Appendix A – Illustrative logframe for CMAM

Hierarchy of Objectives		Indicators	Means of verification	Assumptions
Project Goal	**To improve nutrition status of children 0 to 59 months in the community**	% of children aged 0 to 59 months with weight-for-height < - 2 SDs from the median (WHZ) *Compendium of Indicators*	*Measuring Child Growth* tool, as part of caregiver survey	Accurate weighing technique
Outcome 1	**To ensure a timely diagnosis and effective treatment for children with acute malnutrition**	% of children aged 6 to 59 months, participating in CMAM, with weight-for-height < - 2 SDs from the median (WHZ) *Compendium of Indicators* # / % of wasting children admitted in services Program services accessibility: % of targeted population at <1 day's return walk from OTP	*Measuring Child Growth* tool, as part of caregiver survey Enrollment records	No unfavourable conditions such as civil insecurity or outbreaks No aggravating factors (such as outbreaks resulting in child deaths, poor household food insecurity, etc.)
Output 1.1	Severely malnourished children with complications ages 6-59 months treated through Stabilisation Centre	# / % children admitted to SC # / % children referred from SC # / % children returned to OTP sites from inpatient care	Weekly tally sheets, monthly compilation reports, Full circle referrals cards to inpatient care	Government is committed to project implementation
Output 1.2	Severely malnourished children without complications ages 6-59 months treated through OTP	# / % children enrolled in OTP # OTP sites operated Cure rate of OTP % exits recovered Death rate: % exits died Default rate: % exits defaulted	Weekly tally sheets Monthly compilation reports Admission cards/OTP	The performance of inpatient care operated by other agencies continues to meet international and national standards
Output 1.3	Moderately malnourished children without complications ages 6-59 months treated through SFP	# / % of moderated malnourished children admitted to SFP # / % of children who received the required number of rations % of children recovered (WFHZ>-2)	Weekly tally sheets Admission cards/OTP Monthly compilation reports	There is a good collaboration between WV, local partners and other agencies
Outcome 2	**To improve local capacity to manage malnutrition and related illness**	MoH staff (at health facility level) and community level respond appropriately to malnutrition # / % of health institutions able to manage malnutrition cases and meeting the international performance standards # / % of health institutions that integrated CMAM in their routine health services	Transition plan defined and evaluated Supervision reports	Government committed to continue provision of services
Output 2.1	Improved expertise of MoH staff management of malnutrition	# of health workers trained in CMAM % of health workers CMAM trained who actually work in CMAM services # / % of health institutions with CMAM services meeting internationally accepted standards for CMAM project quality (cure, death and default rates) # EPI vaccinators able to screen children under-5 for malnutrition by project end	Training reports Results of pre- and post-tests Ministry of health reports MUAC screening reports OTP site monthly reports	Health units receive funding to enable them to continue functioning MoH recruits health staff
Output 2.2	Increased ability of community members and local partners to detect disease outbreaks and carry out screening	# community members or local partners able to carry out basic nutrition screening with MUAC tape # community members or local partners able to detect a cases of malnutrition # village health committee members and CORPS able to carry out basic nutrition screening with MUAC tape % of community members or local partners who carried nutrition screening by MUAC and oedema screening	Training reports and material Weekly verbal reports on outbreak Feedback from community Focus group discussions on malnutrition Nutrition centre reports on referral	Community is willing to support and be engaged in project

Appendix B - Suggested project timeline

TABLE: Project timeline

Key Activities	Quarter								
	0	1	2	3	4	5	6	7	8
Conduct baseline nutrition assessment									
Sensitise the WV national office and partners on the importance of *CMAM* programming once the assessment results identify the need									
Assess staffing and volunteer needs for community mobilisation, supplementary feeding programmes, outpatient therapeutic programmes and stabilisation centres in collaboration with partners									
Identify the equipment and supplies required for each of the various components of a *CMAM* programme									
Identify transport needs for each of the *CMAM* programme components									
Determine collaboration and partnership opportunities with other NGOs that are implementing *CMAM*									
Plan for appropriate integration of *CMAM* in the programme environment (if required)									
Develop a phase out strategy for *CMAM* with MoH									
Develop, submit and gain proposal funding									
Source and order relevant commodities, supplies and equipment									
Recruit staff and volunteers									
Sensitise community on programme's aims, methods and target group and gain support to mobilise communities									
Establish SFP									
Establish OTP (at existing health facilities where possible)									
Train health staff (MoH and WV) and volunteers outreach workers									
Community mobilisation and screening of the population to identify the beneficiaries									
Establish SC either through MoH partnership, direct implementation and/or with partnering NGOs									
Promote immunisations and vaccinations in conjunction with MoH, especially measles, VAC supplementation and de-worming									
Provide Health and nutrition education for beneficiaries and the community									
Referral of children with SAM with complications to SC, in case the child needs a hospital referral to higher level health services.									
Progressive transition over of all aspects of *CMAM* programme to MoH and NGO partners as sufficient capacity is reached (see *Section 17*)									
Conduct ongoing monitoring of programme with all local stakeholders (MoH to lead the process)									
Undertake social development study									
Undertake mid-term evaluation									
Undertake coverage survey									
End of project evaluation									
Lessons learnt event									

Appendix C - Key indicators for monitoring and evaluation

TABLE: Monitoring and evaluation indicators

Indicator	Characteristics	What to monitor?
Monitoring	What treatment is the rehabilitation programme?	• The routine collection of medical, nutritional and follow-up data recorded on cards and maintained in an efficient filing system • Effective exchange of information on individual children among the programme components, and between the programme and the community. • Record cards review: case review for proper filling, decision on transfers, defaulters, deaths, cures, absence, non-cure, weight gain, weight loss and SC transfer, numbering system • Ration cards, information on progress (weight, height, ration received) and damage
	Programme appropriateness	• Quantitative indicators, such as mortality, default and cure rates, complemented by qualitative information, help identify issues affecting the programme at a community level and strengthen the community's sense of programme ownership. Quantitative indicators are collected from key informants interview and focus group discussions.
	Programme effectiveness	• Total admissions, exits and the number of children in the programme • The number of admissions by category • The number of exits by category • Additional information on exits, weight gains and lengths of stay.
	Programme coverage	• Point and period coverage
Evaluation	Programme design	• Qualitative: how need identified? and beneficiaries involvement, complementarities to the existing health programme, right target population, baseline analysis versus need, impact on the community if the programme did not take place, consideration of alternatives, use of updated procedures and guidelines, how different components implemented, assumptions considered and risk analysis carried out, partnership and parallel programme, staffing.
	Programme efficiency	• Measures the outputs, qualitative and quantitative, in relation to the inputs. Analyses the cost of the programme with staffing, procurement, transport, overhead, per child treatment, finance and administrative procedures
	Programme effectiveness/impact	• Effectiveness: record cards maintained in an efficient filing system, regular meetings and progress review by participants, actions taken to solve problems and difficulties, analysis carried out to determine why some eligible children were not in the programme, discussions held with local communities • Impact: standard data used to assess the programme includes; Death rates; Default rates; Recovery; Rate of weight gain; and Coverage. Moreover, situation of siblings of those in the programme, adverse effect of participating in the programme like stigma, queuing and actions for mitigation, participation of local health facilities and its impact on the staff (moral and new CMAM techniques)
	Programme sustainability and connectedness	• What will happen when the programme closes? longer-term provision of RUTF and other programme inputs, short-term decisions made and its impact, skills transferred to sustain the interventions and future actions
	Programme Relevance and appropriateness	• Timeliness, programme start date and onset of the problem, cultural appropriateness and food stuff acceptability, inclusion in the programme and demands upon families and communities women access to the programme
	Programme coherence	• Coordination with other agencies, presence of general food and other developmental interventions, alignment with local government priority, in areas with opposing parties follow-up humanitarian principles, protection of beneficiaries (better or worse) staff security
	Programme coverage	• Were any children excluded from the programme? • Were there gender, age, geographical, ethnic and conflict biases to children and women participating in the programme?

Appendix D - Staffing with partners

Ministry of Health provides overall coordination

(Ensures policies, guidelines and resource allocations, coordinates partners, supervises and monitors progress and leads national coordination meetings with partners)

Community Mobilisation

- Community leaders help identify community volunteers for mobilisation.
- WV provides support in training of community volunteers at field level.

Outpatient Therapeutic Program

- MoH provides staff and facilities supervision
- UNICEF creates access to RUTF and routine medicines.
- WV provides training of staff at field level, monitoring and technical advice.
- Community volunteers conduct screening, referrals and follow-up.

Supplementary Feeding Program

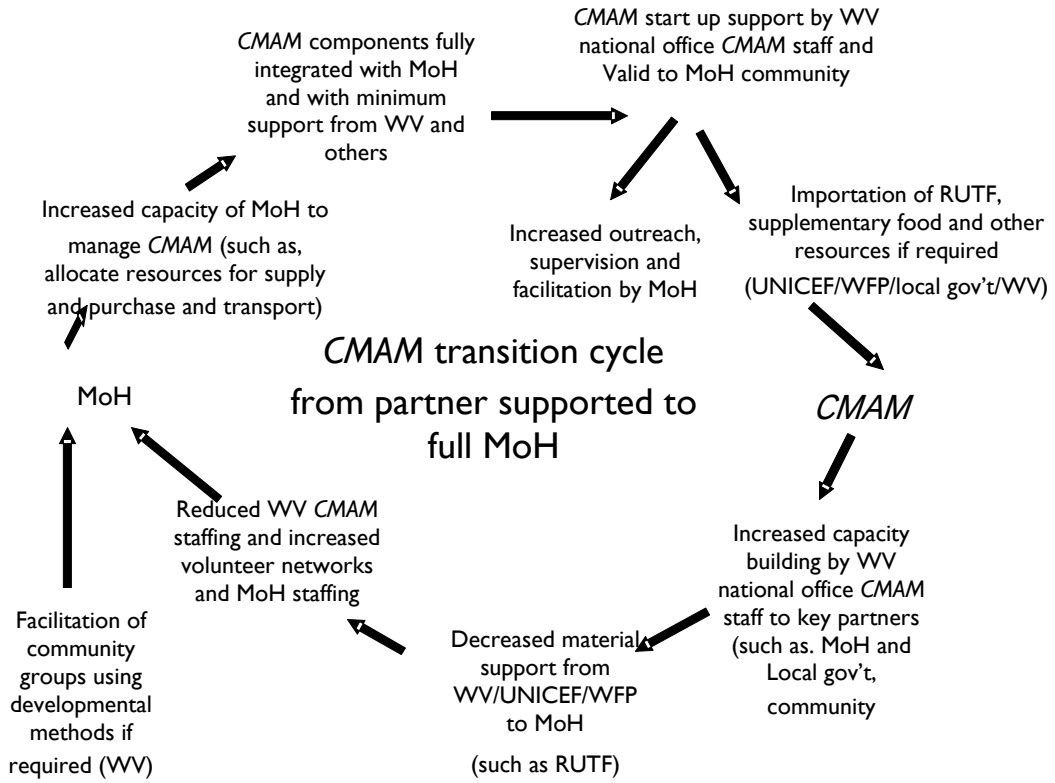
- WFP creates access to supplementary food and operation costs for supplementary food distribution, supervises and provides technical support during implementation.
- WV provides staff and training at field level.

Stabilisation Centres

- MoH provides staff and facilities (such as partner MSF where there is no capacity).
- UNICEF creates access to RUTF and routine medicines.
- WV provides training of staff at field level.

Valid International – In agreed counties, provide training to WV staff in planning, implementing and evaluating CMAM and may partner with WV for operational research.
WV regional CMAM staff – Provide co-ordination of CMAM programming in region, help build national office CMAM capacity and more.

Appendix E - Example of CMAM transition to MoH



Important: WV's primary focus in health and nutrition is on prevention. *CMAM* should always be planned, implemented, and transitioned within the broader WV health and nutrition programming context focused on prevention (such as the 7-11 strategy or the *PD/Hearth* project model).

Appendix F - Guidelines for CMAM staffing

TABLE: Staffing guidelines		
No. required	**Position**	**Job Overview**
1	Project coordinator	Overall coordination of SFP, OTP SC and community components
1	Project assistant	Assist project coordinator
Community mobilisation		
1	CM Team Leader	Coordination of CM activities
Depends on size of project[1]	Community Mobiliser	Implement CM activities as per Social Development Assessment and direction from CM team leader
Supplementary feeding programme		
1	SFP team leader	Coordination of SFP activities
2	SFP measurers	Weigh and measure children
1-2	Health workers and MoH nurses	
1-2	SFP general assistants	To register children
1	SFP food distributor	To mix commodities and distribute rations
Outpatient therapeutic programme		
1	OTP team leader	Coordination of OTP. Note: Should be a qualified health worker (a nurse or medical assistant)
1 per project site	OTP nurse	Responsible for community mobilisation and follow-up of progress in OTP depending on size and caseload
2 per project site	OTP measurers	Weigh and measure children and can help the OTP team leader with tasks such as counting packets of RUTF
Stabilisation centre		
1 per shift of 24 hours care	SC clinical nurse	Should be qualified according to national policy
1-2 per project site	SC nutrition and assistant health staff	Role will vary according to patient numbers
	SC support staff	To prepare or help prepare therapeutic milk and food and clean SC
	NGO liaison and support staff	Help facilitate admissions, discharges, referrals, reporting and liaison with local MoH. They have an advisory and training roll not responsible for direct care of children
	Volunteers	Case finding of malnourished and as well as follow-up and tracking of children following rehabilitation
	Programme staff	Where available, support community mobilisation activities

[1] The size of the community mobilisation team varies from project to project and is determined through the initial social development assessment conducted by the CM team leader with the support of the regional technical advisors. Factors that assist in determining size include number of children in the area, geographic size of programme and ease of movement, capacity of local volunteers and choice of mobilisation method (active or passive case finding, self-referral). In Ethiopia, for example one CMT conducted all training and follow-up as the community health worker network (Health Extension Workers and Community Health Promoters) was strong and the MoH included the task of MUAC measurements and default follow-ups in their job descriptions. In Lodwar, Kenya, restrictions on mobility because of safety concerns demanded that each programme (three) have a CM worker.

Appendix G - Overview of basic resource requirements[2]

CMAM component	Equipment and supplies	Possible partner contributions	Transport	Physical structures
Community mobilisation	MUAC tapes, soap (to compensate carers whose child is referred but not admitted to the programme)	UNICEF-MUAC tapes	• The CMAM 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.	No physical structures required for accommodation as community structures are used.
Supplementary feeding programme	Height boards, scales, MUAC, tapes, registration cards/book, ration cards, corn soya blend, mixing equipment (if giving a premix of CSB and oil), basic medicines (as per protocols), soap and stationary.	• UNICEF height boards and scales • MUAC tapes and essential medicines WFP food rations	• The mobile team needs daily transport. • The CSB and equipment also needs to be transported to each site daily.	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.
Outpatient therapeutic programme	Height boards, scales, MUAC tapes, medicines (as per protocols), RUTF, CSB, OTP cards, ration cards, soap (distributed to all beneficiaries weekly), stationary.	• UNICEF height boards and scales • RUTF	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.	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	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).	• UNICEF height boards and scales • F75	The SC may need transport for referrals in and out of the 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.

[2] Above table formatted with information from resource requirement sections of Valid International CTC Field Manual, 2006.