

Annex 9: Planning Community Mobilisation

Tools	Methods	Considerations	Outcomes Sought
Identify existing paths to treatment of severe malnutrition			
Formal and informal interviews	Discussion with key informants – such as parents, clinic staff, traditional health practitioners - to assess local perceptions.	Moral element to ideas about the causes of severe malnutrition can make this a sensitive topic.	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.
Participant observation	Examination of children brought to clinic for signs of alternative practices.	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 than at the health centre.	This can be in the form of a list or table. Used later to inform the sensitisation messages and outreach plan.
Visual aids	Depict swelling, wasting – to help link specific physical conditions with terminologies and ideas.		
Identify and meet key community figures			
Formal and informal interviews	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.
Focus group discussions (FGDs)			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: <ul style="list-style-type: none"> • 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
<p>Identify sources of motivation</p>	<p>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.</p> <p>Health workers (including traditional health workers) might be motivated by increased effectiveness and by being publicly seen to have our respect.</p> <p>Mothers of treated children will be motivated to share their pleasure at their children's recovery.</p> <p>School children (and their teachers) might be motivated as part of a school club or activity.</p> <p>Shopkeepers might gain from being a source of information.</p>	<p>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.</p> <p>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 easier to spread news about it.</p> <p>Note that tools – e.g. MUAC tapes – can motivate some people as it makes them seem and feel more 'official'.</p>	<p>A plan for the mobilisation.</p>

Annex 10: OTP Action Protocol

Sign	Referral to SC / TFC / Hospital	Outreach Visit
OEDEMA	Grade +++	Oedema persisting.
	Marasmic-Kwashiorkor.	
	Increase in, or development of oedema.	
APPETITE / ANOREXIA	No appetite or unable to eat.	Eats < 75% of the RUTF a week by third visit.
VOMITING	Intractable.	General medical deterioration.
TEMPERATURE	Fever: >39°C.	
	Hypothermia: < 35°C	
RESPIRATION RATE (rr)	≥ 60 respirations/minute for under 2 months.	
	≥ 50 respirations/minute from 2 to 12 months.	
	≥ 40 respirations/minute from 1 to 5 year-olds.	
	≥ 30 respirations/minute for over 5 year-olds.	
ANAEMIA	Very pale, (severe palmer pallor), difficulty breathing.	
SUPERFICIAL INFECTION	Extensive infection requiring IM treatment.	
ALERTNESS	Very weak, apathetic, unconscious. Fitting / convulsions.	
HYDRATION STATUS	Severe dehydration based primarily on recent history of diarrhoea, vomiting, fever or sweating and on recent appearance of clinical signs of dehydration as reported by the carer.	
WEIGHT CHANGES		Below admission weight on week 3.
	Weight loss for 3 consecutive weeks.	Weight loss for 2 consecutive weighings.
	Static weight for 5 consecutive weighings.	Static weight for 3 consecutive weeks.
GENERAL	Carer requests inpatient care.	Returned from inpatient care (first 2 weeks).
		Refused transfer to SC.
NOT RECOVERING	If not recovered after 3 months, refer to hospital for investigation.	

Annex 11: Content of Sensitisation Messages

The following points are intended to stimulate discussion within the implementing agency, and between the agency and the community, and help formulate sensitisation messages that are both appropriate to the context and effective.

General Considerations

- Identify key people in the community who can ultimately facilitate the dissemination of information. They may include traditional leaders, traditional health practitioners and members of women's groups.
- Aim to create a forum for dialogue. Sensitisation messages are most effective when they are discussed and debated with the community. Encourage participants to ask questions, voice their opinions and expand or modify any aspect of the community mobilisation strategy.
- When dealing with traditional health practitioners, highlight the importance of their participation in programme activities.
- When using visual aids such as drawings of malnourished children, draw attention to the physical characteristics of malnutrition, especially those that are noticed and remarked on in the particular community or culture (e.g. children with 'loose skin on their arms like old people').

Malnutrition

- Definition of malnutrition: What are the different terms used to describe malnutrition? Is there a perceived difference between malnutrition and general sickness?
- Signs of malnutrition: What are the signs associated locally with malnutrition? These may include skinny legs/arms and loose skin.
- Causes of malnutrition: What are the perceived causes of malnutrition? Is it food-related?
- Acceptable treatment of malnutrition: How has the community traditionally dealt with malnutrition? Is knowledge of treatment available

to all? Are there specific people in charge of it? Does the formal health service play a role?

- Cases of malnutrition: Are there many cases of malnutrition in the community? How can these be identified?

The CTC Programme

The following points should be explained:

What the programme does

- The programme cares for malnourished children and offers them medicine mixed with food that will allow them to recover. Broadly discuss target groups (malnourished children, pregnant and lactating mothers etc).
- The programme identifies and admits children by measuring them and by comparing them to a normal healthy child. This shows whether they need special food or not.

How the programme does it

- The mother, father or carer brings the child to the CTC distribution site, where appropriate anthropometric measurements are taken of the child.
- If the child is malnourished, he/she is given special food to take home. Broadly describe the characteristics of RUTF using local terms.
- The carer should feed the special food to the child according to the advice given. The carer is taught how to prepare the food and feed the child and keep him/her healthy.
- They return to the site every week or every two weeks, depending on how malnourished they are.
- When the child gets better and his/her weight is back to normal, they are discharged from the programme.

Accessing/Using CTC Services

- Explain the location of CTC sites and discuss possible barriers that may be encountered (e.g. seasonal factors, socio-cultural issues, distance).
- Explain the ways a child may be referred – self-referral, through outreach workers, through volunteers.
- Explain that rejected children may decline and can be re-presented at a later date.
- Explain the procedures they will encounter at the CTC site (screening, medical checks, RUTF appetite test, health education etc).

Annex 12: Equipment and Supplies for SFP (per site)

	Item	Amount
1	SFP file for admission cards	1 per clinic
2	Marker pens (permanent ink)	2
3	Clipboards	2
4	Stapler and box of staples	1
5	Pens	3
6	Scissors	1 pair
7	Notebook	1
8	Calculator	1
9	Small clock with second hand	1
10	Bucket with lid	2
11	Water jug (with lid)	2
12	Plastic cups	10
13	Metal spoons	2
14	Teaspoons or medicine cups	6
15	Thermometer	3
16	Salter scale (25kg) plus pants	1-2 depending on caseload at each clinic
17	Height board	1-2 depending on caseload at each clinic
18	MUAC tape	2
19	Weight for Height % table	1
20	Scale/balance to measure food ration or calibrated container that holds known weight of food ration.	1
Minimum Stock to Keep Topped Up		Amount
1	SFP cards for new admissions	100
2	SFP ration cards for new admissions	100
3	ID bracelets (optional)	100
4	Clear plastic envelopes (for filing cards)	100
5	Bags for carrying food (if required)	100
6	Drinking water	1-4 jerry cans
7	Food: e.g. blended flour	
8	Medicines and dressings	(see medical protocol)

Annex 13: Routine Medicines for Moderate Malnutrition (SFP)

Name of Product	When	Age	Prescription	Dose
Vitamin A*	At admission	< 6 months (if not breastfed)	50 000 IU	Single dose on admission
		6 months to < 1 year	100 000 IU	
		> = 1 year	200 000 IU	
Mebendazole**	At admission	< 1 year	DO NOT USE	NOTHING
		1 to < 2 years	250 mg	Single dose on admission
		> = 2 years	500 mg	Single dose on admission

*Do not repeat the dosage of Vitamin A if the child has already received a supplement of Vitamin A during the LAST 30 days (e.g. in OTP or during a national campaign).

** Or other Antihelminth according to national guidelines e.g. ALBENDAZOLE: <1 year nothing, 1 to <2 years 200mg, > = 2 years 400mg. Both can be given again after 3 months if signs of re-infection appear.

MEASLES: Children older than nine months who have not had a measles vaccination should be referred to the nearest health facility for vaccination.

IRON AND FOLIC ACID: Should not be given routinely unless otherwise stated in National SFP Guidelines. If a child is diagnosed with anaemia then treat according to the WHO or MoH/national protocol.

Annex 14: SFP Ration Card

Mother's Name		Registration Number	/	/	SFP
Child's Name		Sex (M/F)			
Dates of Admission		Age (Months)			
Distribution Site		Address			
Distribution/Week					
Date					
Weight (kg)					
MUAC (mm)					
Ration (type and quantity)					

Annex 15: Training Day Plan

Time	Subject
09.00 – 09.15	Introduction of participants and objectives of the workshop and programme.
09.15 – 10.00	Introduction to CTC and its components.
10.00 – 10.45	Overview of malnutrition (causes, types).
10.45 – 11.00	<i>Break</i>
11.00 – 11.30	Selection of beneficiaries: screening by MUAC / oedema.*
11.30– 12.00	Admission and discharge criteria (OTP, SFP, SC).
12.00 – 12.30	Measurement practical.
12.30 – 13.30	<i>Lunch</i>
13.30 – 14.00	Mobilisation and community outreach.
14.00 – 14.30	RUTF and key messages for carers.
14.30 – 15.00	OTP procedures: registration and numbering, history, medical checks.
15.00 – 15.15	<i>Break</i>
15.15 – 15.45	Detail on drugs used in OTP and action protocols.
15.45 – 16.15	Practical on completing cards.
16.15 – 16.45	Tally sheets.
16.45 – 17.00	Summary and planning.

* If current national guidelines require, WHM can be used as well as MUAC.

This is an orientation and basic training on CTC only and must be followed by direct on-the-job training and supervision at each OTP clinic for the following month.

The timetable should be adjusted depending on the knowledge and experience of participants.

The sessions from 14.30 onwards are essential for health workers and supervisors but optional for other participants.

Additional time is needed for supervisors on reporting systems.

Annex 16: Equipment and Supplies for OTP

Equipment (per site)

	Item	Amount
1	OTP file for admission cards	1 per clinic
2	Marker pens (permanent ink)	2
3	Clipboards	2
4	Stapler and box of staples	1
5	Pens	3
6	Scissors	1 pair
7	Notebook	1
8	Calculator	1
9	Small clock with second hand	1
10	Bucket with lid	2
11	Soap for hand washing	1 bar
12	Small bowl	1
13	Small jug	1
14	Hand towels/paper towels	2
15	Water jug (with lid)	2
16	Plastic cups	10
17	Metal spoons	2
18	Teaspoons or medicine cups	6
19	Thermometer	3
20	Salter scale (25kg) plus pants	1
21	Height board	1
22	MUAC tape	2
23	Weight for Height % table	1
24	Nail clippers	1
Minimum Stock to Keep Topped Up		
1	OTP cards for new admissions	100
2	OTP ration cards for new admissions	100
3	ID bracelets (optional)	100
4	Clear plastic envelopes (for filing OTP cards)	100
5	Bags for carrying RUTF (if required)	100
6	Drinking water	1 jerry can

	Item	Amount
7	Sugar to make 10% sugar water solution	500g
8	Soap. For OTP children plus extra for children referred from the community but not fulfilling admission criteria.	500 bars
9	RUTF	(see separate list)
10	Medicines and dressings	(see separate list)

Medicines (per 500 children)

Routine Medicines: per 500 children		
1	Amoxicillin syrup 125mg/5ml	500 bottles
2	Mebendazole 100mg	4 tins
3	Paracheck (malaria rapid test)	200
4	Fansidar *	1 tin
5	Artesunate tablets *	600 tablets
6	Vitamin A capsules	1 tin
7	Measles vaccine (where not possible to refer to an existing EPI programme)	100 doses

*if Artemisinin-based combination therapy blisters available, 200 kits.

Additional Medicines: per 500 children		
1	Chloramphenicol syrup or tablets	100 bottles or 1 tin
2	Tetracycline eye ointment	50 tubes
3	Nystatin suspension	20 bottles
4	Paracetamol syrup or 100mg tablets	2 bottles or 1 tin
5	Benzyl benzoate 200ml	100 bottles
6	Whitfields ointment	50 tubes
7	Gentian violet – powder	1 tin
8	Betadine solution	2 bottles
9	Quinine (or suitable 2nd line anti-malarial)	1 tin
10	Ferrous Folate (or iron sulphate and folic acid) - for treatment of anaemia	1 tin
11	Cotton wool	5 rolls
12	Examination gloves – non-sterile	1 box
13	Medicine bags	100 bags
14	ReSoMal	2 packets

Notes:

- All medicines must be clearly labelled.
- Daily stocks carried should be reviewed after the first month as requirements will vary depending on number of admissions.
- Amounts carried should be kept as low as possible to facilitate storage.

Other Supplies

Dressing Materials (where needed)		
1	Gauze 10x10	20 packets
2	Small bandage	10 pieces
3	Tape	2 rolls
4	Zinc ointment	10 tubes
5	Normal saline for wounds 100ml or 200ml	10 pieces
6	Dressing scissors	2 pairs

Each child in the OTP consumes about twenty packets of RUTF a week. Total consumption in the OTP is calculated as follows:

RUTF		
A	Number of OTP beneficiaries	A
B	Monthly consumption per child (@20 packets /child/week)	80
C	Monthly packet consumption for OTP	A x B
D	Monthly carton consumption for OTP	C/150
E	Monthly net weight (MT) (@13.8kg/carton)	D x 13.8/1000
F	Monthly gross weight (MT) (@14.9kg/carton)	D x 14.9/1000

Annex 17: OTP Card

OTP Admission Details

Name					Reg. N°				
	District			Village					
Age (months)		Sex	M	F	Date of Admission				
Admission	Direct from Community		From SFP	From SC	Readmission (Relapse)		SC Refusal		
Total Number in Household	Twin		Yes	No	Distance to home (hrs)				
General Food Distribution									
General Ration: HH Registered?	Yes	No	If yes, when last received a ration?						
Admission Anthropometry									
Weight (kg)		Height (cm)		WHM (%)		MUAC (mm)			
Admission Criteria	Oedema	MUAC <110mm	<70% WHM	Other: specify					
History									
Diarrhoea	Yes	No	Stools / day		1-3	4-5	>5		
Vomiting	Yes	No	Passing Urine			Yes	No		
Cough	Yes	No	If oedema, how long swollen?						
Appetite	Good	Poor	None	Breastfeeding		Yes	No		
Reported Problems									
Physical Examination									
Respiratory Rate (# min)	<30	30 - 39	40 - 49	50+	Chest Retractions			Yes	No
Temperature °C					Conjunctiva			Normal	Pale
Eyes	Normal	Sunken	Discharge		Dehydration		None	Moderate	Severe
Ears	Normal	Discharge		Mouth			Normal	Sores	Candida
Lymph Nodes	None	Neck	Axilla	Groin	Disability			Yes	No
Skin Changes	None	Scabies	Peeling	Ulcers / Abscesses		Extremities		Normal	Cold
Routine Admission Medication									
Admission:						Date			
<i>Drug</i>	<i>Date</i>	<i>Dosage</i>		<i>Drug</i>	<i>Date</i>	<i>Dosage</i>			
Vitamin A				Anti Malarial					
Amoxicillin				Date					
2nd visit:									
Mebendazole				Measles					
Other Medication									
<i>Drug</i>	<i>Date</i>	<i>Dosage</i>		<i>Drug</i>	<i>Date</i>	<i>Dosage</i>			

