Chapter 5
Community Mobilisation

Identifying key people who can pass messages about the programme to the rest of the community and potentially act as case-finders is an integral part of community mobilisation.

5. COMMUNITY MOBILISATION

In CTC, the term 'community mobilisation' refers to a range of activities designed to help implementers understand affected communities, build a relationship with them and foster their participation in the programme. It discusses why mobilisation is important to CTC, describes the elements of a successful mobilisation effort and explains how to formulate and implement a mobilisation plan.

5.1 Why Mobilise?

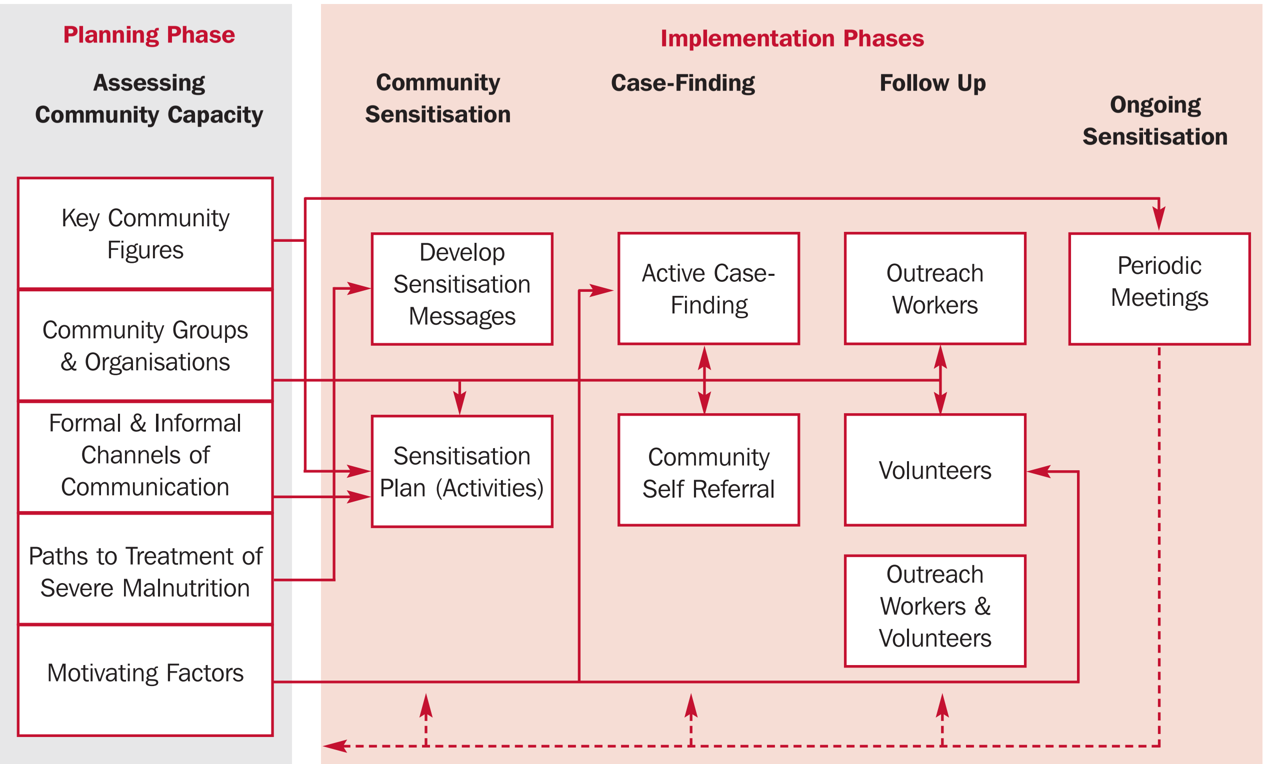
Establishing coverage. CTC's success hinges on the question of coverage. Experience to date with CTC suggests that there is normally a moment when the community comes to recognise the effect of RUTF on sick children. Once recognised, programme admissions increase rapidly, leading to good coverage levels. Reaching this point is largely a matter of effective mobilisation. Without effective mobilisation, the programme may find itself attracting the wrong people (healthy children, families that expect a general ration) and create misunderstanding regarding entitlements. The ill-feeling generated by turning away those who perceive themselves to be entitled can reduce participation among target families. However, with good channels of communication, a clear description of the target population and efforts to allay concerns or misunderstandings, a programme stands maximum chance of creating a positive cycle, in which the good experience of families participating in CTC is related back to their neighbours through word of mouth encouraging attendance and increasing coverage.

Ownership and sustained coverage. CTC relies on an active, volunteer labour force to carry out a variety of outreach functions, including case-finding in the community, assisting with OTP/SFP and following-up OTP children where required. Through efforts to establish genuine community participation, the programme can maximise the chance that volunteers have a good understanding of their duties, that they are selected from the most committed pool of candidates, and that their work is scrutinised and facilitated by community leaders. The objective is to combat any tendency to offload responsibility for difficult programme legwork to a few, already overburdened individuals, and to establish an outreach system that makes the best use of all available community resources – material, human and intellectual.

5.2 Elements of Community Mobilisation

The process of mobilising communities varies widely depending on the context and on the programme's overall objective (e.g. emergency relief versus long-term developmental work). However, in most cases the implementation phase of community mobilisation covers at least four activities: community sensitisation, case-finding, follow-up and ongoing sensitisation.

Figure 8: Elements of Community Mobilisation



5.2.1 Community Sensitisation

Community sensitisation promotes understanding of programme objectives and methods. Typically there are three steps in this process: planning, formulating sensitisation messages, and disseminating these messages. Information gathered in the assessment of community capacity (see Section 4.2) guides planning. The more comprehensive the assessment, the more targeted and effective the sensitisation messages are likely to be. Common features of a sensitisation campaign might include:

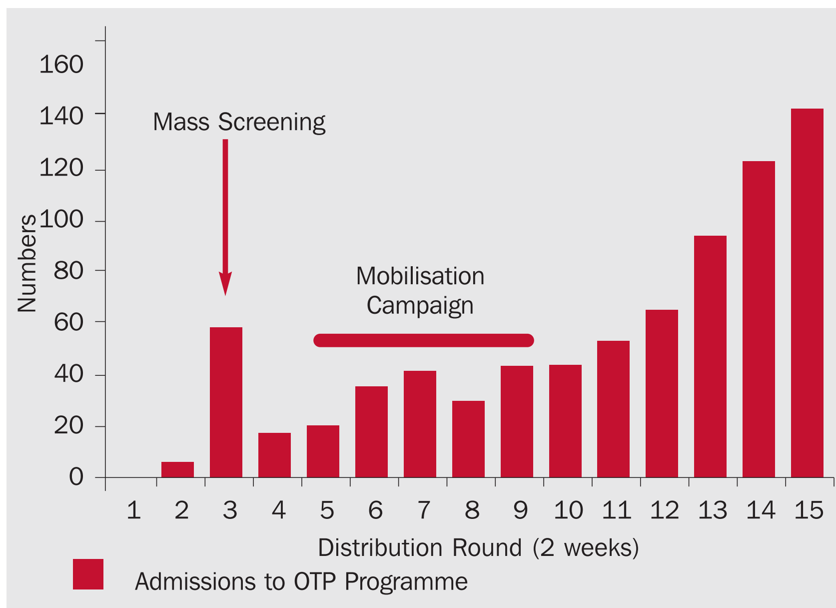
- Information sessions with village leaders;
- Training sessions with Community Health Workers and volunteers;
- Announcing schedule of activities to local people; and/or
- Describing the physical characteristics of target children based on local understanding of, and the terminology used to describe, malnutrition.

Box 4: Traditional Leaders and Community Sensitisation in Malawi

The CTC programme run by Concern Worldwide and Valid International in Dowa District, Malawi since 2001 demonstrates the important role traditional leaders can play in increasing programme uptake and coverage and in identifying and addressing obstacles at a community level. In the initial stage of the programme, there was insufficient communication with local social structures and contact with traditional leadership networks was neglected. This had a substantial impact on programme coverage and uptake at the start. The programme was not well understood and people distrusted the unfamiliar weight-for-height measurement procedure used at that time. The failure of the programme to recognise this and to inform and involve local leaders resulted in low attendance and coverage in the first three months.

Once the reasons for this poor participation were understood, changes were made to the programme. As a result, traditional leaders became more positively involved. Understanding of CTC improved and there was a rapid rise in admissions to the programme (see Figure 9). Seasonal factors and the successful treatment of children in the programme probably contributed to this increase, but the active involvement of traditional leaders in mobilising the community also helped to dispel doubts and increase the community's engagement.

Figure 9: Admissions, Exits and Total in OTP Programme, Dowa District, Malawi, August 2002 - March 2003



5.2.2 Case-Finding

In CTC programmes, self-referrals from the community stimulated by community sensitisation activities may in time represent the bulk of admissions. However, especially at the outset, CTC normally supplements self-referral with active case-finding. The aim is to repeatedly screen children under five years of age, usually via a network of volunteers. There may also be some individuals (teachers, traditional healers, pharmacists) who are normally in contact with malnourished children in the course of their work and who can be recruited into both sensitisation and opportunistic case-finding. The particular balance struck between these two approaches to case-finding will depend on the context. If the programme is an emergency response, rapid high coverage is the priority, making active case-finding important; in a development context, greater weight may be given to sustainability, and an opportunistic approach may be a better use of scarce resources (see Section 5.3.3).

5.2.3 Follow-Up

Follow-up aims to investigate the reasons for absence and defaulting and encourage return to the programme. It also aims to investigate reasons for poor response and provide support for any problems carers are having with the protocols. It should be carried out according to the action protocol (see Annex 10). Deciding on who should carry out the follow-up of children who fall within the action protocol will be context-specific and will depend on the overall numbers of children who require monitoring.

5.2.4 Ongoing Sensitisation

Community sensitisation is an ongoing two-way process between the programme and the community. While much of the activity takes place early in the programme, it should be continually reinforced in order to be effective. The process should be seen as a constant dialogue, in which communities periodically voice their views and suggest alternative courses of action. Regular community contact can help identify new barriers to access, and can provide timely, jointly-developed solutions. The information gathered during the planning stage will help to determine the most appropriate mechanisms for carrying out periodic dialogue with the community.

5.3 Formulating and Implementing a Mobilisation Plan

Defining the mobilisation approach, based on the information collected during planning, starts with the specific components that a given CTC programme will have – for example, the presence of SFP, health education or food security components will each have different implications for mobilisation. So too will the degree of severe malnutrition present in the community. Where SAM is comparatively rare, it may be hard to justify a broad, campaign-style mobilisation, and a narrower mobilisation centred on sensitisation and self-referral may be preferable.

The plan should determine the principal vehicles for mobilisation activities. Using insights from the assessment of local capacity, the plan should identify the most useful health sector partners (e.g. health promoters, community health workers), as well as resources from other sectors, such as women's groups, farmers' unions, traditional health practitioners and youth groups. It is important to consider the long term implications of various mobilisation techniques. For example, choosing between a paid or a voluntary outreach network (see Section 5.3.2).

5.3.1 Develop a Sensitisation Strategy

Once the overall mobilisation approach is formulated, a sensitisation strategy needs to be developed. Sensitisation messages are formulated to provide essential information about CTC; what the programme does, where and how services will be offered and to whom. Messages should be tailored to the target population, using the local vocabulary of malnutrition and addressing in advance potential pitfalls or community sensitivities identified during the community capacity assessment. It may be helpful to consider giving messages in the form of one-page leaflets addressed to specific audiences (secular leaders, traditional healers and local heath sector partners). Messages addressed to a general audience should usually be simple enough that they can be read to an illiterate audience by unsupervised volunteers. They should be brief but comprehensive. Visual aids can greatly enhance the impact of the message and the community's level of engagement with the information offered. Achieving the right balance between simplicity and specificity may require some practice with translation and back-translation. Guidance on the content of sensitisation messages is given in Annex 11.

The messages are formulated for dissemination through channels of communication identified during the assessment stage. These may be a combination of formal and informal, traditional and modern; informal channels tend to be particularly useful. It is important to consult and involve key community figures, community organisations and groups such as volunteer networks and women's associations. Money and material goods can be a strong motivating factor but are inadvisable. People who are paid for delivering messages may not necessarily be convinced of the message or convincing in communicating it. If material benefits are offered, communities often put forward more powerful and privileged individuals to do the work, excluding more motivated, interested and credible people.

5.3.2 Determine the Appropriate Structure for Outreach Activities

Outreach consists of case-finding, case follow-up through home visits, and any other activities undertaken in the community outside the health facility or OTP site. Based on information gathered during the planning stage, a system of outreach can be designed that is appropriate to the local context. The system should take maximum advantage of existing health structures and networks, while recognising their limitations. It should allow room for

community initiative, be aware of potential barriers to access and assign clear responsibility for supporting outreach activities.

Key decisions include deciding on the balance of active and opportunistic case finding, choosing between paid outreach staff and volunteers, and deciding on the level of involvement of traditional practitioners. These decisions are discussed further below. The conclusion from CTC programming to date is that most outreach systems will comprise elements of all these. The needs of outreach in any given location also tend to change over time, from intense activity at the start of a programme to a more routine rhythm of activities, making it appropriate to think in terms of more than one style of outreach.

Opportunistic versus active case-finding. How mobile should case-finding be? At the inception of CTC in nutritional emergencies, in order to identify the majority of cases in a timely manner, active case-finding should be energetically pursued across the widest possible area on a regular basis. This can be done using a large, very mobile team of case-finders with MUAC tapes. It may also be done by less-mobile case-finders working in a similar way but in small catchment areas close to their homes, thus reducing the time they need to devote to case-finding activities. This second option is likely to be more appropriate where access to the community is intermittent due to insecurity and has the advantage of not requiring case-finders to travel large distances. This approach may be supplemented – or replaced in some non-emergency situations – by a more opportunistic approach to case-finding. This involves working with a network of 'CTC focal points' whose social role (church pastor, traditional healer, pharmacist or teacher) means that they come into regular contact with children. These CTC focal points are trained to carry out MUAC measurements and check for oedema on the children they encounter and refer into the programme. This approach might be particularly appropriate where the prevalence of severe malnutrition is low – making it costly and impractical to mobilise the community or employ programme staff to carry out active case finding.

Salaried workers versus volunteers. Discussions during the assessment of community capacity will normally provide a good sense of the issues around paying for outreach work. CTC programmes to date have had good results from the use of both paid and unpaid outreach. The advantage of employing outreach workers is that case-finding tends to be better organised and efficient because workers are accountable to the programme. However, this needs to be weighed against the risks to sustainability: a

programme that wants outreach to continue after the cessation of NGO operations may wish to forfeit this efficiency in favour of lasting outreach arrangements. On the other hand, while using volunteers is arguably more sustainable, the fact that they are unpaid may incline the implementing NGO to engage less closely in the appointment process. This can lead to inappropriate individuals being 'assigned' to outreach by the community leadership. This tendency can be minimised by discussing and agreeing with community leaders the characteristics that are desirable in volunteers – both as individuals (degree of literacy, age and mobility) and as a group (desired gender balance, mix of ethnicities, or religious affiliation). Before volunteers are accepted, it is important to be clear about the degree of effort required of the position and that can be appropriately expected of unpaid workers. Ultimately, many situations call for a mix of paid and unpaid outreach work. For instance, volunteers may be used to visit households in a small area close to their own home, while one or more paid outreach supervisors monitor and support their work over the entire programme area. It is also possible to find ways of offering rewards and incentives without paying salaries – e.g. through in-service training, or by paying allowances during periods of particularly intensive activity, such as initial community screenings.

Involvement of traditional practitioners. In isolated, rural settings, traditional practitioners are usually far more in evidence than government-trained clinical staff, and they represent an important first line of consultation for the families of malnourished children. CTC capacity assessments in Ethiopia, Sudan, Malawi and Zambia have found that numerous OTP cases have previously been under the care of a traditional practitioner – sometimes many months before admission to the CTC programme. The cooperation of traditional practitioners in the referral of swollen or wasted children can allow us to catch the child before malnutrition and disease are too advanced. However, this is sometimes easier said than done. Local clinic or health centre workers may have an adversarial relationship with healers, making it difficult to secure the latter's cooperation; healers tend to work in isolation, making it necessary to meet them on an individual basis; and the arrival of a CTC programme may threaten healers' livelihoods. Sensitivity and perseverance are needed.

5.3.3 Establish Means of Regular Contact with the Community

Once the programme has become operational and mobilisation activities are underway, appropriate mechanisms should be established to maintain

regular contact with the community. The information collected during the planning stage is key to identifying the most appropriate channels, individuals and forums in which to conduct this dialogue. In the past, this has taken the form of monthly meetings with key community figures and regular meetings with members of the community directly involved in the programme. These meetings should aim to provide the community with a forum to discuss CTC-related issues, as well as any information that the community requires or wishes to transmit to the programme implementers. Discussions should aim to be a two-way process of communication. These meetings should ideally be conducted in a setting conducive to open dialogue – in areas with opposing socio-political or cultural groups, integration should be sought only if the outcome seems justified.

Figure 10: Implementing Community Mobilisation

Methods	Considerations	Outcomes Sought
Develop Sensitisation Messages		
Decide on a set of core messages (see Annex 11) and refine them for maximum clarity and brevity, beginning in English. Translate into local language(s), and back-translate to ensure accuracy.	Information on differences in clinical versus local definitions of malnutrition may be important here. Local terms for diseases of swelling and wasting can be used to refer to the target children. Stress the symptoms of wasting and swelling, rather than simply describing the target group as "malnourished".	A one-page leaflet that can serve both as a reference in explanatory meetings held with leaders and community organisations, and as an accurate description of CTC objectives and procedures when read verbatim to community members by unsupervised extension workers (see Annex 11).
Develop Case-Finding and Follow-Up Strategy		
Assessment of existing outreach structures and their applicability to CTC screening. Assessment of other potential case-finding agents (community based organisations (CBOs), Home-based Care groups, clinic staff, community health workers (CHWs) to determine whether additional actors can be harnessed for screening and case-finding.	The prevalence of severe malnutrition will determine the type of outreach that is appropriate. In humanitarian emergencies a blanket mobilisation for mass screening is usually needed. Where severe cases are rare, a more targeted approach can utilise strategically placed individuals (teachers, traditional healers, CHWs) who may be in close contact with the malnourished or their families.	A list or matrix summarising strengths and weaknesses of potential outreach agents, around which screening and case-finding strategies can be formulated.

Assessment of the training and resource implications of the chosen outreach plan/strategy.	Since malnourished children are often from among the most marginalised families in the community, it is important to ensure that outreach plans make provision for excluded groups (occupational, ethnic, spatial).	
Initiate Case-finding and Community Referral		
Outreach by various means, including: • Existing CHWs or other extension staff. • Specially recruited volunteers. • Specially recruited paid workers. • Informal volunteers (e.g. traditional health practitioners). **Referral** by strategically placed individuals in the community (e.g. teachers, traditional healers) and local health facilities using MUAC. **Self-referral** by families and communities.	Experience has shown that if sustainability is an objective, it should be addressed at the planning stage, rather than as an afterthought. If outreach workers are unpaid volunteers, it is important to be clear at the outset about the level of effort expected of them.	Malnourished children are identified in their homes and villages, circumventing barriers to existing health service access. Successful case-finding helps to establish a good understanding among community members about the CTC target group – leading to a surge in appropriate referrals and self-referrals.

Methods	Considerations	Outcomes Sought
Initiate Follow-Up		
Follow-up by various means, including: • CHWs or other health staff as new part of their official duties. • Specially hired workers in the case of short-term emergency programmes. • Trained volunteers – working independently or supporting Ministry of Health (MoH) outreach networks.	Follow-up in the home frequently confronts workers with additional questions about the sick child. Choosing workers who have some clinical or health education experience in the areas of breastfeeding, dehydration and weaning foods can make the home visits more effective.	All OTP cases that fall within the action protocol are followed-up and the condition of the child observed. Parents are re-instructed when necessary on feeding the child. Rate of RUTF consumption is checked and parents advised on adjustments if necessary.
Ongoing Sensitisation		
Including key community figures and other relevant people who can provide direct feedback about the impact of CTC programmes.	Ongoing dialogue with the community must consider possible social, political, religious or ethnic divisions within the beneficiary community. All sectors should be involved in this process (to identify possible marginalised groups).	Identify new barriers to access. Assess impact from a community perspective. Develop joint solutions to problems limiting the impact of the programme. Foster community ownership over the development and implementation of the programme.

5.4 General Considerations

Some challenges are common to community mobilisation. The most important are:

Travel requirements. Volunteers and outreach workers may have to travel long distances on foot each week to visit villages and individual houses. This needs careful consideration when the case-finding strategy is developed. Various factors have to be taken into account: the size of the area and nature of the terrain, the number of case-finders involved and the capacity of the implementing agency to reward them.

Coordination. In situations where many NGOs are working in an area, volunteers may be working alongside others who are supported by a different agency. This is particularly common in large emergency responses. Approaches to active case-finding should be coordinated to avoid counter-productive activity. For example, a strategy based on unpaid volunteer case-finders can be threatened if a neighbouring agency introduces payment for their own volunteers.

Box 5: Traditional Health Practitioners and CTC in South Sudan

Traditional health practitioners such as birth attendants and healers are often the first tier in health response. Among the Dinka of South Sudan, banybith (spearmasters) have a special place as providers of a range of treatment for health-related conditions. Their role has not been significantly challenged by the arrival of 'Western' medicine.

In 2003-2004, CTC programmes implemented by Concern Worldwide and Tearfund in Bahr-el-Ghazal, explored ways to involve banybith. In Aweil East, banybith were initially sceptical but then spontaneously started attending CTC programme sites in order to observe and understand the services on offer. Subsequently they began referring malnourished children to the programme. In other areas of Bahr-el-Ghazal, the agencies approached banybith more proactively in order to boost community awareness of the CTC programme and increase the number of self-referrals.

Involving traditional health practitioners in the CTC programme offered them a way to help their community without undermining their role and position, and strengthened the CTC programme by raising awareness and trust in the community, and generating referrals.

Chapter 6

Supplementary Feeding Programme

SFP programmes provide a supplementary ration for malnourished children and pregnant and lactating mothers, Wollo, Ethiopia.

6. SUPPLEMENTARY FEEDING PROGRAMME

The supplementary feeding component of a CTC programme aims to support moderate acutely malnourished children without complications and others with special nutrient requirements by providing a supplement of energy and/or nutrients in a dry take-home ration. By doing this the SFP seeks to prevent deterioration to severe acute malnutrition; reduce excess mortality by catching children before they are at high risk of dying and prevent deterioration of maternal nutritional status and subsequent poor birth weight. This chapter describes issues involved in the planning of an SFP, admission and discharge criteria, the treatment provided and protocols used. Lastly, the chapter outlines the data required to ensure effective monitoring in the SFP.

The decision to start an SFP is usually based on a raised prevalence of acute malnutrition among children under five years and/or the presence of aggravating factors such as poor food security in the general population, disease epidemics and raised mortality (see Chapter 3). Where this is not the case CTC programmes do not provide supplementary feeding. All severely acutely malnourished children are treated through outpatient and inpatient therapeutic treatment sites (OTP and SCs) and OTP discharge criteria are raised to compensate for the follow-up that would have been given in the SFP.

A wide variety of guides exist detailing the rationale and protocols for running standard emergency SFPs. These can be used in conjunction with this chapter to provide additional detail:

- MSF. *Nutrition Guidelines* (revised), In Draft, 2004.
- UNHCR. *Handbook for Emergencies, Second Edition*. Geneva, 2000.
- USAID Bureau for Democracy, Conflict and Humanitarian Assistance Office of U.S. Foreign Disaster Assistance. *Field Operations Guide for Disaster Assessment and Response: Version 4.0*, September 2005.
- World Food Programme (WFP). *Food and Nutrition Handbook,* Rome, 2001.
- WHO. *The Management of Nutrition in Major Emergencies*, Geneva, 2000.

6.1 Planning

In most situations, an SFP acts as a safety net preventing excess mortality among vulnerable groups. The rations provided should be in addition to, and not a substitute for, the normal diet. A significant and continued reduction in the prevalence of malnutrition in a population is likely only if an SFP is implemented in conjunction with a general food ration. In situations where financial, political or logistical constraints prevent an adequate ration from being provided, supplementary feeding programmes can provide interim support. In such cases, a programme should continue to review and analyse the situation to ensure that the problem is addressed appropriately.

The SFP component of a CTC programme is implemented through a large number of decentralised sites. These are always at the same place as, or near to, the sites chosen for the OTP programme, and should be within a maximum of three hours' walk (a one-day round trip) for all target communities. This facilitates transfer between the OTP and SFP components of a CTC programme. OTP sites are, wherever possible, set up within existing health structures. Space constraints and considerations of other ongoing activities may necessitate placing an SFP nearby, rather than in the health structure itself.

The justification for intervention, the objectives and the target groups and a viable exit strategy must be defined at the start of the programme. (SPHERE, 2004) and (FANTA, 2004/a). The local community should be involved in the planning process in order to avoid common problems such as defaulting and non-response, sharing of food at household level and inappropriate timing of CTC programme days. The objectives of an SFP intervention should be measurable and time-bound. They may include:

- Preventing further deterioration in the nutritional status of moderately malnourished children for a pre-defined time period.
- Preventing deterioration in the nutritional status of a specific target group based on social or socio-economic criteria, for a pre-defined time period.
- Preventing excess mortality in the population.

6.1.1 Staff

The SFP requires at least one clinic staff member to perform medical checks on children who require more in-depth assessment. Ideally, this staff member should be a nurse. If the number of moderately malnourished children is low, it may be possible for existing Ministry of Health staff to

screen, admit and follow up the moderately malnourished children in their catchment area. Nurses and health workers may be assisted by other clinic support staff, such as guards, or cashiers who can be trained to do measurements and other tasks. If numbers are high (in particular during emergencies and at the start of a programme), additional support staff are needed to do measurements, distribute food rations and supervise the programme. In this case it is likely that the SFP will require a separate site nearby rather than alongside the health structures to avoid disrupting existing services.

If there are insufficient staff based at each site, or temporary programme sites have to be set up, they may be managed by mobile teams. Each team can usually visit five sites a week (more if the sites are close together). Each mobile team should comprise at least:

- A team leader, who should ideally have experience in distributions.
- Two measurers to weigh and measure the children. They can also help the OTP team leader with tasks such as counting packets (sometimes referred to as sachets) of RUTF and checking that carers understand the instructions they are given by the team leader. They may be part of the mobile team or they could be extension workers based at programme sites who, on non-programme days, lead mobilisation and follow-up activities in their area.
- One or two general assistants to register the children.
- medicines and carry out basic medical checks for transfer to inpatient care or medical referral for treatment in the clinic or hospital.
- A food distributor to mix food commodities and distribute rations.

In addition, an overall CTC supervisor is needed to manage the teams and ensure coherence between the SFP, OTP, SC and community components of the programme.

An initial one or two days of training is normally sufficient for SFP teams. This must be immediately followed by on-site training. A trainer or CTC supervisor should work with clinic or NGO staff as they admit and follow-up children in the clinics. Direct supervision should be given for the first two days of the programme, when children are being admitted for the first time, and then for the first follow up two weeks later. Supervision should include decision-making concerning transfer to OTP and inpatient care.

6.1.2 Equipment and Supplies

The equipment and supplies needed for an SFP are listed in Annex 12. All equipment and supplies, including food commodities, can be kept and managed at clinic stores if there is capacity, or transported by mobile teams in a strong equipment box. Alternatively, equipment and supplies could be stored in community stores where these exist. In addition, transport is needed for the small number of children who have to be transferred to the stabilisation centre. In an emergency context, transport is normally provided by the implementing NGO. In a longer-term programme, a transport provider must be identified.

6.2 Target Group and Admission/Discharge Criteria

There are usually insufficient resources to assist all vulnerable groups in a population, and it is necessary to identify and prioritise certain groups. This can be done through two types of supplementary feeding intervention:

Blanket supplementary feeding. In which a supplementary ration is provided to everyone in an identified vulnerable group (e.g. children under five or women of child-bearing age) for a defined period in order to prevent deterioration in nutritional status.

Targeted supplementary feeding. In which a supplementary ration is targeted on specific members of vulnerable groups whose requirements may not be met by the general ration (e.g. moderately malnourished children under five years or pregnant and lactating women).

Figure 11: Vulnerable Groups and Target Groups for SFP
(Modified from WHO, 2000/a).

Vulnerable Sub-Group	Specific Target Group
Population under five years.	Moderately malnourished and/or those discharged from therapeutic treatment.
Pregnant and lactating women.	Third trimester mothers, mothers who are visibly pregnant and/or lactating mothers with babies under six months.

Individuals with social and medical problems.	Twins, orphans, unaccompanied children, the physically and emotionally challenged, HIV-infected and affected people, people suffering from tuberculosis.
The elderly.	

CTC has experience so far with the first two sub-groups only and limited experience working with HIV-infected children. This chapter therefore addresses SFPs for children aged 6-59 months and for pregnant and lactating women.

6.2.1 Admission and Discharge Criteria for Children

There are many types of SFP and the admission and discharge criteria vary widely. The following are some common types of criteria in use.

Children are admitted to the SFP if they:

- Have MUAC <125mm (see Section 2.2.3);
- Are less than 80% of median weight-for-height;
- Have been discharged from the OTP.

Children are discharged from the SFP when they:

- Are more than 85% of median weight-for-height for two consecutive programme distributions (for MUAC admissions a fixed length of stay may be required, as for OTP);
- Have been absent for more than three consecutive distributions;
- Have to be transferred to OTP with MUAC <110mm, less than 70% of the median weight for height or on developing nutritional oedema;
- Have to be transferred to a stabilisation centre or hospital due to severe medical complications;
- Are non-responding, i.e. the child does not reach the target weight after four months of treatment;
- After being discharged from OTP, have received at least two months follow up in the SFP and have been more than 85% of the median weight-for-height for two consecutive programme distributions.

6.2.2 Admission and Discharge Criteria for Pregnant and Lactating Women

Pregnant and lactating women are admitted to SFP if they are:

- MUAC <210mm and second or third trimester (visibly pregnant); or
- MUAC <210mm and the baby is under six months of age.

Pregnant and lactating women are discharged from SFP when they are:

- MUAC ≥ 230mm or when their baby reaches six months of age.

A disadvantage of using MUAC in these cases is that, because of the way fat is accumulated, weight increase in women is not directly reflected in an increased MUAC. MUAC is therefore unlikely to increase substantially as a direct result of supplementary feeding. Many women may therefore remain in the programme until their child is more than six months old.

6.3 Treatment Protocols and Procedures

In most situations, the methodology and nutritional and medical protocols need to take into account national protocols for supplementary feeding. This may necessitate some revision of the basic protocols given below. This should be discussed with local health staff and nutrition/health advisors.

6.3.1 Nutritional Management of Moderately Malnourished Children

A dry food ration is provided weekly, every two weeks or monthly. The frequency of provision depends on resources, the need of the target population and ease of access to SFP sites. Food is distributed by weight using a balance or calibrated container and, wherever possible, should be transported home by mothers in their own containers. Where this is not possible, plastic bags can be provided.

The ration for one child should provide a maximum of 1000 to 1200kcal/person/day and 10-12% of energy from protein. The following foods are used (more information on these can be found from various sources):

- UNHCR and WFP. *Food and Nutrition Needs in Emergencies*, 2000.
- USAID. *Commodities Reference Guide*, 2000 http://www.usaid.gov/our_work/humanitarian_assistance/ffp/crg/.

- WHO. *The Management of Nutrition in Major Emergencies*, Geneva, 2000.

Blended cereals. Most blended cereals (corn soy blend is a common example) provide 350-400kcal per 100g of dry product. Supplementary porridges, made up to 150-200kcal per 100 ml, can be made up by carers at home.[6] If available, mineral and vitamin mixes for supplementary feeding should be added to blended cereals which are not pre-fortified. Blended cereals are often mixed with oil and/or sugar prior to distribution. This increases energy density, improves palatability and helps prevent rations being sold. However, the process of pre-mixing can be difficult in emergency settings and can reduce the shelf life of the ration (around two weeks when mixed with oil and sugar). Recipes for the pre-mix are given in Figure 12.

Local foods and family diets. Where possible, supplementary rations should be based on locally available foods, such as beans, rice and vegetables purchased or grown locally. However where animal source foods are in limited supply, a fortified food or a micronutrient supplement should be added.

High-energy and protein biscuits. High energy and protein biscuits are suitable for use in SFPs. They significantly increase the energy content of the supplementary diet and can be particularly useful at the beginning of an emergency operation. However long-term dependence on these products should be avoided. They are expensive and it is unlikely that families will be able to afford them when food aid stops. They may also be more likely to be sold. They therefore should not be given priority over locally available products.

Ready-to-use supplementary foods (RUSF). The nutritional composition of RUTF, which is currently used to treat severe acute malnutrition, may be adapted for moderate malnutrition. This option is being explored (see Chapter 12).

Milk. Whole or dry skimmed milk powder should not be distributed alone as a dry ration because when mixed with water becomes an ideal growth medium for bacteria and causes diarrhoea, or could be used inappropriately as a breastmilk substitute. It can be added to a blended food pre-mix for distribution.

[6] Using one part CSB/pre-mix and three parts water, the mixture is cooked until it has boiled and the consistency has thickened. A local measure is usually used to help the mother decide how much of each ingredient to use at home, e.g. one cup of premix to three cups of water.

Some examples of the composition of a weekly ration using blended cereal are outlined in Figure 12, other examples can be found in MSF's *First Edition Nutrition Guidelines*. (MSF, 1995).

Figure 12: Four SFP Daily Rations *(adapted from WHO. 2000/a)*

Commodity	Ration 1 (g)	Ration 2 (g)	Ration 3 (g)	Ration 4 (g)
Blended food, fortified	200	300	250	140
Sugar	15	20	20	30
Oil	20	0	25	50
DSM	0	0	0	50
Energy (kcal)	1000	1140	1250	1250
Protein (% of energy)	14	8	14.5	14.5

In some countries, blended food is premixed with sugar at source.

6.3.2 Medical Management of Moderately Malnourished Children

The following routine medicines are recommended in an SFP. A table with dosages is given in Annex 13; it should be used in conjunction with national guidelines.

Vitamin A. Children suffering from moderate malnutrition are likely to suffer from Vitamin A deficiency. Ideally, Vitamin A should be provided as a frequent low-dosage supplement. In reality, however, contact opportunities with young children and other vulnerable groups may be infrequent, and guidelines prepared by WHO, UNICEF and International Nutritional Anaemia Consultancy Group (INACG) take this reality into account (WHO, 2005/b). Routine supplementation with Vitamin A on admission is recommended, except for children being referred from a TFC or other health facility where Vitamin A has already been given, or where recent supplementation campaigns have achieved high coverage (see Annex 13). Often both blended cereals (such as corn soya blend (CSB)) and vegetable oil are fortified with Vitamin A. Ensure that in examining the need for Vitamin A supplementation, the content of Vitamin A in the ration is estimated. A child

showing clinical signs of Vitamin A deficiency should be referred immediately to the nearest health facility for treatment according to WHO guidelines.

Antihelminths. To ensure adequate weight gain, it is necessary to treat all children routinely for worm infections with Mebendazole or other appropriate antihelminth.

Measles vaccinations. All children between nine months and fifteen years of age should be immunised with measles vaccine. The vaccination status of the child should be checked on admission and where no record exists, referral should be made to an EPI site or clinic for vaccination. Where no facilities are available for referral, the vaccination should be provided within the programme at the SFP site.

Iron and folic acid. Where anaemia is identified according to IMCI guidelines, treatment should be provided according to WHO guidelines (INACG, 1998) ideally through referral to a health clinic or, where anaemia is severe, to an inpatient facility according to the action protocol (see Annex 10). Preventative daily (recommended by WHO) or weekly doses of iron and folic acid are difficult to provide in emergency feeding programmes due to the lack of follow-up, and so should be avoided unless they are specifically included in a national protocol.

Other treatments. Treatment for moderately malnourished children for additional specific medical conditions, that can be treated on an outpatient basis, should be provided through referral to existing clinic services and administered in line with national and international protocols. Children should remain registered in the SFP programme.

6.3.3 Monitoring and Transfer of Moderately Malnourished Children

Monitoring of children in SFP is important so that deterioration of their condition can be picked up and actioned. Weight and MUAC taken on every visit will allow children fulfilling criteria for OTP to be transferred appropriately.

Children with moderate malnutrition with severe medical complications (characterised by anorexia and life-threatening clinical illness) are sent to an inpatient facility for stabilisation. Where possible, transfer should be made to an inpatient structure, such as a health centre or district hospital. If this is not possible and the CTC programme has set up stabilisation centres, the child should be transferred to one of these. Annex 10 details medical

conditions that should action this transfer to inpatient care. At the inpatient facility these children should be treated in line with IMCI protocols for the management of the child with serious infections and standard WHO paediatric medical treatment protocols. See Chapters 1 to 6 of the WHO and UNICEF publication: *Management of the child with serious infection or severe malnutrition: guidelines for care at the first-referral level in developing countries* (2000). During their time in inpatient care children referred from the SFP should also receive RUTF rather than F75 in order to prevent nutritional deterioration.

6.3.4 Nutritional and Medical Management of Moderately Malnourished Pregnant and Lactating Women

The quantities, types of food and frequency of provision for moderately malnourished pregnant and lactating women depend on the adequacy of the general ration and the foods available, and should be defined to suit the context of the programme. The decision should take into account:

- The national protocol and norms for the area.
- The type, composition and quantity of food appropriate for supplementary feeding of moderately malnourished children, as described above. This provides an appropriate guideline.
- Discussion with key informants and participatory exercises in the community. These will provide information on appropriate methods of distribution and suitable foods.

The aim need not be to achieve nutritional recovery since this is not necessarily the objective. Rather, the aim is to provide additional or special nutritional requirements. This is especially relevant during pregnancy, when the nutritional status of the mother is directly linked to the birth weight of the newborn. Monitoring of women in the programme should link closely with ante and post-natal services, although this may be difficult in emergency settings.

Medical support for this group should be according to national and international protocols and should, where possible, be linked with existing ante-natal services. Routine supplementation in line with general WHO guidelines includes the provision of ferrous-folate for both pregnant and lactating women (INACG 1998) and Vitamin A for post-partum, lactating women only (WHO, 2005/b) and (LINKAGES/CORE, 2004).

6.3.5 Demonstration of Food Preparation

It is important to provide information to carers on the preparation of the supplementary food. This can most simply be achieved through a cooking demonstration at the SFP site, where the proportions of pre-mix to water, the cooking time, and the consistency of the porridge are demonstrated.

This and other health and nutrition topics can be discussed with carers while they are waiting to receive their supplementary food, thereby capitalising on the opportunities of contact. It is important however that health and nutrition education messages are formulated, delivered and discussed in an appropriate manner.

6.4 Data Collection and Monitoring

Essential data are recorded to ensure that children can be tracked through the various components of the CTC programme. Each child is given an individual case number on entering the SFP (see Chapter 9) and retains this number in all CTC programme records, including the SFP record card or register and the SFP ration card.

The case number and information on the child's nutritional and medical treatment and progress are recorded either on individual SFP record cards filed at the programme site, or in an SFP register kept at the programme site. A register may be more manageable with the large numbers of children commonly in SFPs. Agencies usually have their own record cards or registers for this purpose so examples are not given here. The amount of information recorded on the card or register is kept to a minimum. MUAC and weight gain/loss is recorded at every visit and height is recorded at admission and discharge and, for children, once a month if possible. An SFP ration card is also given to the individual or carer. An example is given in Annex 14.