

TIPS ON NUTRITION INTERVENTIONS for the Humanitarian Response Plan



TABLE OF CONTENTS

Introduction and General Comments	5
Cluster Coordination	9
Accountability to Affected Populations (AAP) – for all projects	13
Nutrition Screening and Referral	18
Inpatient Management of Severe Acute Malnutrition	23
Outpatient Management of Severe Acute Malnutrition	29
Management of Moderate Acute Malnutrition (MAM) in the Targeted Supplementary Feeding Programmes (TSFP)	35
Prevention of Moderate Acute Malnutrition – Blanket Supplementary Feeding Programmes (BSFP)	42
Infant and Young Child Feeding in Emergencies (IYCF-E)	47
Managing older people’s malnutrition	52
Cash or Voucher Programmes for the prevention of malnutrition	60
Multiple Micronutrient Supplementation	65
Iron or Iron/folic Acid Supplementation	69
Vitamin A Supplementation	73
Deworming	77
Zinc supplementation for diarrhoea management	80
Iodine supplementation and salt iodization	83
Calcium supplementation	86
Nutritional care and support of HIV-infected children	89
Nutrition survey	93
Nutrition surveillance	97
Direct programme coverage evaluation	100
Annexes	104
Glossary	110



INTRODUCTION AND GENERAL COMMENTS

This guidance has been developed by the Global Nutrition Cluster to support country nutrition clusters and nutrition cluster partners in preparing the Humanitarian Response Plans (HRPs). It provides tips for nutrition clusters to facilitate the planning of a collective response and the development of Nutrition in Emergencies (NiE) interventions by individual cluster partners. The HRP tips can also be used by other clusters to help guide of the inclusion of nutrition sensitive interventions in their respective sectoral plans.

Important remark: this document does not intend to prescribe to nutrition cluster coordinators or partners which kind of intervention is relevant in which context. A sound country situation analysis must therefore be done before the

development of the Humanitarian Response Plan. Once the specific sectoral objectives and type of emergency interventions have been agreed by nutrition cluster members, the HRP tips should be used as examples of how objectives, indicators and monitoring framework could be structured.

For each NiE intervention, the tips includes the following information:

OBJECTIVE

Is what the nutrition cluster as a collective, or the cluster partners in their agency-specific projects intend to achieve. The HRP objective described in this guidance can be used as an overall nutrition cluster objective, but it can also be adapted for the agency-specific project/programmes.

POSSIBLE SPECIFIC OBJECTIVES THAT A PROGRAMME COULD HAVE

Are the objectives that can be used for individual partners' projects. The achievement of those agency-specific objectives will contribute to the achievement the overall nutrition cluster objective.

TARGET GROUPS TO INCLUDE

These are the groups of beneficiaries that could be targeted for specific NiE interventions. Children aged 0-23 months, 0-59 months, pregnant and lactating women, etc. are just a few examples of the groups of beneficiaries that are normally targeted in NiE interventions by the nutrition cluster. The decision on the selection of the target groups should be based on the analysis of nutrition situation and other relevant information.

HOW TO CALCULATE EXPECTED CASELOAD

Is a general note on calculating caseload for each particular group of interventions with links to detailed guidance where the information or guidance exists. The information obtain from this section can be cross checked with existing national guidelines or recommendations on caseload calculation.

SAMPLE ACTIVITIES AND TIPS

Include some of the activities that may be included in the project. It is very important to be specific when describing activities in the project sheets or in the collective cluster response plan. Always think about

integrating nutrition activities with the Food Security, Health, WASH and other clusters' activities and hold discussion with these clusters to ensure they have planned nutrition sensitive interventions in their response plan.

The HRP tips can also be used as an advocacy tool to facilitate discussions around the inclusion of relevant nutrition indicators in other sectoral HRPs, for example complementary feeding in Food security, BF counselling in health, hygiene and IYCF in WASH.

SUGGESTED INDICATORS

Are the indicators that are recommended to be used for monitoring (both situational and response monitoring) and reporting of achievements toward targets set in the Humanitarian Response Plan, as well as in the individual cluster partners' projects. The majority of the indicators used in this document are from the Humanitarian Indicators Registry – HIR- (<http://www.humanitarianresponse.info/applications/ir>) which was developed by the Global Clusters, including the GNC and are recommended for use by the cluster partners, including donors and other implementing partners.

Indicators selection should relate to the planned response and the capacity to monitor it should also be ensured. Output, outcomes indicators must be prioritized in HRP document as opposed to process indicators.

Indicators should be SMART (Specific, Measurable, Achievable, Realistic and Time bound).

For each indicator, the type, the unit of measurement, the short description and the link that provide more information is specified.

TYPE OF INDICATOR

Describes whether indicator is a baseline, a process, an output or/and an outcome type of indicator.

- Baseline indicators measure the baseline or current situation. Baseline indicators may overlap with outcome indicators, (e.g. Global Acute Malnutrition can be a baseline indicator, but also an outcome indicator).
- Process indicators measure how the delivery of goods and/or services is done (e.g. Proportion of severe acute malnutrition cases receiving treatment, covered by home visits treatment). These indicators can be used for individual project monitoring in order to measure the quality of the service provided, but they do not need to be included in the HRP, as the indicators in the HRP should mainly focus on the higher level outcomes and outputs that the cluster is trying to achieve.

- Output indicators measure the delivery of goods and/or services to a targeted population or target groups. These indicators are usually used for individual projects (e.g. number of children 6-59 months with severe acute malnutrition who are newly admitted for treatment).
- Outcome indicators are the short-term and medium-term effects of an intervention's outputs. These are the indicators that are usually used in HRPs. Some of these outcomes indicators can also be used in the individual projects (e.g. Proportion of cases with severe acute malnutrition receiving treatment), and also as other outcome indicators (e.g. Global Acute Malnutrition) of the HRP and they can be found in the Humanitarian Indicators Registry grouped under outcome indicator.

UNIT OF MEASUREMENT

Shows the level at which the information is measured (individual, household, community, and facility), it is therefore important to consider the unit of measure:

- If indicator is measured at facility level, a monitoring and reporting system should be set up in each facility to collect this data.
- If indicator is measured at individual, household or community levels, a separate registration systems, survey/assessment is usually required to collect this data.
- In both cases, appropriate funding should be allocated for collecting data indicators selected at both cluster and individual project levels.

In addition to the indicators for each of the NiE intervention domains, the Humanitarian Indicators Registry includes indicators that can be used and should be considered for inclusion¹ in both the HRP and the individual projects where relevant.

¹. Include some general recommendations on what should be considered while preparing a budget for a project under each area of intervention.

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Process	Facility	Number of feedback received (including complaints) which have been acted upon
Process	Community	Number of information, education and communication (IEC) products distributed to the affected population through agreed communication channels
Process	Facility	Number of people consulted (disaggregated by sex/age) before designing a program/project [alternatively, while implementing the program/project]
Process	Community	Focus Group Discussion Proportion of nutrition programmes that had separate focus group discussions with affected girls, women, boys and men during assessment, planning, implementation, monitoring and evaluation)
Process	Facility	Single sex consultations on effective response - Proportion of partners routinely conducting single sex consultations to discuss about how effectively they respond to distinct nutritional needs of the affected population in order to address any challenges in accessing assistance.
Output	Individual	Satisfaction with access to services - Proportion of target population disaggregated by sex, satisfied with their access to services
Output	Individual	Knowledge of good nutrition/IYCF practices - Proportion of target population disaggregated by sex who have increased knowledge of good nutrition/IYCF practices
Process	Facility	Men participation in nutrition programmes - Proportion of men participating in nutritional education programmes)

TIPS TO CONSIDER WHILE PREPARING A BUDGET

Include some general recommendations on what should be considered while preparing a budget for a project under each area of intervention. As a rule of thumb, one should always consider the cost of supplies, human resources (staff), capacity building/development, administrative, monitoring and evaluation (M&E) and promotional activities cost (eg.: communication costs).

The HRP tips are presented under the key NiE response areas, such as cluster coordination, accountability to affected population, community level nutrition screening and referral, inpatient management of severe acute malnutrition in stabilisation centres (SC), management of severe acute malnutrition in outpatient therapeutic feeding programmes (OTP), management of moderate acute malnutrition through targeted supplementary feeding programmes (TSFP), prevention of moderate acute malnutrition through blanket supplementary feeding programmes (BSFP), infant and young child feeding in emergencies (IYCF-E), management of

acute malnutrition in older people, cash or voucher programmes, multiple micronutrient supplementation, iron or iron/folic acid supplementation, vitamin A supplementation, deworming, zinc supplementation for diarrhoea management, iodine supplementation, calcium supplementation, nutritional care and support of HIV-infected children, PLWs and adults, nutrition survey, nutrition surveillance, and programme coverage evaluation.



CLUSTER COORDINATION

OBJECTIVE

To ensure a predictable, timely, and effective nutrition in emergency response.

The actions under cluster coordination can have the following specific objectives:

- To support service delivery by providing a platform that ensures service delivery is driven by the strategic response plan and strategic priorities and developing mechanisms to eliminate duplication of service delivery. To inform the HC/HCT's strategic decision-making by preparing needs assessments and analysis of gaps, identifying and finding solutions for (emerging) gaps, obstacles, duplication and cross-cutting issues, formulating priorities on the basis of analysis.
- To plan and develop strategy by developing sectoral plans, objectives and indicators that directly support realization of the response's strategic objectives, applying and adhering to common standards and guidelines, clarifying funding requirements, helping to set priorities, and agreeing cluster contributions to the HC's overall humanitarian funding proposals.
- To monitor and evaluate performance by monitoring and reporting on activities and needs, measuring progress against the cluster strategy and agreed results, recommending corrective action where necessary.
- To build national capacity in preparedness and contingency planning.
- To identify advocacy concerns that contribute to HC and HCT messaging and action and undertake advocacy on behalf of the cluster, cluster members, and affected people.

GROUPS TO INCLUDE

Partners, including government, local and international NGOs, UN agencies and observers (Red Cross movement, civil society organisations, academia, etc.)

SAMPLE ACTIVITIES AND TIPS

- Recruitment of Nutrition Cluster Coordinator, Nutrition Information Management Officer and other coordination team staff,
- Support Cluster in performing its core functions,

TIP: For more guidance see the IASC Cluster Coordination Reference Module at country level, revised July 2015 Facilitate the CCPM process and follow up of the implementation of CCPM action plan.

- Support development of the cluster response strategy,
- Ensure monitoring and reporting activities and collective reporting towards targets
- Information management activities to inform decision making (cluster website, reports, updates, bulletins,
- Organization and facilitation of the regular coordination meetings.

- Coordinating preparation of relevant sections of the appeals, the Humanitarian Response Plan, OCHA and agency-specific situation reports, donor updates, other relevant documents,
- Coordination of CHF and other humanitarian pooled funds allocation,
- Coordination of Cluster's capacity building activities,
- Coordination of assessments, CMAM, IYCF-E and micronutrient supplementation activities,
- Coordination of preparedness and contingency planning, DRR and resilience activities.
- Ensure accountability to affected population in Nutrition in Emergency response.

SUGGESTED INDICATORS

Note: Currently, the Humanitarian Indicators Registry (HIR) does not contain indicators related to coordination but you can get outcome indicators from the Cluster Coordination Performance Monitoring survey.

10

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Output	Community	Number of coordination staff hired in a timely manner (for both national and sub-national coordination) (Note: not in the HIR)
Process	Community	Availability of the Terms of reference for the Cluster (Note: not in the HIR)
Process	Community	Proportion of cluster performance monitoring recommendations followed up within specified timeframe (Note: not in the HIR)
Process	Community	Proportion of action points from meeting minutes followed up in a timely manner (Note: not in the HIR)
Process	Community	Proportion of partners reported timely in the past X months (Note: not in the HIR)
Process	Community	Number of Cluster Bulletins produced (Note: not in the HIR)
Process	Community	Number of sub-national coordination hubs established (Note: not in the HIR)
Process	Community	Programme standards established and promoted (Note: not in the HIR)

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING

NB: Budget tips below are for coordination only. Any technical support to the collective (e.g. expert to support all cluster partners with training in SMART survey) would be sought through TRRT mechanism, CLA in country and the cluster partners at country level and it is not included here.

SUPPLIES COST

Equipment to facilitate the work of NCCs and IMOs, such as computers, IM software and tools, office supplies, etc.

STAFF COST

Consider one Cluster Coordinator, one Information Management Officer (IMO) and ½ administrative assistant at minimum (in small emergencies consider double-hatting) In big emergencies consider including sub-national cluster coordinators and information managers, deputy cluster coordinator, co-chair, data entry assistant, database developer, etc.

CAPACITY BUILDING/DEVELOPMENT COST

(Refresher) training of staff in cluster coordination and information management, other trainings.

ADMINISTRATIVE COST

M&E COST

LOGISTICS

Need to ensure that human and administrative resources are available for timely monitoring, evaluation and reporting to HQs, donors and cluster.

Office, transport, support for organizing meetings, workshops and trainings for cluster partners and working groups.

OTHER COSTS

- Security cost;
- Field trip travel costs;
- Cost of sub-national coordination;



ACCOUNTABILITY TO AFFECTED POPULATIONS (AAP) – FOR ALL PROJECTS

OBJECTIVE

To ensure accountability to affected women, men, girls and boys, including older people, persons with disability and other vulnerable groups, throughout nutrition programming, at all stages of the project cycle

13

The programme can have the following specific objectives:

- To ensure programme documents integrate accountability commitments² and guide the delivery of quality nutrition programmes that are appropriate, timely, coordinated, prevent sexual exploitation and abuse (PSEA), and which mainstream core people related issues including age, gender, diversity, disability, protection and communicating with communities.
- To provide appropriate, relevant and timely information that is sensitive to stated information needs and preferences across age, gender and diverse groups,
- To establish two-way communications channels and mechanisms that welcome and facilitate feedback and complaints and provide redress for complaints,
- To incorporate means for nutrition programme participants and other stakeholders to participate in decisions that affect them (from consultation to active involvement), including fair and transparent systems of representation,
- To incorporate AAP and the prevention of sexual exploitation and abuse (PSEA) into programme design, monitoring and evaluation, ensuring continuous learning

². Ref: IASC Commitments on Accountability to Affected Populations and The Core Humanitarian Standard on Quality and Accountability

GROUPS TO INCLUDE

Women, men, girls and boys, including older people, persons with disability and other vulnerable groups, targeted or impacted by nutrition programmes and personnel

HOW TO CALCULATE EXPECTED CASELOAD

100% of programme/project caseload

SAMPLE ACTIVITIES AND TIPS³

- Consult with targeted women, men, girls and boys, including older people and persons with disability, to assess their needs, including regarding information and communication, preferences and trusted sources
- Make an assessment of existing systems of participation and representation to ensure they are fair, truly representative and accountable, and ensure all segments of the communities have a say
- Establish clear channels for nutrition programme participants to register complaints and receive a timely response
- Verify that all nutrition actors are aware of the relevant Codes of Conduct governing their employment that prohibit sexual exploitation and abuse of people receiving assistance
- Ensure the collection and utilisation of sex and age disaggregated data that adheres to recommended age groupings

TIP: SADD should be broken down into 10 year groups wherever possible, and in particular should avoid the grouping of all adult age groups together, which renders older people invisible

SUGGESTED INDICATORS

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Process	Individual	Proportion of surveyed assisted women, men, girls and boys, including older people, persons with disability and other vulnerable groups satisfied that nutrition programmes are relevant to their specific needs and culture
Process	Individual	Proportion of surveyed assisted women, men, girls and boys, including older people, persons with disability and other vulnerable groups informed about the programme (who is included, what assistance people will receive, where people can provide feedback and/or complain) / satisfied with the amount of information they receive about nutrition programmes
Process	Facility	Proportion of nutrition assessments that include questions to assess the information and communication needs, and preferred/trusted methods of receiving information, of assisted women, men, girls and boys, including older people, persons with disability and other vulnerable groups
Process	Individual	Proportion of surveyed assisted women, men, girls and boys, including older people, persons with disability and other vulnerable groups aware of / satisfied with systems in place for representation of their interests
Process	Individual	Proportion of surveyed assisted women, men, girls and boys, including older people, persons with disability and other vulnerable groups informed on how to complain about any aspect of nutrition programmes / consider the complaints mechanisms effective, confidential, accessible and safe
Output	Facility	Proportion of Nutrition cluster project plans on the OPS include reference to age, gender, disability and diversity
Output	Facility	Proportion of nutrition assessments conducted where three or more nutrition actors from different agencies participate together
Output	Facility	Number of Code of Conduct trainings conducted / Proportion of staff attended CoC trainings
Output	Facility	Proportion of nutrition projects that are linked to a formal complaint mechanism (part of wider joint system or specific mechanism developed for the programme)

For more indicators see “Example AAP Indicators Against the IASC Commitments for the NC”

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING

STAFF COST	CAPACITY BUILDING/DEVELOPMENT COST	
<p>No dedicated cost required but Cluster partners and NCC need to ensure they incorporated AAP role in their staffs JD/TOR</p>	<p>(Refresher) training of staff in AAP</p>	
ADMINISTRATIVE COST	M&E COST	LOGISTICS
<p>Not required</p>	<p>Need to ensure that human and administrative resources are available for timely monitoring, evaluation and reporting.</p>	<p>Think of join field visit by the cluster partners and the NC-CT and logistic arrangement for such visit</p>
OTHER COSTS		
<p>Many of the cost can be accommodated within cluster partners cost as well as within NC-CT cost.</p>		



NUTRITION SCREENING AND REFERRAL

OBJECTIVE

To detect acutely malnourished target groups (children under five years old, PLW, older people) among targeted population and ensure early referral of cases to appropriate nutrition programmes

18

The programme can have the following specific objectives:

- To identify population in a community at greater risk of malnutrition through establishment of mass nutrition screening programme;
- To support an on-going nutrition screening programme;
- To ensure adoption and utilisation of standardised protocols for community nutrition screening programmes.
- To build capacity of partners / health workers / community health volunteers in screening
- To mobilize communities and raise awareness on detection of malnutrition and existing treatment services for SAM or MAM

TIP: Conduct a large-scale screening of children for acute malnutrition if you have facilities/ programmes to refer the malnourished children identified for treatment/management. A referral system for treatment of children with severe or moderate acute malnutrition should be established before starting a large-scale screening campaign.

GROUPS TO INCLUDE

- All children under the age of five years
- Pregnant and lactating women (PLW)
- Older people (for more information see section "Managing older people's malnutrition")

HOW TO ESTIMATE THE NUMBER OF CHILDREN TO BE SCREENING IN A POPULATION

Use demographic profile from the last census, nutrition surveys, adjusted for population growth rate if necessary, 100% of the estimated children should be targeted for screening.

Example: If according to the latest DHS in 2012 for a district X, the population was 100,000 people, the population growth rate is 1.02 per year (2%), the proportion of children 6-59 months of age is 15.3%, then the number of children to be screened in 2015 is: $100,000 \times 1.02 \times 1.02 \times 1.02 \times 0.153 = 16,236$ (note that the population growth of 1.02 is multiplied 3 times as since the last survey in 2012 until 2015, three years have elapsed).

SAMPLE ACTIVITIES AND TIPS

- Screening and referral

TIP: Screening and referral should systematically be part of the package of nutrition activities and where possible, integrate/link screening to other sector interventions, i.e. during vitamin A supplementation and vaccination campaigns, during health promotion days, during WASH campaigns, General Food distribution).

- Community mobilisation and outreach
- Adaptation and dissemination of protocols and guidelines.
- Capacity building of staff on nutrition screening methods, interpretation of data and follow-up.
- Assessment and monitoring.

TIP: Work closely with local authorities to gather information on areas that will be targeted by screenings, as this will strengthen community participation and support during implementation and monitoring of the activity.

TIP: When planning screening activities, ensure referral pathways and promote availability of services to which beneficiaries can be referred. A screening in itself does not have any impact on improved nutrition situation if children in need are not referred to facility-based or community-level nutrition programmes and treated. However rapid assessments based on rapid MUAC screenings are sometimes undertaken to identify whether these services are needed or not.

TIP: Where applicable, take into consideration factors that can affect referral such as referral fees and ensure you have solution that can increase referral rates and include this in your costing.

SUGGESTED INDICATORS

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Output	Facility	Children Screened - Number of children screened for acute malnutrition in a community.
Output. process	Facility	SAM referred - Number of cases with severe acute malnutrition referred to inpatient care or hospital or outpatient therapeutic care (OTP).
Output. process	Facility	MAM referred - Number of cases with moderate acute malnutrition referred for treatment
Output. process	Facility	SAM admitted - Number of cases with severe acute malnutrition correctly referred and admitted to inpatient care or hospital or outpatient therapeutic care (OTP).
Output. process	Facility	MAM admitted - Number of cases with moderate acute malnutrition correctly referred and admitted for treatment

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING

SUPPLIES COST

The screening teams should be equipped with minimum supplies needed, and this includes:

- Anthropometric equipment (MUAC tapes for children and adults)
- Supplies for reference and record keeping (registration forms, writing instruments, guidelines, etc)

STAFF COST

Community volunteers or health facilities staff – consider needs for incentives for supervisor

CAPACITY BUILDING/DEVELOPMENT COST

Training of staff in screening and referral, including refresher trainings if needed

ADMINISTRATIVE COST

M&E COST

LOGISTICS

Need to ensure that human resource is available for timely monitoring, evaluation and reporting to HQs, donors and cluster.

Ensure transportation of screening teams, storage of supplies and avoid stock-outs of need supplied

OTHER COSTS

PROMOTIONAL COST

- Security cost;

Cost of information and communication materials development and printing (on health, nutrition education and hygiene promotion)



IMPATIENT MANAGEMENT OF SEVERE ACUTE MALNUTRITION

OBJECTIVE

To reduce the risk of excess mortality and morbidity among children under 5 years old.

23

The programme can have the following specific objectives:

- To provide facility based management service to X boys and X girls under 5 years of age with SAM and with complications
- To improve access and utilisation of existing inpatient therapeutic services
- To improve and maintain access and utilisation of newly established inpatient therapeutic services
- To ensure adoption and utilisation of standardised protocols for the inpatient management of SAM;
- To strengthen referral and counter referral systems from and to all components of care for acute malnutrition: hospital, health centre (HC) and community.
- To build the capacity of government and partners in the appropriate service deliver in Stabilisation Centers (SCs)

GROUPS TO INCLUDE

- All infants below 6 months of age with SAM;
- Children between 6 and 59 months of age who have severe bilateral oedema (++, +++) or severe acute malnutrition with medical complications
- For behaviour changes activities: Caretaker benefiting from communication for development (behaviour changes) activities at facility level should be included.

TIP: For planning purpose, use planning estimates of one caretaker per child (the child that has been admitted for SAM treatment)

Remark: Older people can also receive inpatient treatment when they have severe acute malnutrition and medical complications, for more information refer to section “Managing older people’s malnutrition” in this document.

How to calculate expected caseload:

- The total burden of SAM = existing cases + new cases

Existing cases = SAM prev. x number of girls and boys 6 to 59 months. Disaggregated data may come from recent census, nutrition survey.

New cases = SAM prev. x number of girls and boys 6 to 59 months x 1.6. The incidence rate is generally recommended at 1.6

- Alternatively, total burden of SAM = SAM prev. x population of targeted age group x 2.6

TIP: If the GAM rate is known but the SAM prevalence is not known, consider using on average an estimate of 20% of GAM patients are suffering from SAM.

- When you have your total targeted beneficiaries for SAM treatment, then calculate the number of children who will need SAM inpatient treatment (SCs)
- On average, a 5-20% of children with SAM are expected to be referred to inpatient treatment. This proportion will depend on the status of the CMAM program. At the beginning of a CMAM program a high number of complicated cases can be expected to be referred to the SC, so the proportion will be high and might be around 15 to 20%. In a well functioning CMAM program, this proportion can decrease over the time and be around 5 to 10%.
- Apply programme coverage to obtain the total targeted beneficiaries for SAM treatment in SCs

TIP: According to SPHERE standards, coverage in rural areas should be more than 50%, in urban areas more than 70% and in camp situations more than 90%.

- Example of calculation: We want to estimate the total number of girls 6 to 59 months suffering from SAM with medical complications whom will be targeted by a NiE program and admitted in a stabilisation centre.
- From last year census we know that the total number of girls 6 to 59 months is 86000. SAM prevalence is 1.8%. We agreed that in average 10% of the SAM cases detected will need to be referred to SC. The program is planned in rural areas, so we agreed to apply a coverage of 50%.
- Total burden of SAM for girls 6 to 59 months = $86000 \times 1.8\% \times 2.6 = 4025$
- Number of girls 6 to 59 months who will need inpatient treatment: $4025 \times 10\% = 403$

- Targeted girls 6 to 59 months with SAM and in need of treatment in a SC according to planed program coverage: $403 \times 50\% = 202$

See also:

How do we estimate caseload for SAM and / or MAM in children 6 – 59 months in a given time period? by CMAM forum and “Indirectly estimating potential burden and target caseload”, a guidance developed by UNICEF for its country offices: <http://www.unicefinemergencies.com/downloads/eresource/docs/2.3%20Nutrition/FINAL%20Edited%20Formatted%20SAM%20PRO%20English.pdf>

Sample activities and tips

- Trainings of staff and government on the CMAM protocol.
- SAM treatment should be followed by a period of continued support, generally provided through MAM treatment programming. Planning of SAM and MAM treatment should be done in a way that it promotes a continuum of care for acute malnutrition.
- Provision of supplies (F75, F100, RUTF, drugs for systematic treatment, forms and register, anthropometric equipment, etc.)

TIP: When calculating the supply cost, liaise with the pipeline agencies (usually UNICEF)

- With support from the WASH cluster, ensure services such as rehabilitation of water and sanitation facilities, including for hand-washing and safe waste disposal, procurement and distribution of hygiene kits, etc.; are provided.

TIP: Liaise with WASH Cluster to facilitate planning and implementation of activities

TIP: Link with other sector (Health, Food Security clusters) to address other immediate and underlying causes of acute malnutrition that cannot be directly addressed by the Nutrition cluster

- Behaviour changes communication activities that contributes to the prevention of malnutrition as well as hygiene promotion, early childhood development, HIV/AIDS, TB should be prioritized

TIP: Plan for staff, time and a specific place for behaviour changes activities in the health centre (e.g.: “x” sessions during “y” days/week).

- Referral to HIV testing and follow up on treatment compliance of HIV positive patients need to be prioritized (For details, see section in this document called “Nutritional care and support of HIV infected children”).
- Referral to TB testing and follow up on treatment compliance of TB positive patients who are in the nutrition programme
- Adaptation/printing of tools and guidelines.
- Assessment and monitoring

SUGGESTED INDICATORS

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Outcome, Baseline	Individual	Severe acute malnutrition (SAM) - Prevalence (%) of severe acute malnutrition in children 6 to 59 months of age (disaggregated by sex) based on presence of bilateral pitting oedema and / or weight-for-height z-score less than -3 standard deviations of the median of the standard population (WHO 2006)
Outcome	Individual	Severe acute malnutrition (SAM) in infants 0-5 months - Prevalence (%) of severe acute malnutrition in infants less than 6 months of age (disaggregated by sex) based on presence of bilateral pitting oedema and weight-for-height z-score less than -3 standard deviations of the median of the standard population (WHO 2006)
Output	Facility	SAM new admissions - Number of cases with severe acute malnutrition newly admitted for treatment.
Outcome	Individual	SAM treatment coverage - Proportion of cases with severe acute malnutrition receiving treatment
Outcome	Facility	SAM discharged recovered – SPHERE standard is $\geq 75\%$ (Proportion of discharged cases with severe acute malnutrition who recovered)
Output	Facility	SAM discharged defaulted – SPHERE standard $\leq 15\%$, (Proportion of discharged cases with severe acute malnutrition who defaulted)
Process	Facility	SAM discharged died – SPHERE standard is $\leq 10\%$ (Proportion of cases with severe acute malnutrition who died during treatment)
Process	Facility	SAM discharged non-recovered - Proportion of discharged cases with severe acute malnutrition who non-recovered
Output	Facility	SAM average weight gain - Average weight gain for cases with severe acute malnutrition receiving treatment
Output	Facility	SAM average length of stay - Average duration of SAM treatment
Output	Individual	Access to SAM services - Proportion of the target population with severe acute malnutrition living within less than one day's return walk from management of SAM site – SPHERE standard

Output	Individual	Knowledge of good nutrition/IYCF practices - Number of caretakers disaggregated by sex who have received awareness sessions on good nutrition/IYCF practices
Output	Individual	Referrals - Proportion of children who have been admitted in SC, stabilized and referred to OTP to finish their SAM treatment
Output	Facility	WASH Quality at OTP - Proportion of health centres with inpatient management of SAM services with appropriate water treatment supplies and equipment
Output	Facility	Sanitation facility coverage - Average number of users per functioning toilet
Process	Facility	Proportion of nutrition partners following the CMAM protocol

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING

SUPPLIES COST

The inpatient facility should be equipped with the supplies needed for a severe malnutrition treatment ward/stabilization center and this includes the following items:

- Therapeutic supplies (RUTF, F-75, F-100)
- If national protocols refer to the use of other treatment commodities that are prepared locally, the locally recommended supplies should be available (e.g.: powder milk, oil, sugar, CMV).

TIP: If using locally available ingredients, always consider budgeting for complex mineral/vitamins to prepare and add into the local ingredient.

- ReSoMal for the treatment of dehydration in severe acute malnutrition patients,
- Systematic treatment and other essential drugs.
- Anthropometric equipment (MUAC tapes, medical supplies, weighing scales, height measuring boards),
- Hygiene supplies (gloves, mop, etc...), including soap,
- Other supplies, such as ITNs (insecticide-treated bed net),
- Supplies for reference and record keeping (registration forms),
- Kitchen equipment (therapeutic kit and utensils for caretaker's kitchen/cooking area),
- Laboratory facilities should be accessible either on site or through referral to a nearby health centre.
- Food for caretakers
- Extra ward beds (if identified as a need)

STAFF COST

Requires, on average, one part-time physician, three nurses and a nutritionist. The number of health care providers will vary depending on the number of admissions. There should be a minimum of one feeding assistant for 10 inpatients.

Estimates for number of health care provider should take into account need to ensure 24 hours support by nursing staff

CAPACITY BUILDING/DEVELOPMENT COST

At hospitals, district and regional levels, project needs to include the cost for support to the MOH staff: trainings, supplies, collection of data, coordination mechanism, support to sub-national cluster, etc.

Ensure that you include the cost of hiring of extra staff to address the increased caseload. Plan for a transition strategy and the associated costs of transition.

ADMINISTRATIVE COST

M&E COST

LOGISTICS

Need to ensure that human and administrative resources are available for timely program management, monitoring, evaluation and reporting to HQs, donors and cluster.

Ensure cost of transportation and storage of supplies is included and avoid stock-outs.

Plan for referral and/or transport cost if caregivers are not able to bring children to the hospital or children need to be referred for services outside of the centre.

OTHER COSTS

- Security cost;
- Costs related to ensuring an access to water, sanitation and hygiene should be considered by WASH cluster;

PROMOTIONAL COST

Cost of information and communication materials development (on health, nutrition, education and hygiene promotion), training of staff on communication and promotion activities and the sessions (C4D) for caretakers.



OUTPATIENT MANAGEMENT OF SEVERE ACUTE MALNUTRITION

OBJECTIVE

To reduce the risk of excess mortality and morbidity among children aged 6-59 months

29

This approach aims to maximize coverage and access of the population to treatment for SAM children without medical complication by providing easy access to treatment through outpatient services, closer to home.

The programme can have the following specific objectives:

- To provide community based management services to X boys and X girls under 5 years of age with SAM and without complications
- To ensure access to community-based programmes for management of SAM,
- To support the establishment of new community-based programmes for management of SAM cases,
- To ensure adoption and utilisation of standardised protocols for the outpatient management of SAM cases,
- To strengthen referral and counter

referral systems from and to Outpatient Therapeutic Programs (OTP).

- To build the capacity of the government and partners on the appropriate services to be delivered in the OTP

GROUPS TO INCLUDE

- Children between 6 and 59 months of age with SAM, without medical complication
- For behaviour changes activities: caretakers benefiting from communication for development activities at community level

Remark: Older people who are severely acutely malnourished and have no complications should also be targeted to receive also outpatient treatment for more information refer to section “Managing older people’s malnutrition” in this document.

How to calculate expected caseload:

- The total burden of SAM = existing cases + new cases
- Existing cases = SAM prev. x number of girls and boys 6 to 59 months. Disaggregated data may come from recent census, nutrition survey.
- New cases = SAM prev. x number of girls and boys 6 to 59 months x 1.6. The incidence rate is generally recommended at 1.6
- Alternatively, total burden of SAM = SAM prev. x population of targeted age group x 2.6

TIP: If SAM prevalence is not known, consider using on average an estimate of 20% of GAM patients are suffering from SAM.

- When you have your total targeted beneficiaries for SAM treatment, then calculate the number of children who will be admitted in outpatient treatment (OTP)
- On average, a 80-90% of children with SAM are expected to be admitted in outpatient treatment (OTP)
- Apply programme coverage to obtain the total targeted beneficiaries for SAM treatment in OTP

TIP: According to SPHERE standards, coverage in rural areas should be more than 50%, in urban areas more than 70% and in camp situations more than 90%.

- Example of calculation: We want to estimate the total number of girls 6 to 59 months suffering from SAM without medical complications who will be targeted by a NiE program and admitted in an OTP.

From last year census we know that the total number of girls 6 to 59 months is 86000. SAM prevalence is 1.8%. We agreed that in average 90% of the SAM cases detected will be admitted in OTPs (vs 10% admitted in SC – see section above). The program is planned in rural areas, so we agreed to apply a coverage of 50%.

Total burden of SAM for girls 6 to 59 months = $86000 \times 1.8\% \times 2.6 = 4025$

Number of girls 6 to 59 months who will be admitted in OTPs: $4025 \times 90\% = 3623$

Targeted girls 6 to 59 months with SAM and admitted in OTPs according to planed program coverage: $403 \times 50\% = 1812$

See also:

How do we estimate caseload for SAM and / or MAM in children 6 – 59 months in a given time period? by CMAM forum and “Indirectly estimating potential burden and target caseload”, a guidance developed by UNICEF for its country offices: <http://www.unicefemergencies.com/downloads/eresource/docs/2.3%20Nutrition/FINAL%20Edited%20Formatted%20SAM%20PRO%20English.pdf>

Sample activities and tips:

- Training of health centres staff on CMAM protocol

TIP: Strengthen or create links between community and authorities in relation to mobilization, information sharing, and referrals. Very often programmes forget to create links between community health workers, local authorities and health centre (HC) staff.

TIP: Make sure you have specific activities on engaging local authorities and communities in program design, delivery and feedback.

TIP: If the programme plans to hire specific staff to support the MOH staff to deal with heavy caseload, ensure you have an exit strategy, hand over plan and capacity-building activities right from the beginning of the programme and include the associated cost for handing over of the services.

TIP: SAM treatment should be followed by a period of continued support, generally provided through MAM treatment programming. Planning of SAM and MAM treatment should be done in a way that promotes a continuum of care for acute malnutrition.

TIP: make sure your program also includes activities for the prevention of acute malnutrition.

- Provision of supplies (RUTF, drugs for systematic treatment, forms and register, anthropometric equipment).
- Adaptation/printing of tools and guidelines.
- Facilitate/establish active case finding, referral and follow up (see section above on screening). Communication for development (behaviour changes) activities on prevention of malnutrition, hygiene promotion, early childhood development, HIV/AIDS, TB.

TIP: Plan for staff, time and a specific place for behaviour changes activities in the health centre (e.g.: "x" sessions during "y" days/week).

- Referral to HIV testing and follow up on compliance with treatment if positive patients identified (see section in this document called "Nutritional care and support of HIV infected children").
- Referral to TB testing and follow up of compliance of treatment if positive patients identified
- With support from WASH cluster, provide rehabilitation of safe water and sanitation facilities, including hand-washing and safe waste disposal, procurement and distribution of hygiene kits, etc.

TIP: Liaise with WASH Cluster

TIP: Link with other services addressing immediate and underlying causes of malnutrition (Liaise with Health, Food Security clusters)

SUGGESTED INDICATORS

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Baseline, Outcome	Individual	Severe acute malnutrition (SAM) - Prevalence rate (%) of severe acute malnutrition in children 6 to 59 months of age (disaggregated by sex) based on presence of bilateral pitting oedema and / or weight-for-height z-score less than -3 standard deviations of the median of the standard population (WHO 2006))
Baseline, Outcome	Individual	Severe acute malnutrition based on MUAC and oedema - Prevalence rate (%) children 6-59 months (disaggregated by sex) with MUAC less than 115 mm and/or having bilateral pitting oedema
Output	Facility	SAM new admissions - Number of cases with severe acute malnutrition newly admitted for treatment
Outcome	Individual	SAM treatment coverage - Proportion of cases with severe acute malnutrition receiving treatment
Outcome	Facility	SAM discharged recovered – SPHERE standard is $\geq 75\%$ (Proportion of discharged cases with severe acute malnutrition who recovered)
Output	Facility	SAM discharged defaulted – SPHERE standard $\leq 15\%$, (Proportion of discharged cases with severe acute malnutrition who defaulted)
Process	Facility	SAM discharged died – SPHERE standard is $\leq 10\%$ (Proportion of cases with severe acute malnutrition who died during treatment)
Process	Facility	SAM discharged non-recovered - Proportion of discharged cases who did not recover from SAM when discharged
Output	Facility	SAM average weight gain -Average weight gain for cases with severe acute malnutrition receiving treatment
Output	Facility	SAM average length of stay -Average duration of SAM treatment for patients admitted in OTP, between admission and discharge cured
Process	Facility	SAM follow-up - Proportion of SAM cases receiving treatment, in need of follow-up, who are visited at home
Output	Individual	Access to SAM services - Proportion of the severe acute malnutrition target population living within less than one day's return walk from management of SAM site – SPHERE standard
Output	Individual	Knowledge of good nutrition/IYCF practices - Proportion of target population disaggregated by sex who have increased knowledge of good nutrition/IYCF practices at the end of the project
Output	Facility	Water Quality at OTP- Proportion of health centres providing OTP services with appropriate water treatment supplies and equipment
Output	Facility	Access to Sanitation services: Average number of users per functioning toilet and per OTP
Process	Facility	Proportion of nutrition partners following the CMAM protocol

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING:

SUPPLIES COST

The facility should be equipped with supplies needed for a full course treatment of severe malnutrition, including:

- Therapeutic supplies (RUTF)

TIP: An average full course of treatment for a child with SAM amounts to around 10-15 kg of RUTF over a 6-8 week period, which is approximately one carton of RUTF (150 sachets).

- Locally available ingredients - if national protocols recommend the use of other treatment commodities that are prepared locally, supplies for such products should be available.

TIP: When using locally available ingredients, always consider budgeting for complex mineral/vitamins to prepare and add into the local ingredient.

- Anthropometric equipment's (MUAC tapes, medical supplies, weighing scales, height measuring boards),
- Supplies for reference and record keeping (registration forms)

STAFF COST

The number of staff needed will vary depending on the number of admissions and who is undertaking the specific community based activities. Community level case finding may be done by a dedicated person or the role may be combined with other sectors e.g. with community health worker, WASH extension workers, depending on the context.

CAPACITY BUILDING/DEVELOPMENT COST

The project needs to include capacity building support need for MOH staff at district or regional level such as: trainings, supplies, collection of data, coordination mechanism, support to sub national cluster, etc.

ADMINISTRATIVE COST

M&E COST

LOGISTICS

Need to ensure that human and administrative resources are available to facilitate monitoring, supervision visits, evaluation and reporting to HQs, donors and cluster. You can also plan for coverage survey - For details, refer to chapter "Program coverage evaluation" in this document

Depending on supplies used, you need to ensure appropriate transport and storage of all supplies and avoid stock-outs

OTHER COSTS

PROMOTIONAL COST

- Security cost;
- Costs related to ensuring an access to water, sanitation and hygiene should be considered by WASH cluster;

Cost of developing information and communication materials (on health, nutrition education and hygiene promotion), training of staff on communication and promotion activities and the sessions (Behavior Change) for caretakers.



MANAGEMENT OF MODERATE ACUTE MALNUTRITION (MAM) IN THE TARGETED SUPPLEMENTARY FEEDING PROGRAMMES (TSFP)

OBJECTIVE

To reduce mortality and morbidity risk in moderately acutely malnourished children aged 6-59 months, PLW, older people, chronically ill adults, etc.

To prevent moderately acutely malnourished children aged 6-59 months from becoming severely malnourished

The programme can have the following specific objectives:

- To provide management services to (X boys and X girls under 5 years of age) who are Moderately Accurately Malnourished and X acutely malnourished pregnant and lactating women
- To rehabilitate boys and girls aged 6-59 months, who are moderately acutely malnourished,

Pregnant women and Lactating women with infants less than 6 months of age, PLWHIV (PLWs living with HIV/AIDS – nutrition treatment linked with ART provision) and older people,

- To support adoption and utilization of standardized protocols for the targeted SFP

- To build the capacity of government and partners in the service delivery of appropriate TSFP services.

Remarks: Both TSFP and BSFP programs are more effective when household food security support is provided through either a GFD or a cash transfer in food insecure population

For a better effectiveness of TSFP and BSFP programs it is also important to plan for nutrition sensitive interventions from other sectors like WASH and Health.

GROUPS TO INCLUDE

- Moderately acutely malnourished children aged 6-59 months,
- Acutely malnourished (severe and moderate) pregnant and lactating women with infants 0-5 months,
- Severely, moderately and mildly acutely malnourished PLWHIV
- Moderately acutely malnourished older people (for more information see section "Managing older people's malnutrition")
- Other age/sex groups, if needed

TIP: Refer to Moderate Acute Malnutrition: A Decision Tool for Emergencies, 2014

How to calculate expected caseload:

- Apply MAM prevalence rate of the area of intervention to disaggregated data identified through recent census and multiply by incident rate.

TIP: If MAM prevalence is not known, consider using on average an estimate of 80% of GAM patients are suffering from MAM.

- Apply programme coverage

TIP: According to the SPHERE standards, coverage in rural areas should be more than 50%, in urban areas more than 70% and in camp situations more than 90%.

- Example of calculation: We want to estimate the total number of girls 6 to 59 months suffering from MAM who will be targeted by a NiE program and admitted in a TSFP.

From last year census we know that the total number of girls 6 to 59 months is 86000. MAM

prevalence is 6.7%. The program is planned in rural areas, so we agreed to apply a coverage of 50%.

Total burden of MAM for girls 6 to 59 months = $86000 \times 6.7\% \times 2.6 = 14981$

Targeted girls 6 to 59 months with MAM and admitted in TSFP according to planned program coverage: $14981 \times 50\% = 7491$

See also:

How do we estimate caseload for SAM and / or MAM in children 6 – 59 months in a given time period? by CMAM forum and How do we estimate case load for pregnant and lactating women 6 months postpartum in a given time period? by CMAM forum

SAMPLE ACTIVITIES AND TIPS:

- Establishment and maintenance of MAM programmes,

TIP: Strengthen or create links between community and authorities in relation to mobilization, information sharing, and referrals. Very often programmes forget to create links between community health workers, local authorities and health centre (HC) staff.

TIP: Make sure you have specific activities on engaging local authorities and communities in program design, delivery and feedback.

TIP: If the programme plans to hire specific staff to support the MOH staff to deal with heavy caseload, ensure you have an exit strategy, hand over plan and capacity-building activities right from the beginning of the programme and include the associated cost for handing over of the services.

TIP: Ensure continuum of care for patients referred from another nutrition intervention.

TIP: make sure your program also includes activities for the prevention of acute malnutrition.

- Adaptation and dissemination of guidelines and protocols,
- Capacity building of staff and communities,

- Provision of take-home rations through the regular distribution of specialized nutritious food to be: Note that, the rations are prepared at home when a fortified-blended-food (FBF), oil and sugar ration is provided; eaten as it is when ready-to-use supplementary food (RUSF) or improved FBF, is provided.
- Field monitoring of the programme and reporting
- Nutrition screening programmes (For more details see chapter on Rapid nutrition screening and referral above).

TIP: To run a nutrition screening, you need to have: a proper referral system, a nutrition centre nearby, staff available to conduct the screening. If there is no plan for the referral of children with MAM identified, it is better to postpone the screening.

TIP: Link with other services addressing immediate and underlying causes of malnutrition to make sure nutrition sensitive interventions are planned and implemented (Liaise with Health, WASH and Food Security clusters). Eg.: Food security cluster has to take care of implementation of cash or food based household support in food insecure areas (e.g GFD)

- Construction of screening, waiting and distribution areas.
- Communication for development, behaviour changes activities on prevention of malnutrition, hygiene promotion, early childhood development, HIV/AIDS, TB.

TIP: plan for staff, time and a specific place for behaviour changes activities in the community or centre (e.g.: "x" sessions during "y" days/ week).

- Referral to HIV testing and follow up on compliance with treatment if positive patients identified (see section in this document called "Nutritional care and support of HIV infected children").
- Referral to TB testing and follow up of compliance of treatment if positive patients identified
- With support from WASH cluster implement the activities: rehabilitation of safe water and sanitation facilities, including hand-washing and safe waste disposal, procurement and distribution of hygiene kits, etc.

SUGGESTED INDICATORS

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Baseline, Outcome	Individual	Moderate acute malnutrition (MAM) - Prevalence rate (%) of moderate acute malnutrition in children 6 to 59 months of age (disaggregated by sex) based on presence of weight-for-height z-score less than -2 and equal or greater than -3 standard deviations of the median of the standard population (WHO 2006)
Baseline, Outcome	Individual	Moderate acute malnutrition (MAM) in infants 0-5 months - Prevalence rate (%) of moderate acute malnutrition in infants less than 6 months of age (disaggregated by sex) based on weight-for-height z-score less than -2 and equal or greater than -3 standard deviations of the median of the standard population (WHO 2006)
Baseline, Outcome	Individual	Moderate acute malnutrition based on MUAC - Prevalence rate (%) children 6-59 months (disaggregated by sex) with MUAC less than 125 mm but equal or more than 115 mm
Baseline, Outcome	Individual	Acute malnutrition in Pregnant and Lactating Women - Prevalence rate (%) PLW with MUAC less than 210-230 mm (Note: Countries use a range of different cut-offs depending on resources) or having bilateral pitting oedema
Baseline, Outcome	Individual	Acute malnutrition for PLWHIV - Prevalence rate (%) of PLWHIV with a MUAC below 210mm or having bilateral pitting oedema
Baseline, Outcome	Individual	Acute malnutrition for older people - Prevalence rate (%) of older people with a MUAC below 210mm or having bilateral pitting oedema
Output	Facility	MAM new admissions - Number of cases with moderate acute malnutrition newly admitted for treatment
Outcome	Individual	MAM treatment coverage - Proportion of cases with moderate acute malnutrition receiving treatment
Outcome	Facility	MAM discharged recovered - Proportion of discharged cases with moderate acute malnutrition who recovered, SPHERE standard is $\geq 75\%$
Output	Facility	MAM discharged defaulted - Proportion of discharged cases with moderate acute malnutrition who defaulted, SPHERE standard $\leq 15\%$
Process	Facility	MAM discharged died - Proportion of cases with moderate acute malnutrition who died during treatment, SPHERE standard is $\leq 3\%$
Process	Facility	MAM discharged non-recovered - Proportion of discharged cases with moderate acute malnutrition who non-recovered)
Process	Facility	MAM follow-up - Proportion of moderate acute malnutrition problem cases receiving treatment in need for follow-up at home who are visited at home

Output	Individual	Access to MAM services - Proportion of the target population with moderate acute malnutrition living within less than one day's return walk from management of MAM site
Output	Individual	Knowledge of good nutrition/IYCF practices - Proportion of target population disaggregated by sex who have increased knowledge of good nutrition/IYCF practices at the end of the project
Output	Facility	Proportion of health centres with appropriate water treatment supplies and equipment
Output	Facility	Access to Sanitation services: Average number of users per functioning toilet and per TSF site
Process	Facility	Proportion of nutrition partners following the CMAM protocol

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING:

SUPPLIES COST

39

The facility should be equipped with supplies needed for a full course treatment of severe malnutrition, including

- Food commodities

TIP: For children 6- 59 months: Improved Fortified blended foods (e.g. Supercereal + or CSB++/ WSB++) or ready to use foods (such as large quantity lipid based nutrient supplement e.g. plumpy sup). For malnourished adults (PLW, PLWHIV, older people ..): FBF (Supercereal or CSB / WSB)

- Locally available ingredients - if national protocols recommend the use of other treatment commodities that are prepared locally, supplies for such products should be available.

TIP: When using locally available ingredients, always consider budgeting for complex mineral/ vitamins to prepare and add into the local ingredient.

- Supplies for systematic treatment and other essential drugs and supplements, deworming tablets
- Non-food items (blankets/soap/kitchen items/fuel) - OXFAM kits

TIP: Liaise with relevant cluster on this (Non-food Items (NFI) Cluster, if exists)

- Anthropometric equipment (MUAC tapes, medical supplies, weighing scales, height measuring boards),
- Hygiene supplies, including soap,
- Supplies for reference and record keeping (registration forms, writing instruments).

STAFF COST

The number of staff needed will vary depending on the number of admissions and who is undertaking the specific community based activities. Community level case finding may be done by a dedicated person or the role may be combined with other sectors e.g. with community health worker, WASH extension workers, depending on the context.

CAPACITY BUILDING/DEVELOPMENT COST

The project needs to include capacity building support need for MOH staff at district or regional level such as: trainings, supplies, collection of data, coordination mechanism, support to sub national cluster, etc.

ADMINISTRATIVE COST

M&E COST

LOGISTICS

Need to ensure that human and administrative resources are available to facilities monitoring, supervision visits, evaluation and reporting to HQs, donors and cluster. You can also plan for coverage survey - For details, refer to chapter "Program coverage evaluation" in this document

Depending on the supplies used, you need to ensure appropriate transport and storage of all supplies and avoid stock-outs

OTHER COSTS

- Security cost;
- Costs related to ensuring an access to water, sanitation and hygiene should be considered by WASH cluster

PROMOTIONAL COST

Cost of developing information and communication materials (on health, nutrition education and hygiene promotion), training of staff on communication and promotion activities and the sessions (Behavior changes) for caretakers.



PREVENTION OF MODERATE ACUTE MALNUTRITION – BLANKET SUPPLEMENTARY FEEDING PROGRAMMES (BSFP)

42

OBJECTIVE

To improve the nutritional status of beneficiaries by reducing or preventing acute malnutrition.

The programme can have the following specific objectives:

- To prevent nutritional deterioration and related mortality and morbidity in X boys and X girls 6-59 month of age, PLW or older people (through BSFP as well as through other promotional activities such as infant and young child feeding or hygiene promotion),
- To ensure adoption and utilisation of standardised protocols for the Blanket SFPs

Remarks: Both TSFP and BSFP programs are more effective when household food security support is provided through either a GFD or a cash transfer in food insecure population

For a better effectiveness of TSFP and BSFP programs it is also important to plan for nutrition sensitive interventions from other sectors like WASH and Health.

GROUPS TO INCLUDE

At-risk population groups (e.g. all children under 6-23m, 6-36m or 6-59 months, pregnant and lactating women, older people) in a specified geographic area (community, camp, district, etc.) irrespective of nutritional status.

TIP: In a number of emergencies where GAM prevalence rates are very high and/or resources are limited, the cluster can decide which cut off points to use through consensus. If resources are limited, only children 6-23 months and PLWs focusing on 1000 days can be targeted.

TIP: Refer to [Moderate Acute Malnutrition: A Decision Tool for Emergencies, 2014](#)

How to calculate expected caseload:

- Use demographic profile from the last census, nutrition surveys. Adjust with population growth rate if necessary and apply project coverage.
- If no data available, estimate children 6 -23 months as 6% of the total population and PLW as 5% of total population.
- If resources are available and all children age 6-59 months can be targeted, use 15-20% of the total population to estimate children 6-59 months.

Sample activities and tips:

- Provision of take-home rations through regular distribution of food to be: prepared at home (when a FBF-based premix ration is provided); eaten as it is (when LNS: lipid-based nutrient supplements - is provided),

TIP: Plan how to better facilitate access of target groups, including having a separate areas for distribution, and screening. For waiting areas, consider existing weather conditions

- Or provision of on-site feeding (Food rations should be distributed either as “dry” take home ration or “wet”/ on-site feeding ration. Most supplementary feeding programs, especially BSFP distribute dry ration as it is easy and requires less resource. On-site feeding is, however, justified when there is an extreme short supply of household food, firewood, water and cooking utensils or even when the security situation does not allow beneficiaries to carry food rations home.)

TIP: For distribution of rations, always consider post distribution monitoring, sensitisation of communities and beneficiaries and preparation of the rations.

TIP: Plan how to better facilitate access of target groups, including having a separate areas for distribution, and screening. For waiting areas, consider existing weather conditions.

- Dissemination and adaptation of guidelines and protocols.
- Capacity building of staff.
- Nutrition screening, referral if needed (For more details see Rapid nutrition screening and referral above):

TIP: Screening must be limited to referral and treatment / case management,

TIP: To run a nutrition screening you need to have a proper referral system, nutrition centre nearby, staff available to do the screening.

TIP: If there is no plan for the identified malnourished patients to be referred, it is better to postpone the screening and plan it properly.

- Communication for development and behaviour changes activities on prevention of malnutrition, hygiene promotion, early childhood development, HIV/AIDS, TB).

TIP: plan for staff, time and a specific place for behaviour changes activities in the community or centre (ex. "x" sessions during "y" days/week).

- With support from WASH, the following activities can be put in place: rehabilitation of safe water and sanitation facilities, including hand-washing and safe waste disposal, procurement and distribution of hygiene kits, etc. Depending on the context, nutrition partners will implement these activities directly with the support from the WASH cluster OR the WASH cluster will coordinate the implementation of these activities by WASH partners within nutrition programs.

TIP: Liaise with WASH Cluster on this

TIP: Link with other services addressing immediate and underlying causes of malnutrition. Liaise with Health and FS clusters (for the cash or food based household support in food insecure areas for example under the responsibility of the FS cluster)

Suggested indicators:

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Output	Individual	BSFPs coverage - Proportion of eligible target population enrolled in blanket supplementary feeding programme
Output	Individual	BSFPs coverage - Proportion of target population participating in an adequate number of distributions
Output	Facility	Children Screened - Number of children (disaggregated by sex/age) screened for acute malnutrition in a community.

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING:

SUPPLIES COST

The facility should be equipped with minimum supplies needed, including

- Recommended food commodities for children 6- 59 months are Improved Fortified blended foods (e.g Supercereal + or CSB++/WSB++) or ready to use foods (such as medium quantity LNS e.g plumpy doz), for PLW and other adults: FBF (Supercereal or CSB /WSB)

TIP: See MAM decision, appendix C: <http://nutritioncluster.net/resources/mam-decision-tool-gnc-july-2014-english/>

- Locally available ingredients - if national protocols recommend the use of other treatment commodities that are prepared locally, supplies for such products should be available.

TIP: When using locally available ingredients, always consider budgeting for complex mineral/ vitamins to prepare and add into the local ingredient.

- Anthropometric equipment (MUAC tapes),
- Supplies for reference and record keeping (registration forms).

STAFF COST

CAPACITY BUILDING/DEVELOPMENT COST

The project needs to include capacity building support need for MOH staff at district or regional level such as: trainings, supplies, collection of data, coordination mechanism, support to sub national cluster, etc.

45

ADMINISTRATIVE COST

M&E COST

LOGISTICS

Need to ensure that human and administrative resources are available to facilities monitoring, supervision visits, evaluation and reporting to HQs, donors and cluster. You can also plan for coverage survey - For details, refer to chapter “Program coverage evaluation” in this document

Depending on supplies used, you need to ensure appropriate transport and storage of all supplies and avoid stock-outs

OTHER COSTS

PROMOTIONAL COST

- Security cost;
- Costs related to ensuring an access to water, sanitation and hygiene should be considered by WASH cluster

Cost of developing information and communication materials (on health, nutrition education and hygiene promotion), training of staff on communication and promotion activities and the sessions (Behavior changes) for caretakers.



INFANT AND YOUNG CHILD FEEDING IN EMERGENCIES (IYCF-E)

OBJECTIVE

To reduce the risk of excessive mortality and morbidity amongst infants and children aged 0-23 months.

The programme can have the following specific objectives:

- To protect, promote and support safe and appropriate (recommended) feeding practices for both breastfed and non-breastfed infants and young children aged 0-23 months during emergencies.
- To maintain exclusive breastfeeding rates at x% (pre-emergency rates)
- To promote best practices on IYCF among caregivers

GROUPS TO INCLUDE

- All children 0-23 months (disaggregated by sex),
- Pregnant and lactating women,
- Caregivers of children U2.

TIP: All children under two years old require protection, promotion and support of optimal IYCF, especially infants and young children in exceptionally difficult circumstances, such as HIV-affected populations, orphans, LBW infants, non-breastfed infants and those who are severely malnourished.

How to calculate expected caseload:

- Use demographic profile from the last census, nutrition survey.

TIP: If no such data available estimate children 0-23 months as around 6% of the total population.

- Apply project coverage
- Example of calculation: We want to estimate the total number of children 0 to 23 months who can benefit from an IYCF-E program.

From last year census we know that the total number of children 0 to 59 months is 195000. The program is planned in rural areas, so we agreed to apply a coverage of 50%.

Total number of children 0 to 23 months = $195000 \times 6\% = 11700$

Targeted children 0 to 23 months for an IYCF-E program according to planned program coverage: $11700 \times 50\% = 5850$

See also: How do we estimate caseload for pregnant and lactating women 6 months postpartum in a given time period? by CMAM forum

Sample activities and tips:

- Verify if the country has a policy or guidelines on IYCF-E. If so, plan for review and adaptation to new context and disseminate to all stakeholders
- If no policy or guidelines on IYCF-E exist, develop a joint statement on IYCF-E and disseminate it to all stakeholders (note that the cost for this activity will depend very much on advocacy and communication channels you would use, e.g. radio, TV, public or interpersonal communication a few examples of such channels)
- Verify if the country has a law on the marketing of breastmilk substitutes. If so, disseminate to all stakeholders and monitor compliance with it
- If no law on the marketing of breastmilk substitutes exists, disseminate the International Code on Marketing of BMS (The Code), monitor compliance with it and advocate for its adaptation into national laws.
- Measures should be put in place for appropriate handling of unsolicited breastmilk substitutes
- Support for the adaptation of national IYCF policies, protocols and guidelines, including on HIV and feeding to international standards where needed,
- Assessments of IYCF practices and if possible also on knowledge, beliefs and attitudes and include health workers and other key service providers
- Assessment for non-breastfed infants and ensuring sufficient support is in place as outlined in the IFE Operational Guidelines
- Monitoring of interventions,

Capacity building of relevant staff where needed; this can include staff involved in health & nutrition related activities and also in WASH, child protection and other activities that involve children under 2 and their caregivers, eg.: Community based workers will need to have the required skills to provide one on one and group counselling, establish support groups etc, for mothers experiencing difficulty in breastfeeding, skilled support will be required (often health workers), training on how to assess the mother/baby pair and provide appropriate support, Key messages on IYCF could be incorporated into the tasks of staff from other sectors (WASH, Health, child protection etc)
- Integration of IYCF in other nutrition and other cluster programmes for example provision of home fortification e.g. multiple micronutrient

powders should be complemented by counselling on adequate complementary foods for children above 6 months

- Liaise with the health cluster to ensure adequate services for pregnant women: iron and folic acid supplementation, counselling on diet during pregnancy, screening and referral for treatment of malnourished pregnant and lactating women, malaria prevention and treatment.

TIP: Consider integration IYCF counselling with CMAM services, hygiene promotion session, child protection, Health National days (promotion of IYCF, short messages to broadcast), etc.

- Provision of “safe and supportive” corners/ tents for infant feeding, where needed/possible jointly with child protection;
- Verify the use of an existing IYCF communication strategy, activities and materials. Where available, apply the activities and materials in the emergency setting
- Where needed, development of behaviour changes and communication strategy, including development, field-testing and dissemination of IYCF IEC materials and IEC campaigns.

SUGGESTED INDICATORS:

Remarks: The selection of indicators from the extensive list below has to be done based on needs and program design.

Note that the first 11th baseline/outcomes indicators are the UNICEF and WHO indicators that are measured during surveys. Those indicators cannot be measured routinely.

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Baseline, Outcome	Individual	Early initiation of breastfeeding - Proportion of children 0-23 months who were put to the breast within one hour of birth
Baseline, Outcome	Individual	Exclusive breastfeeding under 6 months - Proportion of infants 0-5 months of age who are fed exclusively with breast milk
Baseline, Outcome	Individual	Continued breastfeeding at one year and at 2 years - Proportion of children 12-15 months of age and 20-23 months of age who are fed breast milk
Baseline, Outcome	Individual	Children ever breastfed - Proportion of children born in the last 24 months who were ever breastfed
Baseline, Outcome	Individual	Predominant breastfeeding under 6 months - Proportion of infants 0-5 months of age who are predominantly breastfed
Baseline, Outcome	Individual	Bottle feeding - Proportion of children 0-23 months of age who are fed with a bottle
Baseline, Outcome	Individual	Not breastfed - Proportion of infants 0<6 months, 0<12 months and 12<24 months not breastfed
Baseline, Outcome	Individual	Minimum meal frequency for children 24-59 months - Proportion of children 24-59 months who are eating 3 meals a day or more
Baseline, Outcome	Individual	Minimum dietary diversity for children 24-59 months - Proportion of children 24-59 months who receive foods from 4 or more food groups
Baseline, Outcome	Individual	Minimum acceptable diet - Proportion of children 6-23 months of age who receive a minimum acceptable diet (apart from breast milk)
Baseline, Outcome	Individual	Introduction of solid, semi-solid or soft food - Proportion of children 6-8 months of age who received solid, semi-solid or soft foods during the previous day
Output	Facility	Number of breastfeeding corners established and functional
Output	Individual	Access to breastfeeding corners - Proportion of breastfeeding mothers of children 0-2 years with access to breastfeeding corners

Process	Facility	Breastfeeding support inclusion - Proportion of programmes that includes support of breastfeeding mothers as a specific programme component
Outcome	Facility	Proportion of mothers relactated - Proportion of mothers who successfully relactated
Process	Individual	Infants who have access to BMS supplies and support - Proportion of non-breastfed infants under 6 months of age who have access to adequate BMS supplies and support
Process	Facility	BMS targeting - Proportion of programmes where BMS are appropriately targeted, based on qualified assessment and governed by accepted criteria
Process	Facility	Preparation BMS education - Proportion of programmes where education and practical training on safe preparation of BMS for caregivers is included
Process	Facility	BMS follow up - Proportion of programmes where there is follow-up of BMS recipients, both at distribution point and at household level)
Process	Facility	BMS labelling language (Proportion of programmes where BMS used is labelled in an appropriate language)
Process	Facility	BMS shelf life (Proportion of programmes where distributed BMS DOES have a shelf-life of at least six months)
Process	Facility	Secure supply of BMS (Proportion of programmes where a secure supply of BMS HAS been established)
Process	Facility	admissions with BMS (Proportion of children who were already on BMS when admitted to the programme)
Process	Individual	Infants in need of BMS (Proportion of children admitted to programme who are in need of BMS)
Baseline, Outcome	Individual	Number of distribution of infant formula, dried or liquid milk to the affected population - Confirmed distribution of infant formula, dried or liquid milk to the affected population
Baseline, Outcome	Individual	Number of inappropriate distribution of infant formula, dried or liquid milk to children 0-<2 years - Confirmed distribution of infant formula, dried or liquid milk to children 0-< 2 years)
Process	Facility	Baby bottles or teats distribution (Proportion of programmes where baby bottles or teats are being used and/or distributed as feeding utensils)
Process	Facility	BMS distribution (Proportion of programmes where BMS are distributed as part of the food aid distribution)
Process	Community	code violations (Number of recorded Code violations)
Output	Facility or community	donations intercepted (Number of donations of BMS, complementary foods, bottles or teats successfully intercepted)
Output	Facility or community	donations not intercepted (Number of donations of BMS, complementary foods, bottles or teats not successfully intercepted)

Process	Facility	The code labelling of BMS (Proportion of programmes where the labels of BMS DO NOT comply with the labelling requirements of the Code)
Output	Individual	IYCF support (Proportion of caregivers received skilled IYCF support)
Output	Individual	IYCF-E orphans and unaccompanied children receiving services (Number of orphans and unaccompanied infants and children 0-23 months who receive nutritional and care support)
Output	Facility	Voucher/cash IYCF (Number of voucher/cash programmes targeting families with children U2 with an IYCF objective)
Output	Facility	Voucher/cash infants (Number of voucher/cash programmes targeting families with infants under 6 months with a breastfeeding objective)
Output	Facility	Code violations followed up (Proportion of reported code violations which were followed up)
Output	Individual	Knowledge of good nutrition/IYCF practices (Proportion of target population disaggregated by sex who have increased knowledge of good nutrition/IYCF practices at the end of the project)
Process	Community	IYCF policy (A national and/or agency policy is in place that addresses IYCF and reflects the Operational Guidance on IFE) – one off indicator
Process	Community	IYCF coordinating body (A lead coordinating body on IYCF is designated)
Process	Community	Body to deal with donations (A body to deal with any donations of BMS, milk products, bottles and teats is designated)
Baseline, Output	Community	IYCF-E Capacity (Proportion of emergency-affected areas that have an adequate number of skilled IYCF counsellors and/or functioning support groups)
Process	Facility	IYCF in HIV context (Proportion of programmes that follows national policy on HIV)

Remark: the list above does not include indicators for the distribution of foods for complementary feeding or supplementation. Refer to TSFP, BSFP and micronutrients supplementation sections to select relevant indicators.

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING:

SUPPLIES COST

The facility should be equipped with minimum supplies needed, including

- Non-food items (tents/blankets/hygiene supplies/kitchen items/fuel)
- Food commodities (complementary foods) with safe storage or security measures,
- BMS (only if in line with the Code on breastmilk substitutes)
- **TIP: Liaise with relevant cluster on this (Non-food Items (NFI) Cluster, if exists)**
- Anthropometric equipment (MUAC tapes, medical supplies, weighing scales, height measuring boards),
- Supplies for reference and record keeping (registration forms).

STAFF COST

- A large pool of community counselors
- Cash or in-kind incentives if required

CAPACITY BUILDING/DEVELOPMENT COST

The project needs to include capacity building support need for MOH staff at district or regional level such as: trainings, supplies, collection of data, coordination mechanism, support to sub national cluster, etc.

ADMINISTRATIVE COST

M&E COST

LOGISTICS

Need to ensure that human and administrative resources are available for timely monitoring, evaluation and reporting to HQs, donors and cluster

Depending on supplies used, you need to ensure appropriate transport and storage of all supplies and avoid stock-outs

OTHER COSTS

PROMOTIONAL COST

- Security cost;
- Costs related to ensuring an access to water, sanitation and hygiene should be considered by WASH cluster

Cost of developing information and communication materials (on health, nutrition education and hygiene promotion), training of staff on communication and promotion activities and the sessions (Behavior changes) for caretakers.



MANAGING OLDER PEOPLE'S MALNUTRITION

OBJECTIVE

To assess, prevent and manage malnutrition in older people

54

The programme can have the following specific objectives:

- Assess the nutritional status of older people
- Prevent moderate and severe malnutrition in older people by targeting them in blanket supplementary feeding programmes
- Treat moderate and severe malnutrition in older people by targeting them in supplementary and therapeutic feeding programmes using CMAM
- Prevent micronutrient deficiencies in older people by ensuring dietary diversity or supplementation of their food ration.

GROUPS TO INCLUDE

The UN definition for older people is people aged 60 years of age and above (≥ 60). However, you might wish to adapt this definition according to the context: in some countries (e.g. Sub Saharan Africa), old age is more of a social or cultural concept (e.g. retiring, or getting white hair...), and it makes sense to target people when they reach the age of 50 or 55 years. Some countries have their own definition.

TIP: if there is no national definition of older people, use the UN definition (≥ 60).

For CMAM activities:

- Older people suffering from SAM (MUAC 185mm and/or bilateral pitting oedema)
- Older people suffering from MAM ($185 < \text{ou} = \text{MUAC} > 210\text{mm}$)

For all other nutrition activities:

- All older people

How to calculate expected caseload:

In rapid MUAC screening:

Use demographic profile from the last census to define the proportion of older people in the area of intervention. Adjust with population growth rate if necessary. 100% of older people estimated should be targeted for MUAC screening.

In nutrition survey:

Use RAM-OP (Rapid Assessment method for Older People); see <http://www.helpage.org/what-we-do/emergencies/ramop-rapid-assessment-method-for-older-people/> - sample size 192 persons

For blanket supplementary programs or micronutrient supplementation programs:

Use demographic profile from the last census to define the proportion of older people in the area of intervention. Adjust for population growth rate if necessary and apply project coverage.

TIP: In some situations, the proportion of people aged 60 and above is quite low (below 5 percent such as in South Sudan) or very high (around two thirds of the displaced people in Ukraine are aged 60 and above). According to the context, your resources and the needs, you might decide to target older people from 50, 55, 60 or 65 years of age. You may therefore wish to adapt the age group according to the proportion of older people in the population.

In the treatment of moderate or severe malnutrition (MAM or SAM):

Apply the MAM or SAM prevalence rate of the area of intervention to disaggregated data identified through recent census, nutrition survey and multiply by incident rate.

TIP: if there is no nutritional data on older people, use available data for children under five. In critical situations, GAM rates will be similar.

TIP: If SAM prevalence is not known, consider using the following rule of thumb i.e. 20% of GAM patients are normally suffering from SAM.

On average, 30-40% of older people with SAM are expected to have medical complications and they need to be referred to inpatient treatment.

TIP: The prevalence of bilateral pitting oedema is a good indicator for the proportion of older people with medical complications in need of a medical check up

Apply programme coverage based on capacity and resources

SAMPLE ACTIVITIES AND TIPS:

- 1. Conduct rapid MUAC screening to detect acute malnutrition among Older People and refer cases to appropriate nutrition programs**
- 2. Conduct nutrition survey (RAM-OP) to measure acute malnutrition prevalence among Older People**
- 3. Ensure inclusion of older people in blanket and targeted supplementary feeding programmes:**

a) Provide blanket supplementary feeding for older people in selected geographical areas where the general food ration is not sufficient or inadequate: complement the general food ration with a monthly food basket providing the missing macro- and micro-nutrients to all older people in selected areas.

And/or

b) Organise supplementary feeding (SFP) for moderately malnourished older people ($185\text{mm} \leq \text{MUAC} < 210\text{mm}$) in areas with high prevalence of malnutrition:

- Train CHW to identify moderately malnourished older people by active detection of cases at community level (MUAC screening)
- Provide regular supplementary food rations comprising nutrient-rich food (e.g. CSB++, staple food+oil+sugar, or ready-to-use supplementary products), and micronutrient sprinkles if necessary
- Organise monitoring and follow up of cases, including community-based follow up.

- 4. In areas where malnutrition prevalence is high, address severe acute malnutrition in older people by including supplementary and therapeutic programme components for older people in existing CMAM (community management of acute malnutrition) programmes:**

a) Identify partner (INGOs and UN agencies) that are willing to include older people in their existing CMAM activities

b) Train CHWs to undertake active detection and referral (using MUAC) of cases of moderate and severe malnutrition in older people

c) Train additional health and community workers to treat severely malnourished older people in in-pa-

tient facilities/ stabilisation centres (for those with medical complications) and as out-patients within the communities (for those without medical complications)

d) Provide therapeutic food to treat severely malnourished older people (F75, F100, ready-to-use therapeutic products) and nutrient-rich food to treat moderately malnourished ones (e.g. CSB++, RUSF) and micronutrient sprinkles if needed.

e) Organize medical treatment and follow up of older people with medical complications: provide relevant treatment or referral to secondary health facilities with which HelpAge has an agreement, ensuring isolated older people are accompanied by a carer when referred.

5. Include older people in micronutrients supplementation activities: distribution of iron, vitamin A, iodine, MNPs, deworming, etc..

SUGGESTED INDICATORS:

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Baseline Outcome	Individual	Acute malnutrition for older people - Prevalence rate (%) of older people with a MUAC below 210mm or having bilateral pitting oedema
Output	Individual	Number of Older People screened – Total number of Older People who have been screened with MUAC, total number of MAM, total number of SAM
Output	Facility	SAM new admissions - Number of cases with severe acute malnutrition newly admitted for treatment
Output	Facility	SAM discharged recovered - Proportion of discharged cases with severe acute malnutrition who recovered
Output	Facility	SAM discharged defaulted - Proportion of discharged cases with severe/moderate acute malnutrition who defaulted
Process	Facility	SAM discharged died - Proportion of cases with severe acute malnutrition who died during treatment
Output	Facility	MAM new admissions - Number of cases with moderate acute malnutrition newly admitted for treatment
Output	Facility	MAM discharged recovered - Proportion of discharged cases with moderate acute malnutrition who recovered
Output	Facility	MAM discharged defaulted - Proportion of discharged cases with moderate acute malnutrition who defaulted
Output	Facility	MAM discharged died - Proportion of cases with moderate acute malnutrition who died during treatment

Output	Individual	BSFPs coverage - Proportion of target beneficiaries enrolled in blanket supplementary feeding programme
Output	Individual	Multiple micronutrients coverage - Proportion of target population that received multiple micronutrient powder/tablets
Output	Individual	Iron folic acid supplementation coverage – proportion of older people receiving micronutrients that contain adequate iron
Output	Individual	Iodine supplementation coverage – proportion of older people who have received iodine supplements
Output	Individual	Vitamin A coverage in older people – proportion of older people having received vitamin A in previous 6 months
Output	Individual	Deworming coverage in older people – proportion of older people who received deworming medication in the previous 6 months
Output	Individual	Micronutrient knowledge (in-depth) - Proportion of target population who knows key elements of the nutrition messages provided on availability, use and benefits of micronutrient supplements or micronutrient rich or fortified foods/ food supplements
Output	Community	Satisfaction with access to services - Proportion of target population disaggregated by sex satisfied with their access to services at the end of the project

Reference document: Nutrition interventions for older people in emergencies, HelpAge International, London 2013

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING:

SUPPLIES COST

According to the different facilities (in-patients, supplementary feeding or OTP) the minimum supplies needed include:

- Supplementary food commodities (CSB++/UNIMIX/RUSF/high energy biscuits etc.)
- Therapeutic supplies (RUTF, F-75, F-100)

Locally available ingredients in order to provide nutritious food culturally acceptable for older people.

TIP: When using locally available ingredients, always consider budgeting for complex mineral/vitamins to prepare and add into the local ingredient.

- ReSoMal for the treatment of dehydration in severe acute malnutrition,
- Systematic treatment and other essential drugs: antimalarial drugs, anti-helminthic, antibiotics, iron, vitamin A, and for the in-patient facility, drugs for chronic diseases such as diabetes and hypertension
- Anthropometric equipment (Adult MUAC tapes, medical supplies, weighing scales for adults),
- Hygiene supplies, including soap, and adult diapers
- Other supplies, such as blankets and ITNs (insecticide-treated bed net),
- Supplies for reference and record keeping (registration forms),
- Kitchen equipment (therapeutic kit),
- Laboratory resources should be accessible either on site or through referral to a nearby health centre.

STAFF COST

RAM-OP: Plan for adequate survey teams
 In patient facilities:
 Requires, on average, one part-time physician, three nurses and a nutritionist and 1 or 2 nursing aids
 OTP:
 Trained community health workers
 1 Nurse to supervise
 SFP:
 1 nurse, trained community health workers

CAPACITY BUILDING/DEVELOPMENT COST

It is likely that the health staff at all levels (community, PHC facility and hospital) have no knowledge in assessing and managing older people’s malnutrition. They will have to be trained. At hospital level, project needs to include support to the MOH staff at district or regional level: trainings, supplies, collection of data, coordination mechanism, support to sub-national cluster, etc. When needed hire extra staff to address the increased caseload. Plan for a transition strategy and the associated costs of transition. Budget also for training of NGO staff (national, regional and district level trainings).

ADMINISTRATIVE COST

M&E COST

LOGISTICS

RAM-OP: plan for transportation of survey teams (car, fuel, communication costs, etc...)

OTHER COSTS

PROMOTIONAL COST



CASH OR VOUCHER PROGRAMMES FOR THE PREVENTION OF MALNUTRITION

60

OBJECTIVE

To improve nutritional status for targeted beneficiaries (households).

Cash or vouchers can be used to gain access to food items in the marketplace.

The programme can have the following specific objectives:

- To strengthen direct purchasing power of the X most vulnerable households and women to cover their basic needs, including nutritional needs and in favour of their children
- To provide access to a nutritionally adequate food basket;
- To improve complementary feeding practices by ensuring that children 6-23 months old receive appropriate complementary food;
- To promote, protect and support safe IYCF practices by targeting families with children 0-23 months old

Remarks:

- It is not easy to analyse the direct impact of cash transfer programs on nutrition but it is important to monitor it.
- Intercluster coordination is strongly recommended when planning and/or developing cash transfer project. The lesson learnt from past experiences **is that «people do not divide their needs by sectors and clusters»: there is a need to have fewer, large scale interventions to complement in-kind support.**

GROUPS TO INCLUDE

Precise targeting criteria must be established at country level in case of cash and voucher initiatives. Targeting criteria should be based on vulnerability criteria = target at risk population.

Blanket coverage may be an option when it is too difficult to target specific group of beneficiaries.

Depending on targeting criteria the groups may be as following:

- Families with children 0-59 months
- Families with children 0-23 months
- Pregnant women

Families with children treated in the MAM or SAM management programmes (cash/voucher can be used to support a very specific program, where the objective is to cover transportation or food for the members of the household left at home).

How to calculate expected caseload:

Use demographic profile from the last census, nutrition surveys. Adjust with population growth rate if necessary. Use percentage of population according to groups targeted (such as present of population with certain income level, etc.). Apply project coverage.

Note that it is likely to be different sources of data if dealing with a refugee crisis.

SAMPLE ACTIVITIES AND TIPS:

- Market assessment (e.g.: Needs to assess if age appropriate fortified complementary foods are available for children 6-23 months, etc...)
- Vulnerability assessment
- Analysis to identify delivery mechanism
- Develop M&E
- Risk assessment with mitigation measures
- Distribution of cash/vouchers to targeted beneficiaries/households,
- In coordination with government development of national standards for emergency cash distribution, and coordination of cash/voucher programmes (e.g.: ToR of cash working group),
- Establishment of ad-hoc cash working group that aim to facilitate coordination on cash
- Communication and promotion,

TIP: Cash transfers need to be accompanied by a good communication strategy to ensure behaviour change in medium- and long-term and achievement of targets. There are some good examples where communication/behavior change messages have benefited a larger population than the cash beneficiaries themselves, e.g. where sessions were organized around the pay point and open to all.

Suggested indicators:

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Output	Facility	Voucher/cash IYCF - Number of voucher/cash programmes targeting families with children U2 with an IYCF objective
Output	Facility	Voucher/cash infants (Number of voucher/cash programmes targeting families with infants under 6 months with a breastfeeding objective)
Output	Facility	Number of beneficiaries receiving cash transfers and vouchers as % of planned
Output	Facility	Quantity of value of cash/voucher received by beneficiary HH (and proportion in relation to food basket)
Output	Facility	Total value of cash or vouchers for food and basic needs distributed, as % of planned
Process	Facility	Frequency of cash assistance to beneficiary HH (months)
Output	Community	Proportion of HHs having a minimum acceptable diet for children 6-23 months
Output	Community	Proportion of HHs having access to a nutritionally adequate food basket

For more indicators see [WFP Cash and Vouchers Manual](#), p 29

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING:

SUPPLIES COST

- Voucher/cash cost
- Support funds associated with vouchers and/or cash transfers,
- Support funds associated with programme activity costs
- Cost of printing vouchers/bank transfers
- Supplies for reference and record keeping (registration forms).

STAFF COST

[Empty box for Staff Cost details]

CAPACITY BUILDING/DEVELOPMENT COST

[Empty box for Capacity Building/Development Cost details]

ADMINISTRATIVE COST

[Empty box for Administrative Cost details]

M&E COST

Need to ensure that human and administrative resources are available for timely monitoring, evaluation and reporting to HQs, donors and cluster.
Analyzing the impact of cash-based programming (may require the intervention of an expert as it is not easy to evaluate but it is needed)

LOGISTICS

Depending on type of transactions

OTHER COSTS

- Security cost
- Developing a mechanism for appeals and complaints

PROMOTIONAL COST

Cost of information and communication materials development (on breastfeeding, complementary feeding, safe IYCF practices, health, nutrition education and hygiene promotion), training of staff on communication and promotion activities and the sessions (C4D) for caretakers.



MULTIPLE MICRONUTRIENT SUPPLEMENTATION

OBJECTIVE

To decrease the risk of acute morbidity and mortality due to common micronutrient deficiencies that occurs during the emergency

65

The programme can have the following specific objectives:

- To improve iron status and reduce anaemia prevalence among children aged 6-23 months of age / pregnant women / older people
- To reduce the risk of low birth weight, maternal anaemia and iron deficiency
- To promote home fortification of foods with MNPs among X children 6-23 months of age

- Pregnant and lactating women
- Older people (for more information see section "Managing older people's malnutrition")

How to calculate expected caseload:

Use demographic profile from the last census, nutritional surveys. Adjust with population growth rate if necessary. Apply planned programme coverage

GROUPS TO INCLUDE

- Children 6-23 months of age (disaggregated by sex);

TIP: if resources allowed children 6-36 or 6-59 months can be considered in emergency situations

TIP: MN powders are generally for children and MN tablets for PLWs

TIP: In areas with high GAM prevalence rate, do not forget to subtract children with GAM as they receive RUTF/RUSF and children receiving BSFP supplies, that already contain micronutrients

SAMPLE ACTIVITIES AND TIPS

- Assessment of nutritional status of population, including anaemia prevalence
- Micronutrient powders/tablets distribution

TIP: consider also implementing other activities like provision of fortified complementary foods or deworming. Note that if fortified complementary foods are provided, then there is no need to provide MNPs as this will be a duplication of intake of micronutrients for the patient.

TIP: In malaria-endemic areas, MNP distribution should be implemented in conjunction with malaria prevention and treatment

- Behaviour change strategy to promote an awareness of the product along with its correct use and hygienic practices to prepare food

TIP: liaise with WASH cluster on this

TIP: Include children 6 months of age and above and encourage continued breast feeding beyond 6 months together with timely introduction of quality appropriate complementary feeding

- Integration of the MNP and MMN into the national policies and strategies

SUGGESTED INDICATORS

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Output	Individual or facility	Multiple micronutrients coverage - Proportion of target population that received multiple micronutrient powder/tablets)
Output	Individual	Micronutrient knowledge (in-depth) - Proportion of target population who knows key elements of the nutrition messages provided on availability, use and benefits of micronutrient supplements or micronutrient rich or fortified foods/ food supplements)

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING:

SUPPLIES COST

- Multiple micronutrient powders (for children) or tablets (for women)

TIP: Plan for a minimum of 6 months with either 60 sachets/ child/ 6months OR 90 sachets /child/6 months OR 120 sachets/child/ 6 months.

- Supplies for reference and record keeping (registration forms).

STAFF COST

CAPACITY BUILDING/DEVELOPMENT COST

ADMINISTRATIVE COST

M&E COST

LOGISTICS

Need to ensure that human and administrative resources are available for timely monitoring, evaluation and reporting to HQs, donors and cluster.

Depending on supplies used, you need to ensure appropriate transport and storage of all supplies and avoid stock-outs

OTHER COSTS

PROMOTIONAL COST

- Security cost

TIP: Liaise with Health Cluster as there might be some cost to share and some micronutrient supplementation might be a part of health interventions.

Cost of information and communication materials development (on micronutrients, health, nutrition education and hygiene promotion), training of staff on communication and promotion activities and the sessions (C4D) for caretakers.



IRON OR IRON/FOLIC ACID SUPPLEMENTATION

OBJECTIVE

To improve iron status and reduce anaemia prevalence among children aged 6-23 months of age

To reduce the risk of low birth weight, prevalence of maternal anaemia and iron deficiency

To improve iron status and reduce anaemia prevalence among women of child-bearing

The programme can have the following specific objectives:

- To increase coverage of iron supplementation among children aged 6-23 months from X % to Y % (boys and girls)
- To provide intermittent iron and folic acid supplementation in X women of child-bearing age.
- To provide daily supplementation with iron and folic acid to X women during pregnancy

GROUPS TO INCLUDE

- Children 6-23 months of age;

TIP: if resources allowed children 6-32 or 6-59 months can be considered in emergency situations

- Women of child-bearing age in populations where the prevalence of anaemia among non-pregnant women is 20% or higher
- Pregnant women
- Older people (for more information see section "Managing older people's malnutrition")
-

How to calculate expected caseload:

Use demographic profile from the last census, nutrition surveys. Adjust with population growth rate if necessary. Apply planned programme coverage

TIP: In areas with high GAM prevalence rate, do not forget to subtract children with GAM as they receive RUTF/RUSF that already contain micronutrients

SAMPLE ACTIVITIES AND TIPS:

- Assessment of nutritional status of population, including anaemia prevalence
- Distribution of iron or iron/folic acid supplements
 - Behaviour change strategy to promote an awareness of the product along with its correct use and hygienic practices to prepare food

TIP: liaise with WASH cluster on this

TIP: consider also including breastfeeding after 6 months of age and correct complementary feeding, encourage continued breast feeding beyond 6 months together with appropriate complementary feeding

TIP: for Malaria endemic areas - need to implement malaria control strategies

- Dissemination of information and advocacy with physicians and health workers
- Integration of the use of iron/folic acid in national policies for antenatal care
- Ensuring availability of iron and folic acid in sufficient quantities (avoiding stock-outs)

70

SUGGESTED INDICATORS:

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Baseline, Outcome	Individual	Prevalence rate of anaemia (Proportion of children below five years of age with Hb concentration of <11 g/dL Proportion of women in reproductive age with Hb concentration of <12 g/dL)
Output	Individual or facility	Iron supplementation coverage rate in children (Proportion of children 6-59 months of age receiving adequate iron supplements)

Output	Individual or facility	Iron-folic acid supplementation in pregnant women (Proportion of pregnant women having received iron-folic acid supplementation daily in previous 6 months/during pregnancy)
Output	Individual or facility	Iron-folic acid supplementation coverage in adolescent girls (Proportion of adolescent girls receiving micronutrient supplements that contain adequate iron)
Output	Individual	Iron folic acid supplementation coverage in older people – proportion of older people receiving micronutrients that content adequate iron
Output	Individual	Micronutrient knowledge (in-depth) (Proportion of target population who knows key elements of the nutrition messages provided on availability, use and benefits of micronutrient supplements or micronutrient rich or fortified foods/ food supplements)

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING:

SUPPLIES COST

- Iron or iron/folic acid supplementation cost
- Supplies for reference and record keeping (registration forms).

71

STAFF COST

CAPACITY BUILDING/DEVELOPMENT COST

ADMINISTRATIVE COST

M&E COST

LOGISTICS

Need to ensure that human and administrative resources are available for timely monitoring, evaluation and reporting to HQs, donors and cluster.

Depending on supplies used, you need to ensure appropriate transport and storage of all supplies and avoid stock-outs

OTHER COSTS

PROMOTIONAL COST

- Security cost

TIP: Liaise with Health Cluster as there might be some cost to share and some micronutrient supplementation might be a part of health interventions.

Cost of information and communication materials development (on micronutrients, health, nutrition education and hygiene promotion), training of staff on communication and promotion activities and the sessions (C4D) for caretakers.



VITAMIN A SUPPLEMENTATION

OBJECTIVE

To reduce child morbidity and mortality among children 6-59 months of age

To prevent night blindness in pregnant women living in areas with severe public health problem

The programme can have the following specific objectives:

- To increase coverage of Vitamin A supplementation among children aged 6-59 months from X % to Y % (boys and girls).
- In settings where there is a severe public health problem related to vitamin A deficiency (prevalence of night blindness is 5% or higher in pregnant women or 5% or higher in children 24–59 months of age), to increase coverage of Vitamin A supplementation among pregnant women from X % to Y %.
- Children with measles;
- Children with SAM (see existing protocol at national or international level regarding administration of Vitamin A and management of SAM cases)
- Older people can also be included in Vitamin A distribution (for more information see section “Managing older people’s malnutrition”)

How to calculate expected caseload:

Use demographic profile from the last census, nutritional surveys. Adjust with population growth rate if necessary. Apply planned programme coverage

GROUPS TO INCLUDE

- Children 6-59 months of age disaggregated as 6-11 months and 12-59 months in populations where the prevalence of night blindness is 1% or higher in children 24-59 months of age or where the prevalence of VAD is 20% or higher in infants and children 6-59 months of age
- Pregnant women in populations where the prevalence of night blindness is 5% or higher in pregnant women or children 24-59 months of age
- Assessment of nutritional status of population, including vitamin A deficiency
- Vitamin A supplementation (capsules) through fixed HC or through national/sub-national campaigns

TIP: Liaise with Health Cluster as often Vitamin A distribution takes place during immunisation campaigns or during the Child Health Days.

- Vitamin A supplementation in children with measles

TIP: Liaise with Health Cluster as this is a part of measles treatment protocol

SUGGESTED INDICATORS:

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Baseline, Outcome	Individual	Prevalence rate of vitamin A deficiency ((1)Proportion of children below five years of age with sub-clinical vitamin A deficiency (2) Proportion of women of reproductive age with clinical vitamin A deficiency)
Output	Individual or facility	Vitamin A coverage in children 6–11 months (Proportion of children 6 - 11 months having received vitamin A supplement in previous 6 months)
Output	Individual or facility	Vitamin A coverage in children 12–59 months (Proportion of children 12 - 59 months having received vitamin A supplement in previous 6 months)
Output	Individual or facility	Vitamin A coverage in pregnant women (Proportion of pregnant women having received vitamin A supplement in previous 6 months)
Output	Individual or facility	Vitamin A coverage in older people (Proportion of older people having received vitamin A supplement in previous 6 months)

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING:

SUPPLIES COST

- Vitamin A capsules cost
- **TIP: For pregnant women plan minimum of 12 weeks of supplementation until delivery**
- Child health cards cost for children without them
- Supplies for reference and record keeping (tally sheet, registration forms).

STAFF COST

CAPACITY BUILDING/DEVELOPMENT COST

ADMINISTRATIVE COST

M&E COST

LOGISTICS

Need to ensure that human and administrative resources are available for timely monitoring, evaluation and reporting to HQs, donors and cluster.

Depending on supplies used, you need to ensure appropriate transport and storage of all supplies and avoid stock-outs

OTHER COSTS

PROMOTIONAL COST

- Security cost

TIP: Liaise with Health Cluster as there might be some cost to share and some micronutrient supplementation might be a part of health interventions.

Cost of information and communication materials development (on micronutrients, health, nutrition education and hygiene promotion), training of staff on communication and promotion activities and the sessions (C4D) for caretakers.



DEWORMING

OBJECTIVE

To reduce child morbidity caused by schistosomiasis and soil-transmitted helminthes

The programme can have the following specific objectives:

- To increase coverage of deworming among children of school-age, adolescents, pregnant women, older people from X % to Y %.
- To provide school-age children not enrolled in or not attending school with anthelmintic treatment and health education.
- To increase coverage of deworming among pre-school children (6 to 59 months) from X % to Y%.
- 80% reduction of the prevalence of schistosome and soil-transmitted helminths.

SAMPLE ACTIVITIES AND TIPS

- Community mobilisation,
- Training activities for teachers, health workers, early child development staff etc.,
- Twice-yearly anthelmintic administration to all schoolchildren;
- Health education and hygiene promotion activities focusing on soil-transmitted helminthic infections to all schoolchildren

77

Groups to include

- School-age children
- Children 6-59 months
- Adolescent girls and boys
- Pregnant women
- Older people (for more information see section "Managing older people's malnutrition")

How to calculate expected caseload:

Use demographic profile from the last census, nutritional surveys. Adjust with population growth rate if necessary. Apply planned programme coverage (consider also proportion of children attending schools and plan your activities and caseload accordingly).

SUGGESTED INDICATORS

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Output	Individual or facility	Deworming coverage in children (Proportion of children 12-59 months who received deworming medication in the previous 6 months)
Output	Individual or facility	Deworming coverage in adolescents (Proportion of adolescent girls and boys who received deworming medication in the previous 6 months)
Output	Individual or facility	Deworming coverage in pregnant women (Proportion of mothers of children 0-59 months of age who took deworming medication during the last pregnancy)
Output	Individual or facility	Deworming coverage in older people (Proportion of older people who received deworming medication in the previous 6 months)

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING:

A recent study (Montresor et al., 2010) estimated the average cost to be between US\$ 0.03 (when only soil-transmitted helminths are addressed) and US\$ 0.13 (when also schistosomiasis is covered) per child.

78

SUPPLIES COST

- Deworming tablets cost
- Child health cards cost for children without them
- Supplies for reference and record keeping (registration forms).

STAFF COST

CAPACITY BUILDING/DEVELOPMENT COST

ADMINISTRATIVE COST

M&E COST

LOGISTICS

Need to ensure that human and administrative resources are available for timely monitoring, evaluation and reporting to HQs, donors and cluster.

Appropriate transport and storage of all supplies and avoid stock-outs, transport of teams

OTHER COSTS

PROMOTIONAL COST

- Security cost

TIP: Liaise with Health Cluster on health education and with WASH Cluster on hygiene promotion as there can be some cost to share.

Cost of information and communication materials development (on deworming, health, nutrition education and hygiene promotion), training of staff on communication and promotion activities and the sessions (C4D) for caretakers.



ZINC SUPPLEMENTATION FOR DIARRHOEA MANAGEMENT

OBJECTIVE

To reduce diarrhoea related mortality and diarrhoea episode severity

80

The programme can have the following specific objectives:

To increase coverage of zinc supplementation for diarrhoea management from X % to Y %.

GROUPS TO INCLUDE

Children 6 – 59 months children with diarrhoea

How to calculate expected caseload:

Use demographic profile from the last census, nutritional surveys. Adjust with population growth rate if necessary. Apply diarrhoea prevalence based on the WHO data and planned programme coverage.

SAMPLE ACTIVITIES AND TIPS:

- Zinc sachets distribution together with ORS
- Behaviour change strategy to promote an awareness of the product along with its correct use and hygienic practices to prepare food

TIP: liaise with WASH cluster on this

TIP: Include also breastfeeding after 6 months of age and appropriate complementary feeding promotion

- Empowering community level workers in zinc use for diarrhoea treatment
- Dissemination of information and advocacy with physicians and health workers
- Integration of the use of zinc for diarrhoea treatment in national policies
- Ensuring availability of zinc in sufficient quantities (avoiding stock-outs)

Suggested indicators:

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Baseline, Output, Outcome	Individual	Zinc utilization for diarrhoea treatment (Proportion of non-SAM children with diarrhoea treated with ORS supplemented with zinc)

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING:

SUPPLIES COST

- Zinc and ORS cost

TIP: consider 10-14 days of zinc supplementation per one diarrhoea incident

- Supplies for reference and record keeping (registration forms).

STAFF COST

CAPACITY BUILDING/DEVELOPMENT COST

81

ADMINISTRATIVE COST

M&E COST

LOGISTICS

Need to ensure that human and administrative resources are available for timely monitoring, evaluation and reporting to HQs, donors and cluster.

Appropriate transport and storage of all supplies and avoid stock-outs

OTHER COSTS

PROMOTIONAL COST

- Security cost

TIP: Liaise with Health Cluster as there might be some cost to share and some micronutrient supplementation might be a part of health interventions.

Cost of information and communication materials development (on diarrhoea, health, nutrition education and hygiene promotion), training of staff on communication and promotion activities and the sessions (C4D) for caretakers.



IODINE SUPPLEMENTATION AND SALT IODIZATION

OBJECTIVE

To reduce prevalence of iron-deficiency disorders

The programme can have the following specific objectives:

- To provide iodine supplement to X PLW
- To provide complementary food fortified with iodine to X children 6-23 months of age
- To provide iodised salt to X households
- To ensure that at least 90% of household have access to adequate iodized salt as per Sphere Standards.
- To promote home fortification of foods with MNPs among children 6-23 months of age (iodine being one of the 15 nutrients in MNPs)

GROUPS TO INCLUDE

- Children aged 6-23 months for iodine supplementation in countries with iodised salt consumption less than 20%
- Pregnant and lactating women for iodine supplementation in countries with iodised salt consumption less than 20%

TIP: In cases where it is difficult to reach pregnant women, supplementation to all women of reproductive age is advised.

- All households for iodised salt distribution in countries with iodised salt consumption 20% or more.
- Older people

How to calculate expected caseload:

Use demographic profile from the last census, nutritional surveys. Adjust with population growth rate if necessary. Apply planned programme coverage.

Sample activities and tips:

- Assessment of population iodine nutritional status
- Distribution of iodine supplements
- Salt iodisation and distribution
- Capacity building of salt industry for production of iodised salt
- Behaviour change strategy to promote an awareness of the product along with its correct use
- Dissemination of information and advocacy messages with physicians and health workers
- Integration of the use of iodine supplementation in national policies
- Ensuring availability of iodine supplements/iodised salt in sufficient quantities (avoiding stock-outs)

SUGGESTED INDICATORS:

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Baseline, Outcome	Community	Prevalence of iodine deficiency (Median urinary iodine concentration (µg/L) in children aged 6-12 years)
Baseline, Output	Households	Iodized salt consumption (Proportion households using adequately iodized salt in previous 6 months)
Output	Individual	Micronutrient knowledge (in-depth) (Proportion of target population who knows key elements of the nutrition messages provided on availability, use and benefits of micronutrient supplements or micronutrient rich or fortified foods/ food supplements)

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING:

SUPPLIES COST

- Iodine supplements or iodised salt cost
- MNP
- Supplies for reference and record keeping (registration forms).

STAFF COST

CAPACITY BUILDING/DEVELOPMENT COST

ADMINISTRATIVE COST

M&E COST

LOGISTICS

Need to ensure that human and administrative resources are available for timely monitoring, evaluation and reporting to HQs, donors and cluster.

Depending on supplies used, you need to ensure appropriate transport and storage of all supplies and avoid stock-outs

OTHER COSTS

PROMOTIONAL COST

- Security cost

TIP: Liaise with Food Security and Livelihood OR Health Clusters as there might be some cost to share and some micronutrient supplementation might be a part of health interventions.

Cost of information and communication materials development (on micronutrients, health, nutrition education and hygiene promotion), training of staff on communication and promotion activities and the sessions (C4D) for caretakers.

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CALCIUM SUPPLEMENTATION

OBJECTIVE

To reduce risk of developing hypertensive disorders during pregnancy

The programme can have the following specific objectives:

- To increase coverage of calcium supplementation among pregnant women from X % to Y %.

86

GROUPS TO INCLUDE

- Pregnant women in areas where dietary calcium intake is low.

How to calculate expected caseload:

Use demographic profile from the last census, nutritional surveys. Adjust with population growth rate if necessary. Apply planned programme coverage.

SAMPLE ACTIVITIES AND TIPS:

- Calcium supplement distribution
- Behaviour change strategy to promote an awareness of the product along with its correct use
- Dissemination of information and advocacy with physicians and health workers
- Integration of the use of calcium supplementation in national policies
- Ensuring availability of calcium supplements in sufficient quantities (avoiding stock-outs)

SUGGESTED INDICATORS:

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Output	Individual	Calcium supplementation in pregnant women (Proportion of pregnant women who received calcium supplements during their last pregnancy)

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING:

SUPPLIES COST

- Calcium supplement cost

TIP: Plan three tablets three times a day until delivery

- Supplies for reference and record keeping (registration forms).

STAFF COST

CAPACITY BUILDING/DEVELOPMENT COST

87

ADMINISTRATIVE COST

M&E COST

LOGISTICS

Need to ensure that human and administrative resources are available for timely monitoring, evaluation and reporting to HQs, donors and cluster.

Appropriate transport and storage of all supplies and avoid stock-outs

OTHER COSTS

PROMOTIONAL COST

- Security cost

TIP: Liaise with Health Cluster as there might be some cost to share and some micronutrient supplementation might be a part of health interventions.

Cost of information and communication materials development (on micronutrients, health, nutrition education and hygiene promotion), training of staff on communication and promotion activities and the sessions (C4D) for caretakers.



NUTRITIONAL CARE AND SUPPORT OF HIV-INFECTED CHILDREN

OBJECTIVE

To identify and ensure appropriate growth and development of children, as well as PLWs with HIV and ensure treatment and follow up

89

The programme can have the following specific objectives:

- To assess, classify and provide nutritional support to children 6 months to 14 years old and PLWs with HIV
- To identify children and PLWs living with HIV and refer for treatment
- To retain children and PLWs in care for HIV

GROUPS TO INCLUDE

- Children 6 months to 14 years old with HIV (disaggregated by sex/age: girls and boys, 0-5, 5-10, 10-14 years old)
- Pregnant and Lactating Women

How to calculate expected caseload:

HIV-infected children and PLWs in need of nutritional care and support: Use demographic profile from the last census, nutritional surveys. Adjust with population growth rate if necessary. Apply HIV prevalence based on national UNAIDS data and planned programme coverage.

SAMPLE ACTIVITIES AND TIPS:

- Assessment of child's and PLWs' nutritional needs and deciding nutrition care plan,
- Provision of HIV testing for children and PLWs failing to thrive (including children and PLWs with severe acute malnutrition (who do not know their status))
- Referral of children and PLWs living with HIV for treatment and provision of adherence support
- Enhancement of breastfeeding counselling and support (see chapter on IYCF) including exclusive breastfeeding for those children under 6 months.
- Implementation and monitoring of nutritional care plan for children and PLWs living with HIV,
- Distribution of supplementary food for children over 6 months and their family and PLWs.

SUGGESTED INDICATORS:

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Output	Community	Proportion of children 6 months to 14 years old with HIV receiving nutritional care and support (Note: not in HR) disaggregated by sex/age: girls and boys, 0-5, 5-10, 10-14 years old
Output	Community	Proportion of PLWs with HIV receiving nutritional care and support
Output	Individual	Number of children failing to thrive who are tested for HIV OR Number of children with SAM tested for HIV
Output	Individual	Number of PLWs failing to thrive who are tested for HIV OR Number of PLWs with GAM tested for HIV
Process	Facility	IYCF in HIV context (Proportion of programmes that follows national policy on HIV)

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING:

SUPPLIES COST

- Supplementary food cost
- Supplies for reference and record keeping (registration forms).

STAFF COST

CAPACITY BUILDING/DEVELOPMENT COST

ADMINISTRATIVE COST

M&E COST

LOGISTICS

Need to ensure that human and administrative resources are available for timely monitoring, supervision, evaluation and reporting to HQs, donors and cluster.

- Depending on supplies used, you need to ensure appropriate transport and storage of all supplies and avoid stock-outs
- Cold chain for samples

OTHER COSTS

PROMOTIONAL COST

- Security cost

TIP: Liaise with Health Cluster as there might be some cost to share and some micronutrient supplementation might be a part of health interventions.

Cost of information and communication materials development (on micronutrients, health, nutrition education and hygiene promotion), training of staff on communication and promotion activities and the sessions (C4D) for caretakers.



NUTRITION SURVEY

OBJECTIVE

To evaluate nutritional status of target population in a determined area

The programme can have the following specific objectives:

- To determine the prevalence of malnutrition (wasting, stunting) among boys and girls aged 6-59 months or/and adults.
- To assess Infant and Young Child Feeding (IYCF) practices among boys and girls 0-23 months.
- To assess the prevalence of anaemia among boys and girls 6-59 months and non-pregnant women of reproductive age (15-49 years).
- To determine the levels of retrospective crude and under five mortality rates in the previous 3 months.
- To determine the coverage of health and WASH interventions (e.g, measles vaccinations, vitamin A supplementation and oral polio vaccine, access to adequate water and sanitation) among children aged 6-59 months.
- To determine the incidence of common diseases (diarrhoea, measles and ARI) among the survey population, two weeks prior to the survey.
- To identify key food security issues influencing the population.
- To determine the possible causes of malnutrition among survey population.
- To recommend a range of interventions most likely to be effective in improving nutritional status.

GROUPS TO INCLUDE

- Children U5 (disaggregated),
- Pregnant and lactating women,
- Older people (by implementing specific nutrition survey called RAM-OP, for more information see section “Managing older people’s malnutrition”),
- Other vulnerable groups

How to calculate number of people to be surveyed:

SMART methodology: www.smartmethodology.org

SAMPLE ACTIVITIES AND TIPS:

- Adaptation of guidelines
- Preparing the background documents, ToR, agreeing on the scope and indicators with all stakeholders.

TIP: A survey needs to be planned at specific times of the year and repeated at the same time each year with the same methodology

- Cost of the consultant/ nutritionist
- Procurement of anthropometric and other equipment required for the survey;

- Survey teams (recruitment and salary)
- Training of survey teams
- Field work and data collection
- Data cleaning and analysis, report writing
- Dissemination cost if formal launch of the survey report is envisaged.

SUGGESTED INDICATORS:

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Output	Facility	Report validated and disseminated (Note: not in the HIR)
Process	Facility	Timeliness of survey report as per proposal (Note: not in the HIR)
Process	Facility	# of surveys conducted as per proposal (Note: not in the HIR)
Process	Facility	# of staff / enumerators / survey teams trained (Note: not in the HIR)

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING:

SUPPLIES COST

- Anthropometric equipment (height measuring boards, scales)
- Other supplies (blood collection, stationery, records, questionnaires, etc.)
- Computers and software for data analysis
- Smartphones or tablets for mobile data collection

STAFF COST

Logistic officer, Survey Teams, Team supervisors, Survey manager, translator

CAPACITY BUILDING/DEVELOPMENT COST

Training of survey team and team supervisors

ADMINISTRATIVE COST

M&E COST

Need to ensure that human and administrative resources are available for timely monitoring, supervision, evaluation and reporting to HQs, donors and cluster.

LOGISTICS

- Transport and logistics for survey teams and supervisors
- Sensitization of community leaders
- Cold chain for samples

OTHER COSTS

- Security cost
- Guidelines' and tools' dissemination and adaptation

PROMOTIONAL COST

Report printing and dissemination costs Cost of information sharing (meeting, bulletin, presentation, on-line, etc)



NUTRITION SURVEILLANCE

OBJECTIVE

To monitor the status of health and nutrition, food consumption patterns and nutrition knowledge of the population.

The programme can have the following specific objectives:

- To provide timely and relevant Food Security, Nutrition & Livelihood Analysis for Emergency Response
- To increase understanding of opportunities to reduce acute and chronic food, livelihood, and nutrition insecurity through improved sector analysis and applied research on underlying causes
- To further organize, develop and incorporate information into an integrated database system and made accessible through managed information systems
- To strengthen technical capacity of institutions and partners in food security, livelihoods, and nutrition monitoring, assessment and analysis

GROUPS TO INCLUDE

- Children U5 (disaggregated),
- Pregnant and lactating women,
- Older people,
- Other vulnerable groups

How to calculate number of people to be surveyed:

SMART methodology: www.smartmethodology.org

97

SAMPLE ACTIVITIES AND TIPS:

- Adaptation of guidelines
- Preparing the background documents, ToR, agreeing on the scope and indicators with all stakeholders.
- Procurement of anthropometric and other equipment required
- Capacity building of relevant staff at sentinel sites/nutrition surveillance sites
- Weekly/monthly analysis of data
- Integration of nutrition surveillance into government health information management system

Suggested indicators:

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Output	Facility	Quarterly, monthly and/or weekly statistics on malnutrition trend disaggregated by geographic area, age and gender is available (Note: not in the HIR)
Process	Facility	# and % of health centres sending activities reports on time (Note: not in the HIR)
Process	Facility	# of surveillance sites reporting regularly (Note: not in the HIR)
Process	Facility	# of staff / enumerators trained (Note: not in the HIR)

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING:

SUPPLIES COST

- Anthropometric equipment (height measuring boards, scales, MUAC etc...)
- Other supplies (stationery, records, questionnaires, etc.)
- Computers and software for data analysis
- Smartphones or tablets for mobile data collection

STAFF COST

Project manager, supervisors,

CAPACITY BUILDING/DEVELOPMENT COST

Training of surveillance staff

ADMINISTRATIVE COST

M&E COST

Need to ensure that human and administrative resources are available for timely monitoring, supervision, evaluation and reporting to HQs, donors and cluster.

LOGISTICS

Transport and logistics for survey teams and supervisors

OTHER COSTS

- Guidelines' and tools' dissemination and adaptation

PROMOTIONAL COST

Report printing and dissemination costs
Cost of information sharing (meeting, bulletin, presentation, on-line, etc)



DIRECT PROGRAMME COVERAGE EVALUATION

OBJECTIVE

To evaluate the proportion of eligible beneficiaries enrolled in a programme

100 **The programme can have the following specific objectives:**

- To classify and estimate the coverage of the nutrition programmes (IYCF, Micronutrients, CMAM etc..) in X district
- To assess the coverage of nutrition programmes (IYCF, Micronutrients, CMAM etc..) for children 6-59 months
- To identify and refer acute malnourished children not covered by the CMAM programme
- To identify barriers to service access

GROUPS TO INCLUDE

- Children U5 (disaggregated),
- Pregnant and lactating women,
- Elderly people,
- Other vulnerable groups

How to calculate number of people to be surveyed:

Coverage monitoring network <http://www.coverage-monitoring.org/>

How to calculate indirect coverage:

For SAM treatment, see UNICEF SAM Programme Guidance document, p.70f. <http://www.unicefinemergencies.com/downloads/eresource/docs/2.3%20Nutrition/FINAL%20Edited%20Formatted%20SAM%20PRO%20English.pdf>

SAMPLE ACTIVITIES AND TIPS:

- Collection of quantitative data: on-going programme and data collected on certain areas of intervention through routine reporting, health facility records, district health records

TIP: Examples of Coverage Survey Methods: SQUEAC, SLEAC, others,

- Capacity building of staff,
- Collection of qualitative data: key informant at community level, beneficiaries, health workers.
- Field visits
- Regular analysis of data and estimation of coverage (indirect estimates using routine data; direct estimation using survey).
- Use of analysed data to inform current nutrition programmes

SUGGESTED INDICATORS:

TYPE OF INDICATOR	UNIT OF MEASUREMENT	INDICATOR
Output	Individual	SAM treatment coverage - Proportion of cases with severe acute malnutrition receiving treatment)
Output	Individual	MAM treatment coverage - Proportion of cases with moderate acute malnutrition receiving treatment)
Output	Individual	BSFPs coverage (Proportion of target beneficiaries enrolled in blanket supplementary feeding programme)
Output	Individual	IYCF messaging / counselling coverage - Proportion of target beneficiaries receiving IYCF messaging / counselling
Output	Individual	Iron supplementation coverage rate in children (Proportion of children 6-59 months of age receiving micronutrient supplements that contain adequate iron)
Output	Individual	Iron-folic acid supplementation coverage in adolescent girls (Proportion of adolescent girls receiving micronutrient supplements that contain adequate iron)
Output	Individual	Women iodine supplementation coverage (Proportion of women of child-bearing age who received iodine supplements)
Output	Individual	Multiple micronutrients coverage (Proportion of target population that received multiple micronutrient powder/capsules)
Output	Individual	Vitamin A coverage in children 6–59 months (Proportion of children 6 - 59 months having received vitamin A in previous 6 months)
Output	Individual	Prophylactic zinc supplementation in children coverage (Proportion of children received prophylactic zinc supplements according to national protocols)
Output	Individual	Calcium supplementation in pregnant women (Proportion of pregnant women who received calcium supplements during their last pregnancy)
Output	Individual or facility	Deworming coverage in children (Proportion of children 12-59 months who received deworming medication in the previous 6 months)
Output	Individual or facility	Deworming coverage in adolescents (Proportion of adolescent girls who received deworming medication in the previous 6 months)
Output	Individual or facility	Deworming coverage in pregnant women (Proportion of mothers of children 0-59 months of age who took deworming medication during the last pregnancy)

WHILE PREPARING THE BUDGET, CONSIDER THE FOLLOWING:

SUPPLIES COST

- Anthropometric equipment (height measuring boards, scales)
- Other supplies (blood collection, stationery, records, questionnaires, etc.)
- Computers and software for data analysis
- Smartphones or tablets for mobile data collection

STAFF COST

- Survey teams
- Team supervisors
- Survey manager
- Data management

CAPACITY BUILDING/DEVELOPMENT COST

Training of survey team, data collector, IM staff and team supervisors

ADMINISTRATIVE COST

M&E COST

LOGISTICS

Need to ensure that human and administrative resources are available for timely monitoring, evaluation and reporting to HQs, donors and cluster.

Transport and logistics for survey teams and supervisors

OTHER COSTS

- Security cost
- Guidelines' and tools' dissemination and adaptation

PROMOTIONAL COST

Report printing and dissemination costs Cost of information sharing (meeting, bulletin, presentation, on-line, etc.)

ANNEXES

OVERVIEW OF NUTRITION IN EMERGENCIES PROGRAMMING:

In the emergency context, the type of malnutrition we are most worried about is acute malnutrition. Acute malnutrition is caused by a (sudden, and) drastic reduction in food intake and/or illness, often aggravated by suboptimal infant and young child feeding practices, leading to a significant loss of body weight (with severe health consequences). There are two levels of classification of acute malnutrition within an individual: severe and moderate. Acute malnutrition is of key concern because children who suffer from severe acute malnutrition (SAM) face a 9 times higher chance of dying compared to children who do not suffer from acute malnutrition.

Acute malnutrition (also called 'wasting')

- At the level of the individual, this is defined through anthropometric (body) measurements, and clinical signs of visible wasting and/or bilateral oedema.
- Acute malnutrition among infants less than 6 months of age is assessed using visible signs of wasting and bilateral oedema. Social criteria such as an absent mother or inadequacy of breastfeeding can indicate nutritional risk.
- Acute malnutrition among children 6-59 months is assessed using the nutritional indices of weight-for-height or weight-for-length (WFH), mid-upper arm circumference (MUAC), and signs of bilateral oedema.
- Adult undernutrition is assessed through Body Mass Index (BMI) (either adjusted or unadjusted by Cormic index) or MUAC in addition to clinical signs. MUAC is the preferred nutritional index during pregnancy and up to 6 months postpartum.
- The degree of acute malnutrition in children 6-59 months is determined by comparing their WFH to what it should be, e.g. the standard, based on the 2006 WHO Growth Standards, or the presence of bilateral oedema. The comparison is made using Z scores (also called Standard deviation or SD), and the classification is either severe acute malnutrition (SAM), moderate acute malnutrition (MAM), or no malnutrition.

- The degree of acute malnutrition in pregnant and lactating women is based on a specific cut-off point in the measurement of MUAC, though the cut-off point varies between contexts.
- Individuals who suffer from acute malnutrition, especially severe, may rebound in terms of weight gain, but the impact lasts forever when this occurs in children. Mental development and growth is affected, and there is increased risk for disease in later life and productivity.
- At the level of the population: The (global) acute malnutrition rate for the population (GAM) is calculated by adding up the estimated percentage of the children 6-59 months who are classified with SAM and the estimated percentage of children 6-59 months who are classified with moderate acute malnutrition (MAM). (The term "global" has no geographic meaning). The percent GAM at any one point in time needs to be analyzed with caution as it represents one point in time. Analysis of the severity of the situation is strengthened by understanding how this percentage of children affected with acute malnutrition compares to previously recorded data and trends, and an understanding of other aggravating factors. The translation of acute malnutrition prevalence/rates into numbers of malnourished children is further based on the estimate of the total child population, and therefore the actual true number of affected children may be different.
- When the prevalence of acute malnutrition (severe + moderate) is more than 15% of children 6-59 months in a given population, or between 10-14% with aggravating factors, then according to WHO the situation is called "serious".

Micronutrient deficiencies.

- Micronutrient deficiencies are also defined as malnutrition. During non-crisis conditions micronutrient deficiencies like iron deficiency (anemia), vitamin A deficiency and many others are very prevalent especially among young children and women. During an emergency, the situation is worse. It is therefore very important to address these deficiencies.

OVERVIEW OF COMMON INTERVENTIONS FOR NUTRITION IN EMERGENCIES:

The following types of food/feeding interventions exist:

General food distribution (GFD) or general food ration (GFR).

- This is meant for the entire population. The ration is often supposed to provide at least the minimum of energy and protein required i.e. 2100 kcal per person per day. This provides the basis for improving short term food security. WFP is responsible for providing the general ration which is typically distributed by implementing partners.

Supplementary food ration/distribution.

- This is meant to boost the energy, protein and micronutrient intake of the vulnerable population – in practice primarily pregnant and lactating women, and children under 5 years of age. The supplementary food consists often of blended foods (mix of cereal and pulses, sometimes milkpowder, and micronutrients) such as Corn Soy Blend. WFP is responsible for providing the supplementary food which is typically distributed by Nutrition cluster partners. When WFP cannot provide the supplementary food, UNICEF as a CLA provided it within the context of a provider of last resort.

Two types of Supplementary feeding programs exist:

- Blanket Supplementary feeding program: If the situation is very bad (when GAM% is very high) then often pregnant and lactating and children under 5 years are targeted to receive supplementary food (“blanket supplementary food/feeding”) regardless of their nutritional status. In situations where cooking is impossible (no firewood or cooking utensils) ready to eat foods like biscuits are often provided, or, as a short term measure, cooked meals may be provided as an alternative (“wet supplementary feeding”). WFP is normally responsible to provide the ration and provide technical support. If they are not able UNICEF could consider supporting this. In camps UNHCR is responsible for ensuring the ration is available.
- Treatment of moderate acute malnutrition (MAM) through Targeted Supplementary Feeding Program: Individuals are admitted

based on their nutritional status, in order to treat moderate acute malnutrition, and also avoid that these individuals will become severely acutely malnourished (SAM). The food provided includes ready to eat specialized foods like pastes such as Supplementary Plumpy, Ready to Used Supplementary Foods (RUSF) or CSB++. All nutrient requirements are included in these foods. Systematic medical treatment is also part of the protocol. WFP is responsible for the provision of the foods. If they are not able UNICEF could consider supporting this. In camps UNHCR is responsible.

Management of severe acute malnutrition (SAM) through a inpatient or outpatient therapeutic feeding care programme

- SAM is a life threatening condition and treatment is meant to treat the condition and save the life. Treatment consists of a package of medical and nutrition interventions. Children with medical complications are treated first in a Stabilization Center (often in a health facility) with close supervision and medical attention, while the children without medical complications can be treated successfully at home in the community as outpatients. The food provided includes Ready to Use therapeutic food (RUTF). All nutrient requirements are included in this food. UNICEF is responsible for the provision of the foods and for the program implementation (which is carried out through implementing partners (NGOs). In camps UNHCR is responsible.

Micronutrient interventions.

- The interventions above provide a significant amount of micronutrients to those who need it most, and many include systematic supplementation as part of individual treatment protocols. However, additional provision is needed of micronutrients:
- Vitamin A supplementation to all children 6-59 months as a lifesaving intervention. Vitamin A reduces to mortality risk and is key as a priority intervention to be done in combination with measles vaccination campaign.
- Micronutrient supplementation for children and mothers at health facility level and community level, including vitamin A, zinc, Iron-folate, multiple micronutrients
- Fortified foods and it is important to ensure to ensure that all foods provided are fortified i.e. oil fortified with vitamin A, fortified blended foods, biscuits, iodized salt, etc

Infant and Young Child Feeding in Emergencies

- Protection, promotion and support to optimum infant and young children feeding practices are very important as these practices are heavily challenged during emergency. The key actions needed are:
- Support to care takers and health workers on optimum infant and young child feeding practices including:
 - Early initiation of breastfeeding within 1 hour of birth;
 - Promotion of exclusive breast feeding for the first 6 months of life;
 - Promotion of continued breast feeding from 6 to 24 months and beyond;
 - Timely initiation of appropriate complementary feeding 6 months on wards.
- Establishment of safe areas for women to breastfeed and receive counselling
- Where appropriate, provision of Ready to Use Infant Formula (RUIF) for the few infants who have lost their mothers, under proper supervision and guidance
- Issuing of a joint statement on Infant and Young Child Feeding
- Support to policy on Breast Milk Substitute (BMS) code implementation and monitoring
- **Nutrition Education linked to WASH and Health**
 - Information and Training support for caregivers and community mobilization and education
 - Development of awareness campaigns that provide information and behaviour change communication on hygiene, health and nutrition

Assessment, Nutrition Surveillance/Information Management and Monitoring

- Input into multi-sectoral rapid assessments
- Support to the implementation of nutrition surveys
- Supply of equipment
- Establishment/strengthening of nutritional surveillance systems and monitoring
- Monthly trend analysis of all cluster partners feeding center statistics

Response Area and Typical Activities Undertaken:

- Therapeutic Feeding Programme
- Provision of Therapeutic Supplies (Plumpynut, F100, F75, resomal etc.);
- Provision of Equipment such as TFC kits, measuring boards, weighing scales and MUAC tapes, registers etc.;
- Provision of drugs such as amoxicillin, anti-malarials, vitamin A, deworming and folic acid special ORS (Resomal);
- Establishment of community and facility based sites for the management of severely malnourished children;
- Training of staff on the proper management of acute malnutrition on both "out-patient" basis and inpatient basis at the "stabilization centres."

Targeted Supplementary Feeding Programme

- Provision of supplementary food (CSB, WSB, Supplementary Plumpy) if WFP is unable to do so);
- Provision of systematic drugs, equipment etc.;
- Establishment of Supplementary Feeding distribution sites;
- Training of government and NGO worker SFP management and individual treatment.

Blanket Supplementary Feeding Programmes

- Provision of supplementary foods ;
- Training of health worker and NGO working on screening
- Distribution of the blanket supplementary food.

Infant and Young Child Feeding in Emergencies

- Support to care takers and health work on optimum infant and young child feeding practices;
- Early initiation of breastfeeding within 1 hour of birth;
- Promotion of exclusive breast feeding for the first 6 months of life;
- Promotion of continued breast feeding from 6 to 24 months and beyond;
- Timely initiation of appropriate complementary feeding 6 months on wards.

- Establishment of safe areas for women to breastfeed and receive counselling;
- Where appropriate, provision of Ready to Use Infant Formula for few cases who have lost their mothers, under proper supervision and guidance;
- Issuing of a joint statement on Infant and Young Child Feeding;
- Support to policy on Breast Milk Substitute (BMS) code implementation and monitoring.

Micronutrient Deficiency Control and Prevention programme

- Procurement of Vitamin A, Zinc and Multiple Micronutrient Powders (MNP);
- Distribution of the Vitamin A, Zinc and MNP through government and NGO campaigns and routine supplementation routines;
- Training of health workers.

Nutrition Education linked to WASH and Health

- Information and Training support for caregivers and community mobilization and education;
- Development of awareness campaigns that provide information and behaviour change communication on hygiene, health and nutrition.

Assessment, Nutrition Surveillance/Information Management and Monitoring

- Input into multi-sectoral rapid assessments;
- Support to the implementation of nutrition surveys;
- Supply of equipment;
- Establishment/strengthening of nutritional surveillance systems and monitoring;
- Monthly trend analysis of all cluster partners feeding center statistics.

- Coverage of the nutrition programme
- Availability of Nutrition supplies including food, drugs and equipment
- Ability to monitor the nutrition, food security and health situation
- Ensuring food security including the availability and adequacy of general rations (including iodized salt and fortified grain/cereals) to the affected population
- Ensuring availability of health service and water and sanitation services as this is important is determining if the situation will deteriorate or not.

In the recovery

- Repair and construction of nutrition rehabilitation centres for managing severely malnourished children with complications
- Build on local capacity, including community practices to ensure delivery of a comprehensive nutrition package/services
- Training of government staff on management of acute malnutrition
- Development and monitoring of adherence of guidelines for CMAM and nutrition surveys
- Development of a comprehensive nutrition response plan
- Establishment of Nutrition Surveillance system
- Livelihood support such as cash for work, food vouchers

Issues to follow

In Acute Emergency

- An assessment to properly establish what the nutritional situation is and determine corresponding needs is essential
- NGOs, UN and government capacity on the ground to implement programmes

GLOSSARY

Acute malnutrition

Acute malnutrition, also known as wasting, is a sign of 'thinness' and develops as a result of recent rapid weight loss or a failure to gain weight. In children, it is measured through the weight for height nutritional index or mid-upper arm circumference. In adults, it is measured by body mass index or mid upper arm circumference. An individual can be moderately wasted or severely wasted.

Adequate basic ration

An adequate ration meets the population's minimum energy, protein, fat and micronutrient requirements for light physical activity, and is nutritionally balanced, diversified, culturally acceptable, fit for human consumption and easily digestible for children and other affected vulnerable groups.

Anaemia Caused

by lack of iron, folate or vitamin B 12, anaemia is difficult to diagnose accurately from clinical signs which include pallor, tiredness, headaches and breathlessness.

Angular stomatitis

A sign of riboflavin deficiency characterized by inflammation in the corners of the mouth

Anthropometric status

The growth status of an individual in relation to population reference values

Anthropometry

Body measurements used as a measure of an individual's nutritional (anthropometric) status

Artificial feeding

Feeding of young infants with breast milk substitute

Ariboflavinosis

A clinical condition resulting from a deficiency in riboflavin (vitamin B2) characterized by the presence of angular stomatitis

Beriberi

Caused by thiamin deficiency, there are many clinically recognizable syndromes including wet beriberi, dry beriberi and infantile beriberi.

Bitot's spots

Clinical sign of vitamin A deficiency characterized by dryness accompanied by foamy accumulations on the conjunctiva that often appear near the outer edge of the iris

Blanket feeding

Feeding of all an affected population without targeting specific population groups

Blended food

A pre-cooked fortified mixture of cereals and other ingredients such as pulses, dried skimmed milk and vegetable oil. Blended foods include wheat soy blend, corn soy blend and 'faffa'.

Body mass index (BMI)

Acute malnutrition in adults measured using body mass

BP5:

fortified high-energy biscuits designed to be used in the first phase of disaster relief operations.

BP 100:

a nutrient-fortified wheat-and-oat bar for use in the rehabilitation and treatment phase of severely malnourished children and adults. It is especially useful in contaminated environments and in cases where no therapeutic feeding facility can be established.

Breastmilk substitutes (BMS)

Any food being marketed or otherwise represented as a partial or total replacement for breastmilk, whether or not suitable for that purpose

Chronic malnutrition

Chronic malnutrition, also known as stunting, is a sign of 'shortness' and develops over a long period of time. In children and adults, it is measured through the height for age nutritional index.

The Code

The International Code of Marketing of Breast-milk Substitutes was adopted by the World Health Assembly in 1981. There have been subsequent resolutions.

Colostrum

The first thick yellow milk secreted by the breasts in the last few weeks of pregnancy and the first two to three days after childbirth, until breastfeeding is established. Colostrum contains high levels of protein, and antibodies.

Community based Management of Acute Malnutrition (CMAM).

This approach aims to maximize coverage and access of the population to treatment of SAM by providing easier access to treatment through outpatient services, closer to homes.

Complementary feeding

Age-appropriate, adequate and safe solid or semi-solid food in addition to breastmilk or a breastmilk substitute. The process starting when breast-milk or infant formula alone is no longer sufficient to meet the nutritional requirements of an infant, and therefore other foods and liquids are needed along with breast-milk or infant formula. The target range for complementary feeding is generally considered to be 6-23 months.

Corn soy blend (CSB)

Type of blended food

Cretinism Severe

mental and physical disability that occurs in the offspring of women with severe iodine deficiency in the first trimester of pregnancy

'Dry' feeding

Food provided in the form of a dry (take home) ration

Early warning system (EWS)

An information system designed to monitor indicators that may predict or forewarn of impending food shortages or famine

Emergency school feeding

Food provided either as a cooked meal or supplement in school or as a take-home ration to improve school attendance and performance, and to alleviate hunger

Enrichment

When those micronutrients lost or removed during food processing are added back or restored in the final product (e.g., wheat flour is enriched with vitamin B1, niacin and iron)

Exclusive breastfeeding

An infant receives only breastmilk and no other liquids or solids, not even water, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines.

F-75 & F-100:

see therapeutic milk. F-75 is the 'starter' formula to use during initial management, beginning as soon as possible and continuing for 2-7 days until the child is stabilised; F-100 is used as 'catch-up' to rebuild wasted tissues. F-100 contains more calories and protein. Both are a dry powder.

Follow-on/follow-up formula

Specially formulated milks for infants of six months and over

Food fortification

The addition of micronutrients during or after processing to a food, bringing the micronutrients to levels over and above the amounts in the original food product

Food security

Access by all people at all times to sufficient, safe and nutritious food needed for a healthy and active life

Food taboos

Food that should not be eaten on cultural or religious grounds

Fortified foods

Foods to which fortificants are added

Fortificant

The vitamins and minerals added to fortified foods

General food distribution (GFD) or general food ration (GFR)

Free distribution of a combination of food commodities to an emergency affected population

Global acute malnutrition (GAM)

Moderate and severe acute malnutrition measured by weight for height less than -2 Z scores or less than 80 per cent of the median plus oedema

Goitre

Swelling of the thyroid gland in the neck caused by iodine deficiency

Growth monitoring and promotion (GM&P)

An individual child's growth (weight-for-age) is measured at intervals and the results plotted on a 'Road to Health' chart.

Home-modified animal milk

A breastmilk substitute for infants up to six months prepared at home from fresh or processed animal milk, suitably diluted with water and with the addition of sugar and micronutrients

Home-based care

Programmes to care for the chronically ill by providing support to sick people at home

Infant and Young Child Feeding (IYCF) -

Term used to describe the feeding of infants (aged less than 12 months and young children (aged from 12 to 23 months) This programme focuses on the promotion and protection of breastfeeding and exclusive breastfeeding, timely introduction of complementary feeding and continued breast feeding. Issues of policy and legislation around infant formula and breast milk substitute are also addressed by this programme.

Infant Feeding in Emergencies (IFE)

Infant and young child feeding (IYCF) in emergencies (IFE) is concerned with protecting and supporting optimal infant and young child feeding (IYCF) for children under the age of two years in emergency situations. This includes protection and support for early, exclusive and continued breastfeeding, reducing the risks of artificial feeding for non-breastfed infants, and appropriate, timely and safe complementary feeding. Infants who are not breastfed and who are particularly at risk in emergency settings also need protection and support.

Infant formula

A breastmilk substitute formulated industrially in accordance with applicable Codex Alimentarius standards

Infant feeding equipment Bottles, teats, syringes and baby cups with or without lids and/or spouts

Inpatient care

Patients with complicated severe malnutrition (metabolic disturbances) are treated in inpatient care before continuing treatment in outpatient care. Alternative terms are Phase I, therapeutic feeding unit, therapeutic feeding centre or stabilization centre.

International code The International Code of Marketing of Breast-milk

Substitutes was adopted by the World Health Assembly in 1981.

Iodine deficiency disorders (IDD)

A range of abnormalities including goitre and cretinism

Kwashiorkor Clinical form of malnutrition associated with growth failure (in children) and characterized by oedema (swelling) and loss of appetite

Low birth weight (LBW)

A birth weight of less than 2.5 kg

Macronutrients Fat,

protein and carbohydrate that are needed for a wide range of body functions and processes

Malnutrition

A broad term commonly used as an alternative to under-nutrition, but technically it also refers to over-nutrition. People are malnourished if their diet does not provide adequate nutrients for growth and maintenance or they are unable to fully utilize the food they eat due to illness (under-nutrition). They are also malnourished if they consume too much calories (over-nutrition).

Marasmus Clinical

form of malnutrition associated with growth failure (in children) and characterized by a severe loss of body weight or wasting

Micronutrients

essential vitamins and minerals required by the body throughout the life cycle in miniscule amounts.

Micronutrient

deficiency diseases (MDDs) When certain micronutrients are severely deficient, due to insufficient dietary intake and/or insufficient absorption and/or suboptimal utilisation of the vitamins or minerals, specific clinical signs and symptoms may develop. The classic nutritional diseases, such as scurvy, beriberi and pellagra, are good examples of these sorts of disease.

Micronutrient malnutrition

The existence of sub-optimal nutritional status due to a lack of intake, absorption, or utilisation of one or more vitamins or minerals. Excessive intake of some micronutrients may also result in adverse effects.

Mid-upper arm circumference (MUAC)

The circumference of the mid-upper arm is measured on a straight left arm (in right handed people) midway between the tip of the shoulder (acromium) and the tip of the elbow (olecranon). It measures acute malnutrition or wasting in children 6-59 months. The MUAC tape is a plastic strip, marked with measurements in mm. MUAC < 115 indicates that the child is severely malnourished; MUAC < 125 indicates that the child is moderately malnourished.

Moderate Acute Malnutrition (MAM):

defined as weight-for-height between minus two and minus three standard deviation from the median weight for height of the standard reference population.

Multiple Micronutrient Powder (MNP).

In a little sachet to sprinkle on the food. Proposed for children 6-59 months and pregnant/lactating women in a context of food insecurity.

Night blindness

Inability to see well in the dark or in a darkened room. It is an early sign of vitamin A deficiency.

Nutritional index Derived by relating an individual's body measurement with the expected value of an individual of the same height (or age) from a reference population. Weight-for-height is the nutritional index commonly used to reflect acute malnutrition (wasting) in emergency nutritional assessments.

Nutritional requirements

The amount of energy, protein, fat and micronutrients needed for an individual to sustain a healthy life

Nutritional screening

Carried out to identify and select malnourished children in the population

Nutritional status

The growth or micronutrient status of an individual

Nutrition surveillance

The regular collection of nutrition information that is used for making decisions about actions or policies that will affect nutrition

Nutrition survey

Survey to assess the severity and extent of malnutrition

Obesity

A person is obese when their body mass index (weight/height²) exceeds 30.

Oedema

The excessive accumulation of extracellular fluid in the body. Bilateral oedema (fluid retention on both sides of the body) is a clinical sign of severe acute malnutrition, and is referred to as nutritional oedema.

Outpatient Therapeutic Care Programm (OTP):

outpatient care for treatment/management of malnutrition which connects treatment in the health facility with follow-up in the home and community rehabilitation.

Pellagra

Caused by niacin deficiency, which affects the skin, gastrointestinal tract and nervous systems and is sometimes called the 3Ds: dermatitis, diarrhoea and dementia

Percentage of the median

The anthropometric status of an individual expressed as a percentage of the expected value (or median) for the reference population

Plumpy'nut

a common ready-to-use therapeutic food (RUTF). It is a high protein and high energy peanut-based paste that tastes slightly sweeter than peanut butter. Plumpy' Nut requires no water for preparation or refrigeration and has

a 2-year shelf life, making it easy to deploy in difficult conditions to treat severe acute malnutrition. It is distributed under medical supervision, predominantly to parents of malnourished children where the nutritional status of the children has been assessed by a doctor or a nutritionist. See Therapeutic Paste.

Public nutrition approach

Broad-based approach to addressing nutritional problems that recognizes that nutritional status is affected by a complex mix of factors

Rapid nutrition assessment

An assessment is carried out quickly to establish whether there is a major nutrition problem and to identify immediate needs. Screening individuals for inclusion in selective feeding programmes is also a form of rapid nutrition assessment.

Ration

The ration or food basket usually consists of a variety of basic food items (cereals, oil and pulses) and, possibly, additional foods known as complementary foods (meat or fish, vegetables and fruit, fortified cereal blends, sugar, condiments) that enhance nutritional adequacy and palatability.

Ready-to-use infant formula (RUIF),

A type of breast milk substitute that is nutritionally balanced and packed ready to use for infants who for some reason have no options to be breastfed

Ready-to-eat meals,

A type of emergency ration that is a nutritionally balanced, ready-to-eat complete food. They generally come in two forms: as compressed, vacuum packed bars or tablets.

Ready-to-use supplementary foods (RUSF),

Specialized products for use in the management of moderate acute malnutrition. Available as pastes, spreads or biscuits. They are ready to eat and do not get contaminated by bacteria.

Ready-to-use therapeutic foods (RUTF),

Specialized products for use in the management of severe acute malnutrition. They are a solid version of F100 with the same macronutrient and micronutrient composition plus iron. Available as pastes, spreads or biscuits. They are ready to eat and do not get contaminated by bacteria.

Recommended daily allowance (RDA)

The average daily dietary intake level that is sufficient to meet the nutrient requirements of nearly all (approximately 98 per cent) healthy individuals

Reference population

Also known as growth standards and based on surveys of healthy children, whose measurements represent an international reference for deriving an individual's anthropometric status

Rehabilitation phase

The third phase of treatment for complicated SAM or initial treatment for uncomplicated SAM, its aim is to promote rapid weight gain and to regain strength through regular feeds of high nutrient and energy dense foods (F100 or RUTFs). It is ideally implemented as outpatient treatment.

Re-lactation

Induced lactation (breastfeeding) in someone who has previously lactated

Replacement feeding

Feeding infants who are receiving no breastmilk through alternative methods

Resomal-Rehydration

Solution for children with severe acute malnutrition

Rickets

Caused by vitamin D deficiency, it affects bone development resulting in bowing of the legs when severe.

Scurvy

Caused by vitamin C deficiency, typical signs include swollen and bleeding gums, and slow healing or reopening of old wounds.

School feeding

Provision of meals or snacks to school children to improve nutrition and promote education

Seasonality

Seasonal variation of various factors, such as disease, different sources of food, the agricultural cycle, that affect nutritional status

Selective feeding programmes

Supplementary feeding or therapeutic care programmes

Sentinel site Purposively selected community or service delivery site, used to detect changes in context, programme or outcome variable. Communities or areas are purposively selected for a number of reasons, such as vulnerability to food insecurity in times of stress. Sentinel sites can range from health centres to villages to districts.

Severe acute malnutrition (SAM):

is a result of recent (short-term) deficiency of protein, energy together with minerals and vitamins leading to loss of body fats and muscle tissues. Acute malnutrition presents with wasting (low weight for height) and/or the presence of oedema (i.e. retention of water in the tissues of the body). Defined as weight-for-height minus three standard deviations from the median weight-for-height for the standard reference population, mid upper arm circumference (MUAC) less than 115 mm, visible severe thinness, or the presence of nutritional oedema.

Stabilization Centre (SC):

Inpatient care facilities established for the treatment of SAM with complications.

Stabilization phase The initial phase of inpatient treatment for complicated SAM, its aim is to stabilize and readjust patient's metabolism through use of special foods (F75) and medical treatment. It allows close monitoring of the patient and urgent therapy if complications developed. It is also known as Phase I or the initiation phase.

Stunting See Chronic malnutrition

Supplementary feeding programme (SFP) There are two types of SFPs. Blanket SFPs target a food supplement to all members of a specified at risk group, regardless of whether they have MAM. Targeted SFPs provide nutritional support to individuals with MAM. To be effective, targeted SFPs should always be implemented when there is sufficient food supply or an adequate general ration, while blanket SFPs are often implemented when general food distribution (GFD) for the household has yet to be established or is inadequate for the level of food security in the population. The supplementary ration is meant to be additional to, and not a substitute for, the general ration.

Supplementary suckling

A technique used to induce lactation by providing therapeutic milk to the infant while he or she is suckling. When suckling, the child gets therapeutic milk from a tube attached to the mother's nipple. Suckling stimulates breastmilk production, which eventually replaces therapeutic milk.

Supplementation

Provision of nutrients either via a food or as a tablet, capsule, syrup, or powder

Targeting Restricting

the coverage of the intervention to those identified as the most vulnerable

Therapeutic care Feeding and medical treatment to rehabilitate severely acutely malnourished children

Therapeutic Feeding Programme (TFP) –

Is the programme that admits and treats Severely Acutely Malnourished (SAM) either at health facility level or as outpatient.

Therapeutic milk (see F100 and F75)

Milk-based products developed to meet the energy, macro and micronutrient needs of the severely malnourished and promote metabolic balance (F75) and weight gain (F100)

Therapeutic paste:

a generic term referring to lipid based products used in the treatment of severe acute malnutrition.

Transition phase Second phase of inpatient treatment for complicated SAM, its aim is to adapt progressively to the large amounts of food and nutrients that will be offered in the rehabilitation phase (outpatient or inpatient) and to monitor the patient.

Undernutrition

An insufficient intake of energy, protein or micronutrients, that in turn leads to nutritional deficiency

Underweight

Wasting or stunting or a combination of both, measured through the weight-for-age nutritional index

Vulnerability

The characteristics of a person or group in terms of their capacity to anticipate, cope with, resist and recover from the impact of a natural (or human-made) hazard

Wasting See **Acute malnutrition**

Weight-for-age

A measure of underweight

Weight-for-height A measure of acute malnutrition or wasting

'Wet' feeding Food aid provided in the form of a cooked ration to be consumed on site

Wet nursing Breastfeeding by a woman of a baby that isn't her own

Wheat soy blend (WSB)

a blended food

Xerophthalmia

Caused by vitamin A deficiency, it includes a range of eye signs including night blindness, Bitot's spots and corneal ulceration.

