Annexes

Annex 1: Definitions of Grades of Oedema

Grades of Oedema	Definition
Absent	Absent
Grade +	Mild: both feet/ankles
Grade + +	Moderate: both feet, plus lower legs, hands, or lower arms
Grade + + +	Severe: generalized oedema including both feet, legs, hands, arms and face

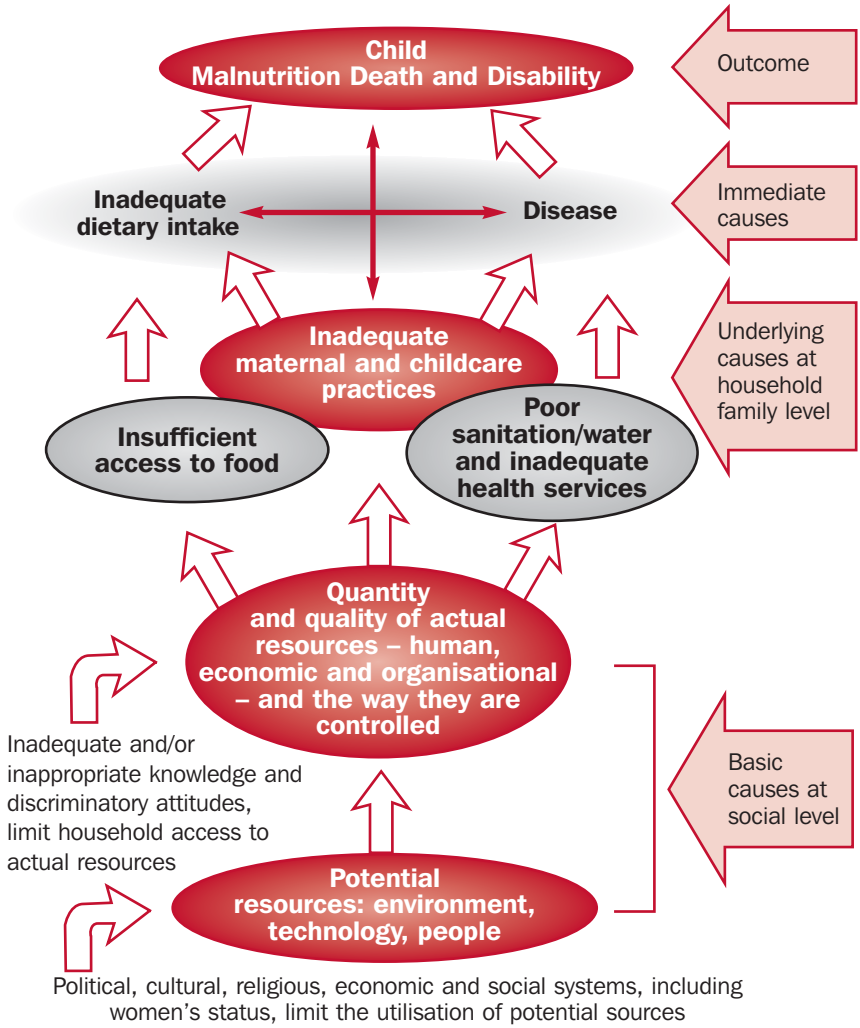
Annex 2: Sources of Bias in Nutrition Surveys

Type of Bias	Cause
Incomplete coverage	• Inaccurate or out-of-date sampling frame. • Large-scale population movements, distress migration. • Sampling subsections of the population, famine camps, feeding centres. • Geographical bias towards more accessible, affluent or urban areas.
Age or sex bias	• Samples of varying age composition, Younger children are more susceptible to wasting, while older children are more susceptible to stunting. All nutrition indices therefore vary according to the age structure of the sample. • If the population does not allow one sex to be measured for cultural reasons.
Non-random measurement error	• Systematic errors because of faulty weighing equipment or incorrect measuring techniques. • Inadequate training and supervision. • Non-standardised measuring equipment.

Annex 3: Causes of Child Malnutrition

(adapted from UNICEF, 1990)

This conceptual framework on the causes of malnutrition was developed in 1990 as part of the UNICEF Nutrition Strategy. The framework shows that causes of malnutrition are multi-sectoral, embracing food, health and caring practices. They are also classified as immediate (individual level), underlying (household or family level) and basic.



Annex 4: Logframe Refresher

The logical framework (logframe) defines a project's goal, purpose, outputs and activities. These are logically linked, taking into account certain defined assumptions.

The framework is presented as a 4x4 matrix.

Hierarchy of Objectives	Objectively Verifiable Indicators	Means of Verification	Assumptions and Risks
Goal: Highest level objective that the project will help to address (the project rationale).	The evidence (quantitative/qualitative) that will be used to judge achievement of the goal.	The specific sources of data necessary to verify the indicators of the goal.	External factors necessary to achieve the objectives.
Purpose: Impact the project intends to bring about with the outputs.	The evidence (quantitative/ qualitative) that will be used to judge achievement of the purpose.	The specific sources of data necessary to verify the indicators of the purpose.	External factors necessary for project purpose to contribute to the project goal.
Outputs: Specific results that the project will deliver.	The evidence (quantitative /qualitative) that will be used to judge the achievement of the outputs.	The specific sources of data necessary to verify the indicators of the outputs.	External factors necessary for project outputs to achieve the purpose of the project.
Activities: The actions carried out during the project to accomplish the outputs.	Inputs: A summary of the project budget and other key inputs relative to the tasks.i	The specific sources of data necessary to verify the indicators of the activities.	External factors necessary for activities to result in project outputs.

The top two rows describe what it is you are trying to do and the bottom two rows describe how you are going to do it, Goals and Purposes are what we want to achieve and should not be changed. Outputs and Activities are like theories or hypotheses about how to achieve the aims – if they do not work well, they should be changed.

The first column (from the left) shows the hierarchy of objectives, defined in the table above. The second column shows indicators: measurements that will verify whether or not the objectives have been achieved. The intention of each part of the project is clear from the choice of indicators. Indicators should be expressed in terms of time, quantity and quality. They may also need to specify cost and/or place. They should be plausible and easy to measure.

The third column addresses how to verify that the indicators have been met. This column is used to plan the schedule for confirming that each objective has been achieved. The objectives and the indicators are part of the project. The column refers to measurements taken by the project in the environment. These are generally recorded details such as publications, surveys, project notes and reports.

The final column addresses important assumptions and risks, i.e. external conditions affecting the project that are either outside the control of the project, or the project chooses not to exert control over them. When considered along with the hierarchy of objectives, these should produce the necessary and sufficient conditions for achieving the next level up, e.g. IF [activities] AND [assumptions] THEN [outputs]. If something is in the direct control of the project, it cannot be an assumption or a risk. If a risk seems important (i.e. it is both likely to happen and is of serious consequence to the project's success), then the project design should be changed so that it can be managed and so cease to be a risk.

Logframe Logic

The hierarchy of objectives expresses a chain of cause and effect. Moving down the objectives, the logic is: in order to achieve the purpose, we must have the following outputs. Moving up the objectives, the logic is: if we have these inputs, we can achieve these outputs.

Hierarchy of Objectives	Objectively Verifiable Indicators	Means of Verification	Assumptions and Risks
GOALS: **If** we do these	to this standard	(measured like this)	**and** this assumption holds, **then** we are on track to accomplish bigger goals.
PURPOSE: **If** we do these	to this standard	(measured like this)	**and** this assumption holds, **then** we can contribute to the goals.
OUTPUTS: **If** we do these	to this standard	(measured like this)	**and** this assumption holds, **then** we will accomplish the purpose.
INPUTS: **If** we do these	to this standard	(measured like this)	**and** this assumption holds, **then** we can accomplish the outputs.

The logic implies that the lower order objective(s) are both necessary and sufficient to achieve the higher order objective(s). If the objectives at one level are insufficient to reach the objectives at the next level, the project cannot do what it is trying to do. If the objectives at one level are not all necessary for reaching the next level, resources will be wasted and the project will risk losing its focus. (An exception here is the relationship between the purpose and the goals – the purpose need not be necessary and sufficient to achieve the goals: it should merely be necessary and sufficient to make an important contribution to the achievement of the goal).

Annex 5: Example of a CTC Logframe

Hierarchy of Objectives	Objectively Verifiable Indicators	Means of Verification	Assumptions and Risks
GOAL: May be: • Wider emergency programme aims, e.g. minimising losses associated with a nutritional crisis. • Longer term aims, e.g. more general developments and improvements within the health service system.	These are important for the overall evaluation of a wider programme. They are less relevant for the monitoring and management of the CTC programme.		
PURPOSE Likely to concern the development or performance of a system that provides effective treatment for acute malnutrition for a defined population.	The purpose is the central aim of the project. It is important therefore to be able to measure it as *the project progresses* and to make any necessary changes to the outputs and inputs. Indicators are to be targets (with dates so that progress can be measured) for: • Measures of mortality and the recovery of children in the programme. • Measures of coverage. • Sustainability.	Data needed to show progress made towards the purpose.	The ability of the programme's purpose to contribute to the wider goals is likely to be full of assumptions. However, as these involve the performance of other (non-CTC) programmes, they are usually not crucial to the CTC programme.

Hierarchy of Objectives	Objectively Verifiable Indicators	Means of Verification	Assumptions and Risks
OUTPUTS Likely to refer to the performance of the various components of the CTC programme (community mobilisation, OTP, SFP, SC). Typical output objectives include: • OTP: Recovery rates for enrolled children. • Community mobilisation, SFP and OTP together: most eligible children are covered by the programme.	Measurable targets are needed for each component and for anticipated interaction between them. They must ensure that coverage (the priority of CTC) is monitored as soon as possible so that activities can be properly phased. Some examples: • OTP: indicators concerning OTP centre performance in terms of recovery rates, defaulters etc. It may be possible to specify target numbers for each centre according to the estimated caseload of the catchment area. • Estimates and measures of coverage should be used as early as possible. Community mobilisation investigations should feed back into planning of other components.	Specific methods to measure indicators may need to take into account introduction of new activities during the programme. For example, coverage surveys will be needed; it may be useful to consider proxy indicators for early monitoring of coverage.	This cell makes explicit the factors that could prevent the project achieving its purpose. Some examples: The performance of the SC can be stated as an assumption if it is run by another agency as the TC programme cannot refer children to a facility providing poor treatment. If the agency is unlikely to achieve the required standards, the plan may need to be altered to manage the risk (e.g. assisting the agency to meet the required standard, or finding an agency with the capacity and skills to run the SC). The capacity and performance of the agency/ies responsible for delivering the general ration can be stated as an assumption as the CTC programme is unlikely to succeed in its absence. Plans may need to be developed to manage this risk. Security problems can affect the ability to work in certain ways (or even at all) in an unstable ornsecure area. It may require measures to minimise the risk such as avoiding certain locations, working only with clearances and permits, or negotiations with combatants for safe access.

Hierarchy of Objectives	Objectively Verifiable Indicators	Means of Verification	Assumptions and Risks
ACTIVITIES These are the actions needed to achieve each of the outputs. Much of the specific planning appears here. Typical input objectives might include: • OTP: OTP sites are available and accessible to all on a weekly basis; centres function with adequate screening, treatment; staff trained etc. • Community mobilisation: Key community members are identified and mobilised for case finding; resistance to service uptake is assessed and addressed; dialogue with key actors in communities is maintained; etc.	Measurable targets are needed for each component. These ensure that the inputs of the various components function properly within a specific timeframe. Some examples: • OTP: Maximum distance between CTC programme site and target community is less than 3 hours walk within x weeks; screening, diagnosis and prescribing in CTC centres functioning correctly within x weeks; waiting time no more than x hours/minutes at centres within x weeks; etc. • Community mobilisation: Relevant community institutions are identified within x weeks and are actively case finding within y weeks; potential obstacles to case finding are identified by x date and addressed by y date.	Most verification will come from reports on progress in the establishment of the programme components.	Many small practical assumptions and risks may be identified here. Confronting them explicitly and thinking about how likely they are and how damaging they could be to the programme might mean plans need to be revised.

Annex 6: Indicators for Assessing Quality and Appropriateness

Indicator	Means of Verification
CTC Programme as a Whole	
Existing health service capacity is assessed and aspects of integration discussed and planned with the relevant authorities, organisations and NGOs, including plans for the gradual phase-out of NGO support.	• Meeting reports. • Planning workshop output (capacity grid and action plan produced – see Annex 7).
Local authorities and other service providers understand the need for the programme, its objectives and the targeting criteria.	• Reports from key informant interviews.
Key community figures actively participate in planning, and are consulted periodically throughout the programme.	• Consultation/strategy plan.
Communities understand the need for the programme, its objectives and the targeting criteria.	• Focus group discussion reports. • Key informant interviews.
The NGO/implementing organisation has knowledge of the key people in the community involved in decisions concerning health-seeking behaviour for children.	• Social development study reports. • Focus group discussion reports. • Community meeting minutes.
The NGO/implementing organisation has knowledge of attitudes existing in the community towards the programme.	• Social development study reports. • Focus group discussion reports. • Meeting minutes.
Coverage >70% for rural environments, >70% for urban environments, and >90% for camp environments.	• Coverage survey - CSAS method (see Section 9.4.1).
More than 90% of the target population is within one day's return walk of the SFP/OTP programme centre (including treatment time).	• Review of cards (distance travelled is on record cards). • Focus group discussions with beneficiaries and non-beneficiaries. • Discussions with key community figures.

Indicator	Means of Verification
Investigations are carried out to identify barriers to access for children not being covered.	• Coverage survey (questionnaires for severely acutely malnourished children identified who are not in the programme). • Focus group discussion reports. • Key informant interviews.
Appropriate mechanisms are in place to incorporate feedback from the community into CTC programming to maximise coverage and compliance.	• Regular team meeting minutes.
Nutritional and medical care is provided according to evidence-based CTC protocols and international medical guidelines.	• Review of cards. • Supervision visits.
Admission of children to the programme is based on CTC criteria.	• Tally-sheets.
Equal attention is given to community mobilisation and clinical care (SPHERE, 2004).	• Staffing levels. • Resource allocations.
Mechanisms are in place for the tracing of children between components of the programme (SPHERE, 2004).	• Numbering system. • Review of cards.
Clear and manageable monitoring systems are in place (SPHERE, 2004).	• Tally-sheets. • Food testing reports. • Coverage survey reports. • FGD reports. • Community meeting minutes. • Nutrition surveys. • Meeting and visit reports. • Review of cards.

Indicator	Means of Verification
Monitoring figures are reviewed regularly and feed into the planning cycle.	• Monitoring plan. • Monitoring reports. • Programme planning meetings.
Particular to SFP	
>75% of exits recovered (SPHERE, 2004).	• Tally sheet reports.
Cases of failure to recover are investigated.	• Review of cards.
<3% of exits died (SPHERE, 2004).	• Tally sheet reports.
<15% of exits defaulted (SPHERE, 2004).	• Tally sheet reports.
Causes of default are investigated.	• FGD reports. • Outreach reports.
Programme is linked to existing health structure if available and appropriate, and protocols are followed to identify health problems and refer accordingly (SPHERE, 2004).	• Review of cards. • Referral procedures.
Appropriate and timely referrals are made to OTP or inpatient SC care according to SFP referral and medical action protocol (see Annex 9). >75% of exits recovered (SPHERE, 2004).	• Review of cards.
Appropriate and timely referrals are made to inpatient care according to the OTP action protocol. (The number of referrals may be higher at the beginning of the programme where more cases of complicated acute malnutrition are encountered).	• Tally sheet reports. • Review of cards.
Particular to OTP	
Cases of failure to recover are investigated (through discussion at programme site with carers, home visits and referral for further medical investigations e.g. when HIV/AIDS or TB is suspected).	• Review of cards.

Indicator	Means of Verification
<10% of exits died (SPHERE, 2004). (The lowest possible death rate is aimed for. The death rate in SC would be expected to be higher than in OTP as it treats the most severe cases – mortality rates may also be higher where there is a high prevalence of HIV/AIDS).	• Tally sheet reports.
Causes of death are monitored continuously. (This can lead to improvements in care and can have a major impact on mortality in the SC and OTP by identifying problems early (e.g. water quality, cross infection, disease epidemic)).	• Compilation report on deaths.
<15% of exits defaulted (SPHERE, 2004). (Default rate is a measure of the acceptability of the programme. A high rate may reflect poor access to the programme, inappropriate care/treatment in the programme or events outside of the programme such as population movement, insecurity or harvest).	• Tally sheet reports.
Causes of default are investigated in order to enable appropriate modification of the programme.	• Review of cards (reasons are recorded on cards). • Outreach reports (where reasons are compiled). • Reports of focus group discussions with key community members and beneficiaries.
Discharge criteria include non-anthropometric indices such as good appetite and the absence of diarrhoea, fever, parasitic infestation and other untreated illness (SPHERE, 2004).	• Review of cards. • Supervision visits.

Indicator	Means of Verification
The average length of stay in OTP is < 60 days and weight gains >4g/kg/day. (Lower rates of weight gain are more acceptable in outpatient programmes because the risk of exposure to infection and the opportunity costs for beneficiaries are much lower).	• Monthly reports.
Constraints on caring for malnourished children and affected family members should be identified and addressed (SPHERE, 2004).	• Review of cards (reasons for non-response are recorded on cards). • Outreach reports (where reasons for non-response are compiled). • Focus group discussion reports. • Reports of discussion with key informants.
Causes of readmission are investigated. (Some reasons for high numbers of readmissions may be chronic health problems (HIV/AIDS, TB), poor health environment, disease outbreaks, poor overall food security and lack of general ration, poor care practices).	• Review of cards.
Capacity of existing systems is monitored. (As the programme is integrated to some extent into existing systems (services and community), it is important to monitor the capacity of these systems throughout the programme).	• Meeting minutes. • Capacity grid (see Annex 7) and action plan updates.
Particular to SC	
The average length of stay in SC is 4-7 days. (Certain cases may take longer to stabilise e.g. children with HIV/AIDS. However if the average length of stay of all cases is prolonged, the SC should evaluate its medical and logistical practices to identify the cause).	• Monthly reports.

Indicator	Means of Verification
Referrals to hospital are <10% of exits. (If referrals to hospital form a greater percentage of exits from the SC, the causes need to be investigated. Further staff training may be required).	• Register book.
Clinical status of the child is regularly monitored.	• Review of cards.
Feeding of children is monitored.	• Observation during supervision visits.
Minimum of one feeding assistant for ten inpatients.	• Staffing plan.
Carers are involved in caring for their children and understanding treatment regimes. (This allows for better transition to OTP where carers retain responsibility for the treatment of their child).	• Carer interviews. • Observation during supervision visits.
Discharge criteria are based on non-anthropometric indices: freedom from serious medical complications, reduction of oedema, and return of appetite.	• Review of cards. • Supervision visit reports.
Feeds are calculated and prepared accurately.	• Food balance reports. • Supervision visit reports. • Review of cards.
Standard hygiene practices are used in general and when storing, preparing and handling food. (Hands washed with soap after defecation (staff and beneficiaries) and before food is handled. Foods should be thoroughly cooked and served promptly. No cooked food should be kept for more than two hours without refrigeration. Persons with infections on their hands should not handle food).	• Supervision visit reports.

Annex 7: Capacity Grid

Capacity to Implement OTP

Activity	Who Currently	How Currently	MOH Capacity To Do	Gaps	Solutions*
Supply of drugs to site					
Supply of RUTF to site					
Supply of cards, bands and reporting formats to site					
Screening and registration of severely malnourished at HC					
Medical assessment of the OTP child					
Giving medicines and RUTF (according to OTP protocol) to the OTP child					
Health and nutrition education					
Weekly beneficiary monitoring -					
ID non-response and defaulters					
Link to volunteer for follow-up					
Discharge of beneficiaries					
Referral to SC/hospital					
Fill in tally sheets					
Storage of drugs and RUTF					
Stock control for drugs and RUTF					
Ongoing training of clinic workers in OTP protocols and reporting					

*Modification to programme/protocols, support needed, or ideas of how to resolve,extra discussions needed and with whom.

Capacity to Implement SC

Activity	Who Currently	How Currently	MOH Capacity To Do	Gaps	Solutions*
Supply of drugs to site					
Supply of RUTF and milks to site					
Supply of cards, bands and reporting formats to site					
Screening and registration of severely malnourished					
Medical assessment					
Calculate milk feeds and supervise feeding					
Monitoring of beneficiary					
Health and nutrition education					
Referral to hospital					
Discharge of beneficiary to OTP					
Provision of food for carers					
Fill in tally sheets					
Storage of drugs and RUTF					
Stock control for drugs, milk and RUTF					
Ongoing training of SC workers in phase 1 protocols and reporting					

***Modification to programme/protocols, support needed, or ideas of how to resolve,extra discussions needed and with whom.**

Capacity for Community-Led Case-Finding and Follow-Up

Activity	Who Currently	How Currently	MOH Capacity To Do	Gaps	Solutions*
Mobilisation					
Active case-finding					
Follow-up of non responders					
Follow-up of defaulters					
Health and nutrition education					
Supervision of volunteers					
Meetings for feedback and problem-solving with volunteers					
Feedback from community on the programme					
Ongoing training for volunteers					
Links with other sectors e.g. medical treatment, growth monitoring, nutrition education and agricultural and extension programmes					

***Modification to programme/protocols, support needed, or ideas of how to resolve,extra discussions needed and with whom.**

Capacity for Supervision and Monitoring the Programme

Activity	Who Currently	How Currently	MOH Capacity To Do	Gaps	Solutions*
Supervision of OTP sites					
Supervision of SCs					
Checking and collection of tally sheets for OTP					
Checking and collection of tally sheets for SCs					
Compilation of monitoring reports					
Dissemination of monitoring reports					
Checking and collection of RUTF and meds stock control sheets					
Compilation of stock reports					
Checks on storage conditions					
Coordination/links with other programmes					
Problem solving and coordination meetings					
Review of progress towards integration objectives					

***Modification to programme/protocols, support needed, or ideas of how to resolve,extra discussions needed and with whom.**

Annex 8: Overview of Resources Needed for a CTC Programme

Here we offer an overview of the resources needed, in addition to the normal requirements of any programme.

Staff

- Community mobilisation and outreach:
  - A community supervisor; and
  - A team of community volunteers.

Supplementary feeding programme:

- A team leader (ideally with experience in food distributions);
  - Two measurers;
  - One or two health workers or Ministry of Health nurses;
  - One or two general assistants; and
  - A food distributor.

- Outpatient therapeutic programme:
  - One team leader (a qualified health worker - nurse or medical assistant);
  - Two measurers; and
  - One assistant if numbers make it necessary.

- Stabilisation centre:[12]
  - Health staff (a minimum of one per shift for 24-hour care);
  - Nutrition/assistant health staff;
  - Support staff; and
  - NGO liaison/support staff.

[12] If the OTP is functioning well, the SC caseload should be low (normally between five and ten patients, depending on the catchment area). Staff roles may therefore be combined.

An overall CTC supervisor is also needed to manage the various components of the programme.

Training should be provided to all staff. A one-day orientation is given at the start of the programme followed by regular training and feedback days for staff and volunteers.

The budget for human resources will depend on where and how the programme is being implemented and by whom. Local salaries and per diems should be in line with the norm in the area. If per diems are given for training and allowances provided to Ministry of Health staff, these should be based on the Ministry's scale.

Equipment and Supplies

The materials required by the various components of a CTC programme are described in the chapters below and detailed lists are given in the other annexes. The following provides an overview of resources needed, in addition to the normal requirements of any programme.

- **Community mobilisation:** MUAC tapes, soap (to compensate carers whose child is referred but not admitted to the programme).
- **Supplementary feeding programme:** Height boards, scales, MUAC tapes, registration cards/book, ration cards (see Annex 14), corn soya blend, mixing equipment (if giving a premix of CSB and oil), basic medicines (as per protocols), soap, stationary.
- **Outpatient therapeutic programme:** Height boards, scales, MUAC tapes, medicines (as per protocols), RUTF, CSB, OTP cards (see Annex 17), ration cards (see Annex 27), soap (distributed to all beneficiaries weekly), stationary.
- **Stabilisation centre:** Height board, scales, MUAC tapes, drugs (as per protocols), F75, RUTF, SC cards (see Annex 29), stationary, equipment for preparing F75, cooking equipment (if cooking for carers).

Transport

- **Community mobilisation:** The CTC supervisor needs transport to sites. Volunteers are from the local community, so can normally travel on foot. A transport allowance is needed for training sessions held in a central location.

- **Supplementary feeding programme:** The mobile team needs daily transport. The CSB and equipment also needs to be transported to each site daily.
- **Outpatient therapeutic programme:** The OTP team needs transport to the site. RUTF and drugs also need to be transported to each site, initially weekly then later on a monthly basis if and when stocks can be left securely on site.
- **Stabilisation centre:** The SC may need transport for referrals in and out of the centre.

Physical Structures

- **Community mobilisation:** No physical structures should be needed for accommodation as community structures are used.
- **Supplementary feeding programme:** Many places have adequate accommodation in existing structures or shaded areas under trees. If not, temporary shelter will have to be provided. Local materials should be used if possible. Poles and plastic sheeting may be needed.
- O**utpatient therapeutic programme:** The OTP can be carried out in a simple temporary structure or under a tree, providing an area where children can be weighed and measured out of public view. If the OTP is run from a local health facility, additional accommodation may not be necessary if an area of the health facility can be allocated for the OTP.
- **Stabilisation centre:** Ideally the SC is run from an existing inpatient facility in a hospital or health centre so there should be no need to build a new structure. However, rehabilitation work or extension of an existing facility may be necessary. If there is no suitable inpatient facility, a structure will need to be built to provide adequate shelter.

Annex 9: Planning Community Mobilisation

Tools	Methods	Considerations	Outcomes Sought
Identify existing paths to treatment of severe malnutrition			
Formal and informal interviews Participant observation Visual aids	Discussion with key informants – such as parents, clinic staff, traditional health practitioners - to assess local perceptions. Examination of children brought to clinic for signs of alternative practices. Depict swelling, wasting – to help link specific physical conditions with terminologies and ideas.	Moral element to ideas about the causes of severe malnutrition can make this a sensitive topic. Informants may be reluctant to discuss "traditional" treatments, especially where these are actively discouraged by the modern system, so discussions are usually more productive if conducted where people live, rather that at the health centre.	A rough idea of the range of local ideas about causes of swelling and wasting and local terms used for these conditions; and the variety of people who may be involved in diagnosis and treatment of children. This can be in the form of a list or table. Used later to inform the sensitisation messages and outreach plan.
Identify and meet key community figures			
Formal and informal interviews Focus group discussions (FGDs)	Speaking with personnel involved in other public health interventions (e.g. immunisation, micronutrients) to identify local roles and individuals that have an influence on participation (e.g. religious leaders, political office holders, traditional elders, etc).	Seek gatekeepers who must initially be informed and involved out of courtesy, but also individuals with whom it will be important to establish a more regular working relationship.	Avoidance of harm – e.g. from proceeding without assent of community leaders. Creation of a consultative network of community contacts for sounding ideas and problem solving.

Tools	Methods	Considerations	Outcomes Sought
Identify and meet with community groups and organisations			
Formal and informal discussions	As a starting point MoH staff are likely to have a mental list of important partners (e.g. CBOs), but also involving NGOs and the extension staff of other ministries (e.g. Agriculture, Social Welfare, Women's Affairs) for a more complete picture.	In addition to formal groups and organisations there is likely also to be a parallel network of formal and informal cultural institutions (savings groups, funeral societies, initiation groups, healing societies, elders).	A list of community groups and social institutions, subdivided according to their utility to key CTC mobilisation challenges (e.g. disseminating info, identifying malnourished children, providing security or volunteer labour, helping with follow-up in the homes).
Identify and assess formal/ informal channels of communication			
Formal and informal discussions Focus group discussions (FGDs)	Ask people where and how they get news and information, and then gauge which of these channels (announcements by community leadership, talking with neighbours at water points, discussions in the marketplace, health education messages from CHWs, etc.) are suitable for which CTC messages.	The novel elements of CTC (MUAC, RUTF) are sometimes the subject of intense rumour and speculation. One objective at this stage is to identify the most effective ways to replace fear of the unknown with accurate information. Who can most convincingly pass this information to families?	Useful channels of communication are identified for specific communications challenges, such as: • Explaining anthropometry and admission criteria. • Securing compliance with RUTF regime. • Distinguishing CTC from similar services and procedures. • Reaching the most marginalised families with programme information.

Tools	Methods	Considerations	Outcomes Sought
Identify sources of motivation			
	On the basis of knowledge of community gained through other planning meetings (above) assess for each relevant actor how they might be motivated to play the roles envisaged for them and how this motivation can be built and mobilised. Health workers (including traditional health workers) might be motivated by increased effectiveness and by being publicly seen to have our respect. Mothers of treated children will be motivated to share their pleasure at their children's recovery. School children (and their teachers) might be motivated as part of a school club or activity. Shopkeepers might gain from being a source of information.	Note that where there are a lot of cases requiring treatment, the news will travel fast because there will be lots of examples to learn from and because the news about the programme will be relevant to a lot of people. Note that the programme itself will affect motivation – if it provides a reliable service and if case finding is accurate (few false positives) it will be ea ier to spread news about it. ` Note that tools – e.g. MUAC tapes – can motivate some people as it makes them seem and feel more 'official'.	A plan for the mobilisation.