition Coordinator, DHMT, Dedza district
Alisa Cameron	USAID, Health Team Leader
Lilly Banda-Maliro	USAID, Health Specialist
Mark Visocky	USAID, Team Leader-Sustainable Economic Growth

Itinerary

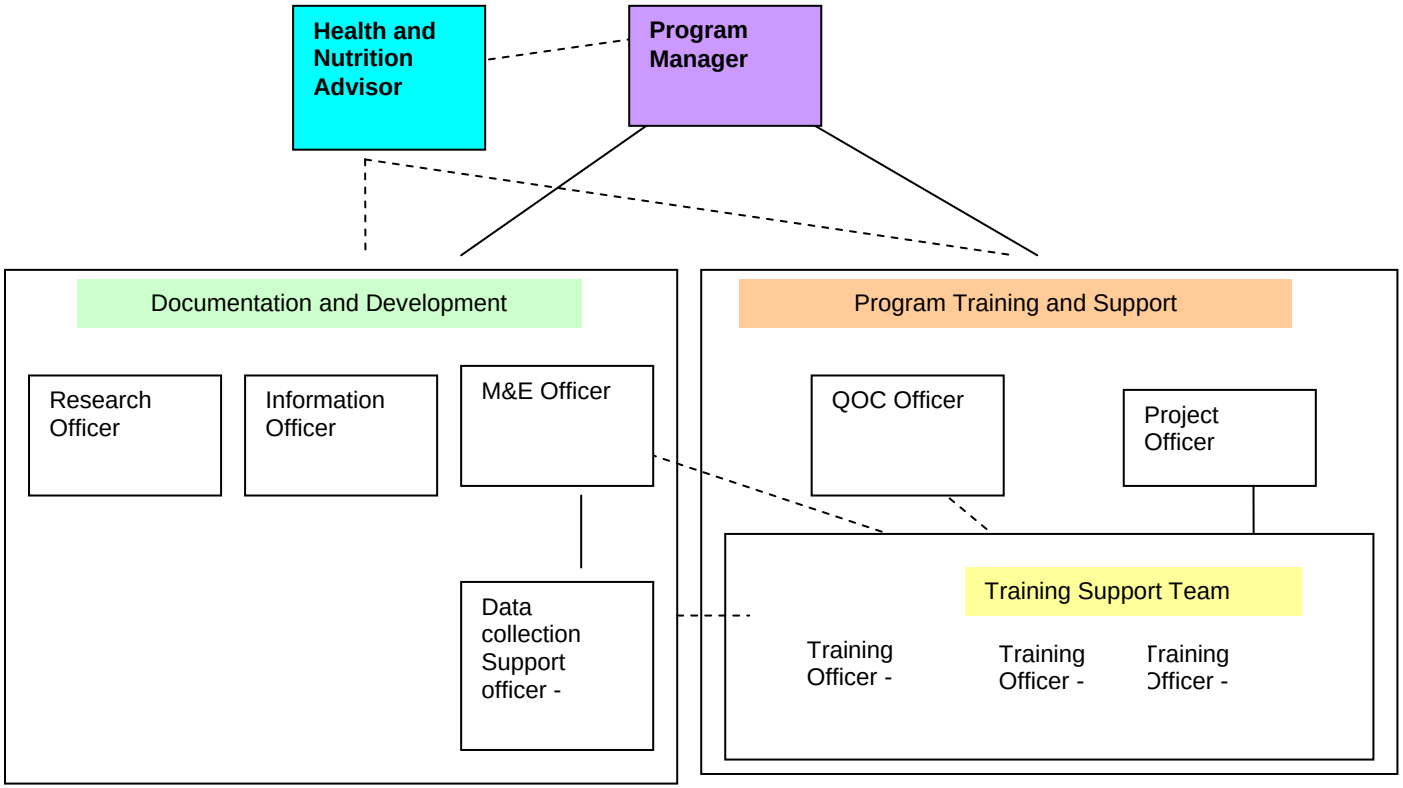
March 18th	Arrive Lilongwe	**March 26th**	Travel to Blantyre
March 19th	Meetings with CAS management staff Meeting with Concern Deputy Country Director	**March 27th**	Meetings with DHO and DHMT, Blantyre Meetings with GOAL Meetings with College of Medicine Site visit to Moyo House, NRU
March 20th	Meeting with UNICEF Visit to Baylor Pediatric AIDS clinic Meeting with World Food Program Meeting with Dr. Mary Shawa, OPC	**March 28th**	Travel to Machinga Meetings with DHMT, Machinga Travel to Dedza Meetings with DHMT and Concern Universal, Dedza
March 21st	Meeting with Ministry of Health (Nutrition Unit) Meeting with Management Sciences for Health Meeting with Clinton Foundation Meetings with Valid International team Meeting with Valid Nutrition	**March 29th**	Meetings with CAS team
March 22nd	Visit to Dowa Meeting with Concern CTC staff Meetings with District Health Office	**March 30th**	Meetings with USAID Debrief at OPC Meeting with CAS management staff
March 23rd	Visit to OTP Lilongwe (Health Center Area 25) Meeting with Concern Country Director	**March 31st**	Meeting with Valid International Draft of summary report
March 25th	Meeting with Theresa Banda Meetings with CAS staff	**April 1st**	Depart Malawi

Annex 2: Intermediate Results (IR's) and outputs for CAS: Phase 1 (Feb - 2006 Jan 30th 2007)[25]

Intermediate Results	Progress in phase 1
IR 1. Training and development of training materials	
▪ Training provided to at least 8 DHO's in emergency interventions	Thyolo (MSF-Belgium) Blantyre (GOAL) Salima, Msimba, Balaka , Chikwawa, Mulanje (MSH) Dedza (Concern Universal) Mangochi (SC-US) Lilongwe, Dowa, Nsanje, Nkhotakota (Concern Worldwide) Machinga DHO Karonga DHO
▪ Development of training materials	Draft training manual developed based on national CTC guidelines
IR 2.Partnership support and mentoring	
▪ Partnerships developed	-Partnerships developed with five NGO partners Operational plans developed with 3 organizations and TORs with 2 organizations
▪ Mentoring activities	-Supervision and support visits with MSF-B, MSH and CWW. On the job training provided where problems identified Exchange visits to Dowa for national CTC trainers, MSF, Concern Universal, CWW, DHOs (Machinga and Karonga)
3. Network support, documentation of best practice and lessons learned	
▪ Support to CTC networks, documentation of best practice and lessons learned	-Facilitated set up of CTC Technical Working Group -Four CTC learning forums with high participation -Facilitation of national stakeholders' workshop -Development and distribution of CTC review report
4. Policy analysis and advocacy	
▪ Policies analyzed and relationships developed	-Development of interim national guidelines -RUTF logistics and procurement -Training and operational costs included in DIPS
5. Research	
▪ Conduct research	1. Audit of identification and classification of oedema by CTC implementers 2. Antibiotic resistance study Planned: Follow up on defaulters to determine causality Identify underlying factors for relapses Follow up of recovered children who are HIV positive Decentralization of CTC beyond the health center Stigma around RUTF usage

[25] CAS annual review and planning meeting, January 17-18, 2007. (Draft document)

Annex 3: CAS staff organagram



Annex 4: Sample TOR with MSF

TERMS OF REFERENCE FOR CAS MSFb

1. AGREEMENT

This paper constitutes the core terms of reference to guide the collaboration between CTC Advisory Service (CAS) and Medicins Sans Frontiers Brussels (MSFb),Malawi Country Office. It also outlines the scope of collaboration, key roles and responsibilities and plan for implementation between CAS and MSF.

2. Background

The Malawi Ministry of Health, in partnership with Concern Worldwide, CHAM institutions and Valid International, has been implementing the Community-based Therapeutic Care (CTC) approach in the management of severe acute malnutrition since 2002. Following the success of this approach, MoH is now rolling out CTC as a national strategy.

The MoH agreed with Concern to form the CTC Advisory Service (CAS), which is aimed at supporting the CTC roll-out process. CAS is a non-profit organization within Concern Worldwide, and focuses on technical support to CTC implementing partners. (Refer to ToR with Ministry of Health).

In view of this, **CAS** proposes to support the MSF in providing CTC services in Thyolo District. This ToR will guide the partnership with **MSF** and will be ongoing until the partner feels that CAS services are no longer needed.

3. Purpose

To enhance the effectiveness of nutrition practitioners in the implementation and management of CTC in Malawi through provision of technical support as

4. Roles and Responsibility of MSF

- To share with CAS on an ongoing basis the following:
  - schedule of activities requiring support from CAS
  - training plans & contents
  - Output monitoring data on program performance
- Contribute to the documentation of activities in CTC (best practices, challenges etc)
- Make available key staff to participate in the partnership reviews
- To inform CAS at least I week in advance of program specific needs related to CAS support

5. Roles and Responsibilities of CAS

- Conduct support needs assessment and analysis together with the partners
- Support MSF in the provision of trainings when required; Reviewing of training materials and facilitation.
- Arrange partnership review meetings quarterly to review progress.
- Support MSF in coordination of CTC implementation with the MoH/DHO
- Support MSF the in the coordination of phasing in and out process.
- Facilitate information-sharing networks among CTC implementing partners in the country
- Assist with implementation of the Interim National Guidelines for CTC.

6. OUTPUTS BY CAS

- Support Needs Assessment completed, analyzed, and recommendations given
- Partnership developed and maintained
- Quarterly partnership review meetings carried out and documented
- Best practices identified and published and acknowledge partners
- Feedback reports provided, with recommendations
- Support visit reports provided, with recommendations

7. REPORTING

CAS will be updating partners in trends and issues in CTC through a quarterly bulleting.

Annex 5: Learning Forum Report 2

ISSUE 1

JANUARY 1, 2007

CTC Learning Forum Report

Second CTC Learning Forum
September, 2006
Mangochi district

Highlights

- *This is the first report on the proceedings of the CTC Learning Forum*
- *Learning Forum theme: "Managing Referral Networks*

Inside this issue:

Introduction

Community-based Therapeutic Care (CTC) was first implemented in Malawi in Dowa and Nkhotakota districts in 2002 and 2003 respectively, by Concern Worldwide and the Ministry of Health, with the support of Valid International. CTC has proven to be instrumental in the treatment of acutely malnourished children under five years of age. The programme has improved coverage of therapeutic feeding services, reduced length of stay in the Nutrition Rehabilitation Units (NRUs) and has met international standards for recovery, default, and death rates of treated children.

As a result, the Ministry of Health is interested in scaling up the intervention throughout Malawi as a component of the Essential Health Package.

Since 2004 a number of NGOs have started implementing CTC in various districts. A wide variety of experiences and challenges are being faced in each of these districts, and there is a strong need for organisations to share their experiences and lessons learnt so that all the implementers benefit.

CTC Learning Forum

The CTC Learning Forum was formed in July 2006. The Forum holds quarterly meetings to present and discuss developments in CTC. The aim of the Learning Forum is to bring together key stakeholders to share experiences, lessons learnt, and best practices.

On September 14th, 2006, the second meeting of the CTC Learning Forum was held in Mangochi District, hosted by the District Health Office of Mangochi and Save the Children US (SC-US).

The meeting was attended by programme staff from a variety of NGOs and districts that are currently implementing or planning CTC projects. The Learning Forum included visits to an NRU and OTP to observe CTC activities, followed by presentations and discussions.

Referral networks

The theme of the September CTC Learning Forum was "Managing Referral Networks." Referral networks are essential in CTC for referring malnourished children from the community, as well as for monitoring the treatment of the child as he moves between the various components of CTC, including the NRU, Outpatient Therapeutic Programme (OTP), and Supplementary Feeding Programme (SFP).

At the Learning Forum, several organisations presented their experiences in managing referral networks both at the community and the health centre level. This report summarises the experiences and lessons learnt that were shared.

Managing Referral from the Community:

Experiences of Save the Children US

Referral of malnourished children from the community was part of the case study presented by Ken Chisanga, Outreach Coordinator for Save the Children US. Chisanga said that the importance of community level referral could not be overemphasised as it identifies the resource needs of clients and improves programme delivery.

He added that referral for CTC starts in the community. Most of the work at the community level is done by volunteers, who screen children for severe malnutrition using MUAC and assessment of oedema, and then refer them to the nearest health centre. Community volunteers are also trained to assess the health situation in their villages, and carry out health education using posters.

Community volunteers are responsible for screening, referral, and follow-up of CTC programme participants. When a severely malnourished child is identified, the volunteer gives a referral letter to the child's caregiver for further assessment at the nearest health facility. If the child is absent from OTP services or defaults, the volunteer follows up the child at home using picture-coded forms to determine the reason for absence. The reasons included on the form are: Distance to site, funeral, child is sick, family has moved, mother/father is sick, or child is dead.

A separate picture-coded form is used in the case of a child's death while enrolled in the programme. These forms are used to allow illiterate volunteers to participate in the programme.

Save the Children US conducts regular refresher training every 4 months for its volunteers to strengthen their work performance and regards this as an important element of the CTC programme.

Incentives for volunteers to perform outreach activities

In Mangochi, volunteers are chosen by their communities and endorsed by a Village Health Committee, the body to which volunteers then report. Mr. Chisanga reported that volunteers value the refresher trainings they receive, where they receive certificates signed by the DHO and the NGO, as well as being given refreshments and 250 Malawi Kwacha as a lunch allowance. They also appreciate receiving T-shirts, caps, and stationery to help them in their work.

Challenges faced by community outreach programme

Volunteers were initially trained to refer children having bilateral pitting oedema and /or MUAC < 12.5 cm, which was the enrolment cut-off for supplementary feeding programmes (SFP). However, when SFP phased out at the end of May 2006 only children with MUAC < 11cm were eligible for treatment in CTC. Due to volunteer confusion over the cut-offs, many children were referred to the OTP sites and then were turned away because they did not meet the eligibility criteria. This created great disappointment in mothers, who felt they had come for nothing, and who then started to mistrust volunteers. Refresher training for volunteers was reported to have solved this problem.

ISSUE 1

Referral of Patients between Health Services

In CTC, a child may be treated in either an inpatient NRU or as an outpatient at OTP sites located in health centres, depending on the presence of appetite and medical complications. A child may be admitted directly to the NRU, and then transferred to an OTP upon stabilization. Alternatively, a child may be admitted first in the OTP, and then be referred to the NRU if his condition deteriorates. Therefore, it is important that health centres are able to communicate with each other so that children are not lost upon referral. Children should also be monitored after discharge to ensure that they do not relapse.

In Mangochi, a number of methods were presented that allow a child to be tracked throughout his treatment within the CTC programme. Some of those included:

Referral from the NRU to OTP is done using an NRU discharge slip so that health centre staff know what treatment and medications have already been given in the NRU.

Children who fail to respond to treatment are referred for further assessment (NRU, outpatient medical care, HIV testing and counselling). The diagnosis is indicated in the health passport book.

Upon discharge or referral to outpatient medical care, children have their treatment and nutritional status indicated in the health passport books.

When children are absent or default from the programme, Health Surveillance Assistants (HSA) send a tracking form to the assigned volunteer to find out reasons for absenteeism and to encourage the child to return. The form is then returned to the HSA.

In case of death, the assigned volunteer makes a follow-up visit to find out the reported cause of death.

Discharge procedure

When children are successfully cured, they are referred home after having their outcome indicated in the health passport. The assigned volunteer is notified of the discharge.

Challenges associated with health centre referral

Shortages of staff and inadequate communications systems are a major challenge in tracking children who are referred between different health services. In addition, the lack of transport for children who must be stabilised in the NRU means that health centres cannot ensure that caregivers actually attend the NRU when they are referred. In sites where communication between the NRU and the health centre is possible, volunteers are used to follow-up children who do not attend OTP or NRU services after they are referred.

Exchange Visit to Lungwena Health Centre OTP

According to the Ministry of Health, malnutrition is among the ten leading causes of death in health facilities and a major contributor to the high infant mortality rate in Malawi. To address this health problem Save the Children US is supporting three rehabilitation units and 35 OTP sites in Mangochi.

Members of the CTC Learning Forum went for a field visit to Lungwena Health Centre in Malindi to appreciate what Save the Children US and Ministry of Health are doing in linking with community volunteers to provide care to severely malnourished children. The members met with Community Nurse Mary Kafoteka, and observed children being screened for CTC enrolment. The community nurse explained that most of the children served in the OTP lived along the lake, as there are few farming activities in those areas.

According to Ms. Kafoteka, volunteers in Mangochi have been trained on how they can identify malnourished children in the communities using MUAC and assessment of oedema. Volunteers use a color-coded MUAC tape that does not have any numbers marked. This simplifies the assessment of MUAC, and SC-US reported that results have been very good.

After children are referred to the health centre by the community volunteer, a nurse assesses the child to see if he is eligible for enrolment to the OTP. Ms. Kafoteka stressed the importance of conducting an appetite test at each OTP visit, and was seen counselling a mother on feeding her malnourished child.

She added that when the child is discharged the volunteers carry out follow-up visits, and in case of relapse refer the child back to the health centre. The only means of communication on referrals to the NRU is sending a wireless message, which isn't always possible. It was noted, though, that most children attend the NRU when referred.

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Harmonizing CTC and NRU Protocols in Lilongwe District

At the time of the CTC Learning Forum, Lilongwe district was still using traditional NRU protocols in the district NRUs, while providing OTP and community outreach services in a large number of health centres. Ms. Fanny Chirwa, CTC Supervisor for Concern Worldwide, presented on the challenges of harmonizing CTC and NRU protocols and referral in this district.

Lack of clinician involvement

Ms. Chirwa reported that in Lilongwe, many clinicians perceived CTC as a community programme, rather than a medical treatment, and were therefore not willing to become involved in CTC activities. As a result, HSAs were often responsible for managing all OTP activities, including medical assessment.

Due to the high risk of mortality and illness associated with severe malnutrition, it has been agreed in Lilongwe that HSAs should not implement OTP activities without a nurse available to handle the clinical aspect of the programme.

Ms. Chirwa said that it is essential to bring clinicians on board from the very stages of implementation of CTC, avoiding repeating the mistakes seen in some NRUs, where clinicians were not involved at the early stages, leading to high death rates.

It was also noted that HSAs are often given additional tasks like VCT, and should not be given more responsibilities than they have the capacity to implement.

Referral mechanisms

Before CTC protocols were implemented in Lilongwe NRUs, when a child was successfully cured he/she was sent back to the community just like any other patient, after being given health education. Beneficiaries admitted to Nambuma NRU, the only NRU implementing CTC, were stabilised and then discharged to OTP.

All beneficiaries admitted directly to OTP in Lilongwe are assigned to a community health volunteer on admission. HSAs oversee the community outreach activities of volunteers, and assist the volunteers with following-up beneficiaries who are difficult to convince due to other beliefs, such as religious opposition to medical care.

OTP cards and health passports are used for referral and recording treatment information at the NRU or Hospital. Volunteers use notebook papers to transfer information to or from the community. Beneficiaries that have been admitted into the CTC programme are recorded in the health centre register. When a child dies while enrolled in the programme, volunteers report the death using the small OTP ration card.

Challenges and recommendations

Ms. Chirwa noted that because traditional NRU treatment may require long inpatient stays, many caretakers refused to go for treatment at the NRU when referred from the OTP. In addition, the difficulty of getting clinicians to make time to attend CTC services resulted in poor medical assessment of some children. She recommended that clinicians be involved in CTC training and set-up from the very start of the programme.

Ms. Chirwa also emphasised that there is a need to form a good communication system between volunteers and health personnel. The system should be simple and sustainable to make sure that the beneficiaries are properly followed and their treatment is completed. The community should be well informed so that any relapse can be referred at the right time.

CTC LEARNING FORUM REPORT

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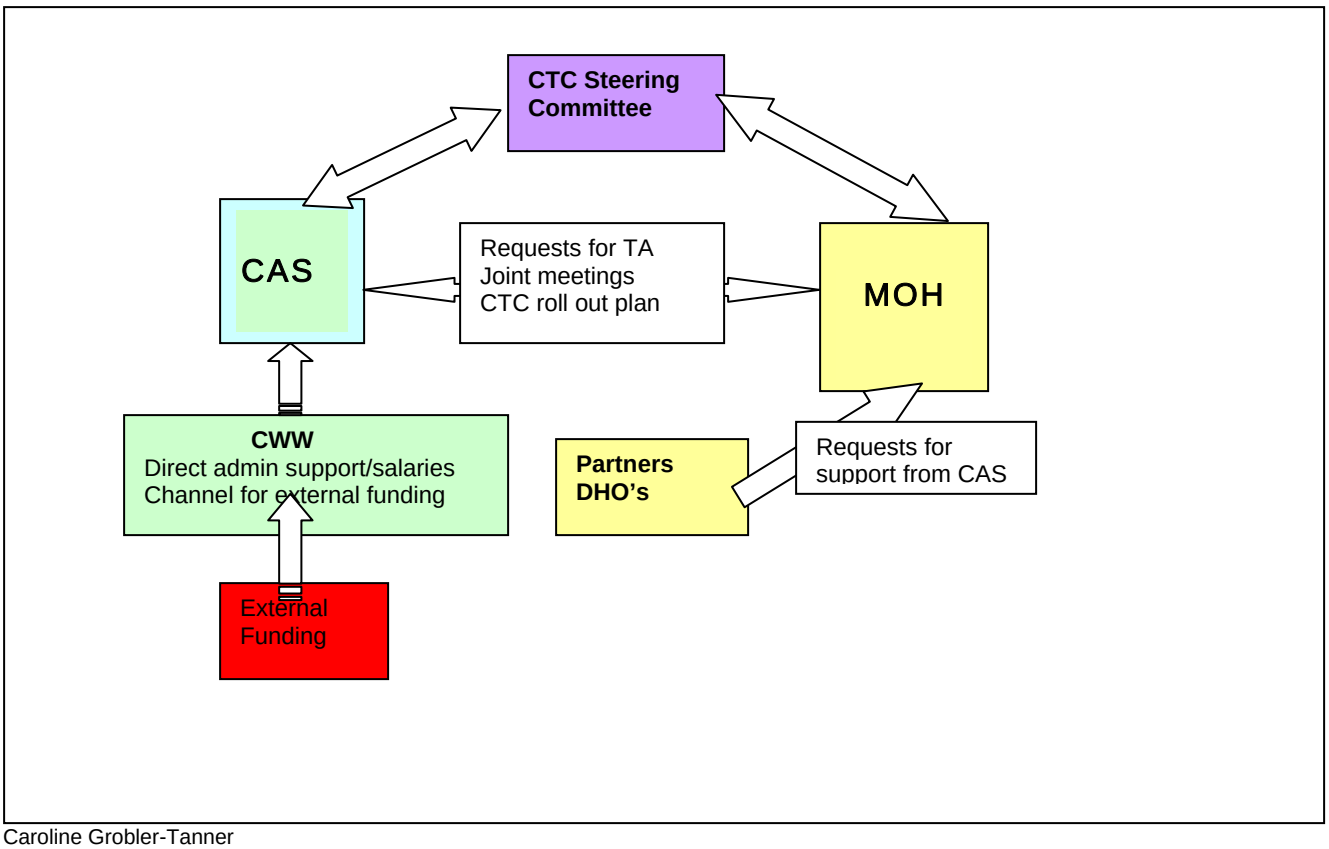
Annex 6: CAS flow diagram



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Annex 7: CAS package of services. Example of an operating plan for one year (June 2007-May 2008)

Name of partner/DHO:													
Month	J	J	A	S	O	N	D	J	F	M	A	M	
Package of CAS services													
Capacity assessment Using capacity assessment tool	X												
Orientation, establish operating agreement and plan and package of services		X											
Initial training				X									
Follow up training and mentoring (on site set up)					X	X							
Ongoing mentoring							X		X		X		
Support in supervisory visit							X						
Support in DIP planning and budgets									X	X	X		
Support for data collection and analysis				X			X			X			
Refresher training							X					X	
Quality assessment (looking at impact indicators) 6-8 months after set up											X		
Facilitate coverage survey (If appropriate)												X →	
Conduct review/evaluation												X →	

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