Cluster	Code	Domain	Title	Description	Unit	Unit Description	Numerator	Disaggregation	Key Indicator	Types	Response Monitoring	Standards	Threshold	Guidance on Phases	General guidance	Guidance for pre-crisis	Comments	Data Sources	Sector cross-tagging
Nut	N-1	Prevention and Management of Acute Malnutrition	Global acute malnutrition (GAM)	Prevalance rate (%) of global acute malnutrition in children 6 to 59 months of age based on presence of bilateral pitting oedema and / or weight-for-height z-score less than -2 standard deviations of the median of the standard population (WHO 2006)	%	%	Number of children aged 6-59 months that meet the criteria for global acute malnutrition	Geographical area, age, sex	Yes	Baseline; Outcome	Yes		WHO TRS 854. Severity classification: 5,10, 15%	preparatory; Phase III and IV	Should be based on a methodologically solid anthropometric nutrition survey finding and include Confidence Intervals		Note that WFH and MUAC do not measure the same things and are not comparable	Population-based surveys with representative sampling methods (MICS, DHS, SMART)	Health;Food Security;Nutrition;Water Sanitation Hygiene
Nut	N-2	Prevention and Management of Acute Malnutrition	Global acute malnutrition (GAM) in infants less than 6 months	Prevalance rate (%) of global acute malnutrition in infants less than 6 months of age based on presence of bilateral pitting oedema and /or weight-for-height z-score less than -2 standard deviations of the median of the standard population (WHO 2006)	%	%	Number of infants less than 6 months that meet the criteria for global acute malnutrition	Geographical area, sex	Yes	Baseline; Outcome	Yes		WHO TRS 854. Severity classification: 5,10, 15%	preparatory; Phase III and IV	Should be based on a methodologically solid anthropometric nutrition survey finding and include Confidence Intervals		Note that WFH and MUAC do not measure the same things and are not comparable	Population-based surveys with representative sampling methods (MICS, DHS, SMART)	Health;Food Security;Nutrition;Water Sanitation Hygiene
Nut	N-3	Prevention and Management of Acute Malnutrition	Severe acute malnutrition (SAM)	Prevalance rate (%) of severe acute malnutrition in children 6 to 59 months of age 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)	%	%	Number of children aged 6-59 months that meet the criteria for severe acute malnutrition	Geographical area, age, sex	Yes	Baseline; Outcome	Yes		No standard WHO thresholds; this indicator cut-off should be interpreted in consideration of other indicators including morbidity, mortality and proportion of GAM; Reference: WHO child growth standards and the identification of severe acute malnutrition in infants and children. A Joint Statement by the World Health Organization and the United Nations Children's Fund, 2009.	preparatory; Phase III and IV	Should be based on a methodologically solid anthropometric nutrition survey finding and include Confidence Intervals		Note that WFH and MUAC do not measure the same things and are not comparable	Population-based surveys with representative sampling methods (MICS, DHS, SMART)	Health;Food Security;Nutrition;Water Sanitation Hygiene
Nut	N-4	Prevention and Management of Acute Malnutrition	Severe acute malnutrition (SAM) in infants less than 6 months	Prevalance rate (%) of severe acute malnutrition in infants less than 6 months of age 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)	%	%	Number of infants less than 6 months that meet the criteria for severe acute malnutrition	Geographical area, sex	Yes	Baseline; Outcome	Yes		No standard WHO thresholds; this indicator cut-off should be interpreted in consideration of other indicators including morbidity, mortality and proportion of GAM; Reference: WHO child growth standards and the identification of severe acute malnutrition in infants and children. A Joint Statement by the World Health Organization and the United Nations Children's Fund, 2009.	preparatory; Phase III and IV	Should be based on a methodologically solid anthropometric nutrition survey finding and include Confidence Intervals		Note that WFH and MUAC do not measure the same things and are not comparable	Population-based surveys with representative sampling methods (MICS, DHS, SMART)	Health;Food Security;Nutrition;Water Sanitation Hygiene
Nut	N-5	Prevention and Management of Acute Malnutrition	Moderate acute malnutrition (MAM)	Prevalance rate (%) of moderate acute malnutrition in children 6 to 59 months of age 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)	%	%	Number of children aged 6-59 months that meet the criteria for moderate acute malnutrition	Geographical area, age, sex	Yes	Baseline; Outcome	Yes		No standard WHO thresholds; this indicator cut-off should be interpreted in consideration of other indicators including morbidity, mortality and proportion of GAM	preparatory; Phase III and IV	Should be based on a methodologically solid anthropometric nutrition survey finding and include Confidence Intervals	Prevalence easy to derive by subtracting SAM from GAM	Note that WFH and MUAC do not measure the same things and are not comparable	Population-based surveys with representative sampling methods (MICS, DHS, SMART)	Health;Food Security;Nutrition;Water Sanitation Hygiene
Nut	N-6	Prevention and Management of Acute Malnutrition	Moderate acute malnutrition (MAM) in infants less than 6 months	Prevalance rate (%) of moderate acute malnutrition in infants less than 6 months of age 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)	%	%	Number of infants less than 6 months that meet the criteria for moderate acute malnutrition	Geographical area, sex	Yes	Baseline; Outcome	Yes		No standard WHO thresholds; this indicator cut-off should be interpreted in consideration of other indicators including morbidity, mortality and proportion of GAM	preparatory; Phase III and IV	Should be based on a methodologically solid anthropometric nutrition survey finding and include Confidence Intervals	Prevalence easy to derive by subtracting % SAM from % GAM	Note that WFH and MUAC do not measure the same things and are not comparable	Population-based surveys with representative sampling methods (MICS, DHS, SMART)	Health;Food Security;Nutrition;Water Sanitation Hygiene
Nut	N-7	Prevention and Management of Acute Malnutrition	Childhood stunting	Prevalance rate (%) of stunting in children 0 to 59 months of age based on height-for-age z-score less than -2 standard deviations of the median of the standard population (WHO 2006)	%	%	Number of children 0 to 59 months of age that meet the criteria for stunting	Geographical area, age (0-5, 6-11, 12-23, 24-35, 36-47. 48-59), sex	Yes	Baseline; Outcome	Yes		WHO TRS 854. Severity classification: 20,30,40 %	preparatory; Phase III and IV	Should be based on a methodologically solid anthropometric nutrition survey finding and include Confidence Intervals	Aim should be to assess stunting in the entire age group 0-59 months	Disagregation by sex and age group should be aimed for. Note: if surveys being undertaken include 0-59 then use this age group - if not - and the survey is including 6-59 then we may use 6-59. Ideally the % should be adjusted for 0-59 months)	Population-based surveys with representative sampling methods (MICS, DHS, SMART)	Health;Food Security;Nutrition;Water Sanitation Hygiene
Nut	N-8	Prevention and Management of Acute Malnutrition	Global acute malnutrition based on low MUAC	Prevalence rate (%) of children 6-59 months with MUAC less than 125 mm and/or having bilateral pitting oedema	%	%	Number of children aged 6-59 months that meet the criteria for wasting based on MUAC	Geographical area, age, sex	Yes	Baseline; Outcome	Yes		WHO child growth standards and the identification of severe acute malnutrition in infants and children. A Joint Statement by the World Health Organization and the United Nations Children's Fund, 2009.	Phase I,II; added to surveys Phase II,IV	When possible to use representative surveys, alternatively - rapid nutrition assessment with smaller number of children can give an idea of the situation - but these findings from a rapid nutrition assessment - with small numbers of children need to be treated with caution and should NOT be presented as prevalence but as number of children			Population surveys with representative sampling methods (MICS, DHS, SMART) & rapid nutrition assessment	Health;Food Security;Nutrition;Water Sanitation Hygiene
Nut	N-9	Prevention and Management of Acute Malnutrition	Severe acute malnutrition based on low MUAC	Prevalence rate (%) children 6-59 months with MUAC less than 115 mm and/or having bilateral pitting oedema	Percentage	Percentage	Number of children aged 6-59 months that meet the criteria for severe wasting based on MUAC	Geographical area, age, sex	Yes	Baseline; Outcome	Yes		WHO child growth standards and the identification of severe acute malnutrition in infants and children. A Joint Statement by the World Health Organization and the United Nations Children's Fund, 2009.	Phase I,II; added to surveys Phase II,IV	When possible to use representative surveys, alternatively - rapid nutrition assessment with smaller number of children can give an idea of the situation - but these findings from a rapid nutrition assessment - with small numbers of children need to be treated with caution and should NOT be presented as prevalence but as number of children			Population surveys with representative sampling methods (MICS, DHS, SMART) & rapid nutrition assessment	Health;Food Security;Nutrition;Water Sanitation Hygiene
Nut	N-10	Prevention and Management of Acute Malnutrition	Moderate acute malnutrition based on low MUAC	Prevalence rate (%) children 6-59 months with MUAC less than 125 mm but equal or more than 115 mm	%	%	Number of children aged 6-59 months that meet the criteria for moderate wasting based on MUAC	Geographical area, age, sex	No	Baseline; Outcome	Yes			Phase I,II; added to surveys Phase II,IV	When possible to use representative survey, akternatiely - rapid nutrition assessment with smaller number of children can give you a idea of the situation - but these findings from a rapid nutrition assesment - with small numbers of children need to be treated with caution and should NOT be presented as prevalence but as number of children	Prevalence easy to derive by subtracting % severe wasting based on low MUAC from % wasting based on low MUAC		Population-based surveys with representative sampling methods (MICS, DHS, SMART)	Health;Food Security;Nutrition;Water Sanitation Hygiene
Nut	N-11	Prevention and Management of Acute Malnutrition	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)	%	%	Number of Pregnant and Lactating Women that meet the criteria for acute malnutrition based on MUAC	Geographical area, age	No	Baseline; Outcome	No			suggest all phases	There are NO agreed international Cut off points for MUAC for PLW so National MUAC cut off points may vary, If available/possible, use representative survey, if not - rapid nutrition assessment with smaller number of PLW can give you some idea of the situation		PLW may be a problematic to define and identify, SMART surveys provide data for women with children, so definition of lactating should be mothers with infants 0-5 months; caution on excluding women in first pregnancy	Population-based surveys with representative sampling methods (MICS, DHS, SMART) or rapid nutrition assessment	Health;Food Security;Nutrition
Nut	N-12	Prevention and Management of Acute Malnutrition	Stunting in women of reproductive age	Prevalence rate (%) of women 15-49 years old who have height less than 145 cm	%	%	Number of women 15-49 years that meet the criteria for stunting	Geographical area	No	Baseline; Outcome	No			preparatory; Phase III and IV	Should be based on a methodologically solid anthropometric nutrition survey finding and include Confidence Intervals			Population-based surveys with representative sampling methods (MICS, DHS, SMART)	Health;Food Security;Nutrition
Nut	N-13	Prevention and Management of Acute Malnutrition	Undernutrition for adults	Prevalence rate (%) of adults with BMI less than 17.00 kg/m2 and/or having bilateral pitting oedema	%	%	Number of adults that meet the criteria for undernutrition	Geographical area, age, sex	No	Baseline; Outcome	No		WHO TRS 854 classification: mild thinness (BMI = 17.00-18.49 kg/m2), moderate thinness (BMI = 16.00-16.99 kg/m2), and severe thinness (BMI < 16.00 kg/m2).	suggest preparatory and phase iv and beyond	Should be based on a methodologically solid anthropometric nutrition survey finding and include Confidence Intervals		Anthropometric data should be interpreted with a contextual analysis of the associated nutritional risks for the population using underlying causes	Population-based surveys with representative sampling methods (MICS, DHS, SMART)	Health;Food Security;Nutrition
Nut	N-14	Prevention and Management of Acute Malnutrition	Undernutrition for children over 5 years and adolescents	Prevalence rate (%) of children and adolescents 5-19 years of age with Z-scores defined as BMI-for-age index less than -2 standard deviations from the medium BMI of a standard population of children/adolescents of the same age and/or having bilateral pitting oedema	%	%	Number of children children and adolescents 5-19 years that meet the criteria for undernutrition	Geographical area, sex	Yes	Baseline; Outcome	No		WHO Reference 2007 www.who.int/growthref.	Preparatoryand phase iv and beyond	Should be based on a methodologically solid anthropometric nutrition survey finding and include Confidence Intervals		Particularly important for adolescent women		Health;Food Security;Nutrition
Nut	N-15	Prevention and Management of Acute Malnutrition	Acute malnutrition for older people	Prevalence rate (%) of older people with a MUAC below 210mm or having bilateral pitting oedema	%	%	Number of older peole that meet the criteria for acute malnutrition	Geographical area, sex: in preparatory, Phase III and IV, disagregate by severity (<185mm and between 185 and 209mm)	Yes	Baseline	Yes	HelpAge guidelines	MUAC >210mm: no malnutrition; MAM: MUAC <210mm SAM: MUAC<185mm or oedema (Help Age guidelines 2013)	In preparatory phase as well as phases I and II: use rapid assessment methods In phases III and IV, organise surveys with larger samples or use rapid assessment method, with multi-indicator questionnaire	Rapid assessment methods can be used at any phase. The questionnaire should include questions about socio-econimic status, health, household food security, water and sanitation.	In preparatory phase,: Collect baseline demographic data about the percentage of people 50 and above (or 60 and above) disaggregated by sex and by age groups of 5 years (50-59, 60-64, 65-69, 70-74, 75-80, 80 and above) Assess household food security Organise focus group discussions with older people to have an idea of their access to food.	older people are defined as "people aged 60 and above" (UN definition), but in some contexts (e.g. Somali, Ethiopia, Sudan etc), can be 50 and above (as people are considered "old" from this age); Note: Nutritional oedema in older people may be difficult to distinguish from other types of oedema, so suggestion to separate BMI and oedema cases if necessary	surveys: rapid assessments	Food Security;Nutrition
Nut	N-16	Prevention and Management of Acute Malnutrition	Minimum meal frequency for children 24-59 months	proportion of children 24-59 months who are eating 3 meals a day or more	%	%	Number of children 24-59 months who are eating 3 meals a day or more	Geographical area, age, sex	No	Baseline	No			preparatory; Phase I and II; Phase II and IV	Use 6-23 months age group indicator as proxy for 24-59 months, and assume older age group is worse off CAN be an important ALERT indicator in early phases of an emergency		Indicator used for IYCF for 6-23 month age group based on WHO indicator	surveys; rapid assessments;	Food Security;Nutrition
Nut	N-17	Utilization	Adequate Cooking facilities	proportion of households with capacity to prepare food safely (fuel, water, cooking utensils, food)	%	%	Number of households who have a supply of fuel, water, cooking utensils and food at the time of the survey	Geographical area	Yes	Baseline	No			preparatory; Phase I and II; Phase II and IV	Use the food security cluster indicator guide once it is completed		link to nfi, food sec, wash when available. We have suggested his indicator for FS cluster: % of HHs with capacity to prepare food safely. Cooking equipment, storage, fuel, safe water, hygiene. Shelter sector will include cooking utensils and maybe fuel in nfi list. Most recent FSC Indicator is missing is utensils - so suggestion to advocate to get this included at global level	rapid assessments; other cluster assessment data	Food Security;Nutrition;Water Sanitation Hygiene

Nut	N-18	Prevention and Control of Micronutrients Deficiencies	Minimum dietary diversity for children 24-59 months	proportion of children 24-59 months who receive foods from 4 or more food groups	%	%	Number of children 24-59 months who receive from 4 or more of the following food groups: * grains, roots and tubers * legumes and nuts * dairy products (milk, yogurt, cheese) * flesh foods (meat, fish, poultry and liver/organ meats) * eggs * vitamin-A rich fruits and vegetables * other fruits and vegetables	Geographical area, age, sex	No	Baseline	No		No standard identified, only WHO source indicator	preparatory; Phase I and II; Phase II and IV	Use 6-23 months age group indicator as proxy for 24-59 months, and assume older age group is worse off - CAN be an important ALERT indicator in early phases of an emergency (WHO uses a parameter of previous 24 hours)		Indicator used for IYCF for 6-23 month age group based on WHO indicator (Reference - http://www.unicef.org/nutrition/files/IYCF_indicators_part_III_country_profiles.pdf)	surveys; rapid assessments;	Food Security;Nutrition
Nut	N-19	Prevention and Control of Micronutrients Deficiencies	level of risk to common micrinutrient deficiencies (high, medium, low)	qualitative assessment of nutritional risk of common micronutrient deficiencies (anaemia, iodine deficiency, Vit A deficiency (nightblindness), scurvy, beri beri, vitamin D deficiency) based on composite indicator analysis on prevalence rates, diet analysis, water quality and diarrhoeal disease, case finding	Score	high, medium, low		By deficiency; geographical area, sex, potentially vulnerable groups: PLW, children 6-59 months, other potentially vulnerable groups	Yes	Baseline	No		SPHERE 2011, appendix 5 - thresholds (http://www.spherehandbook.org/en/appendix-15/)	Preparatory; Phase II, III, IV	List prevelence rates for micronutrient status known for any vitamins and minerals and collect additional informationon diet, water quality and disease, to assess the severity of the risk for specific population groups		Consider separate indicators as for prevalence surveys different age groups are used and indicators will be for different population groups. - see SPHERE. Also according to SPHERE we should use not "estimated number of people" but "proportion of people", as threshold is in %	use survey data ; estimate from numbers of affected population by type of vulnerable groups	Health;Food Security;Nutrition
Nut	N-20	Prevention and Control of Micronutrients Deficiencies	Vitamin A coverage in children 6--59 months	Proportion of children 6 - 59 months having received vitamin A in previous 6 months	%	%	Number of children 6 - 59 months that received vitamin A in the previous 6 months (mother's recall or card verified)	Geographical area, age (6-11, 12-23 months), sex	Yes	Baseline;Output	Yes			preparatory; Phase III and IV			That indicator applies for children living in settings where VAD is a public health problem; WHO follows the GAVA recommendation and advocates for two doses in the last year	population surveys with representative sampling methods (MICS, DHS, SMART)	Health;Nutrition
Nut	N-21	Prevention and Control of Micronutrients Deficiencies	Iron supplementation coverage rate in children	Proportion of children 6-59 months of age receiving nicronutrient supplements that contain adequate iron	%	%	Number of children 6-59 months who received micronutrient supplements with adequate iron in/with one of their meals the previous day	Geographical area, age (6-24, 24-59 months), sex	No	Baseline; Outcome	Yes			preparatory; Phase III and IV			WHO recommends 12.5 mg iron daily for children 2-23 months (with normal birth weight) in areas where anemia in children ? 40%; 20 -30 mg iron for children aged 2-5 years. Note as this cut-off assesses the problem rather late, alternatively WHO recommends for 24-59 months in areas where ?20% anemia, intermittend supplementation with 25 mg once a week. See: Guidelines for the use of iron supplements to prevent and treat iron deficiency anemia: http://www.who.int/nutrition/publications/micronutrients/anaemia_iron_deficiency/1-57881-020-5/en/index.html	population surveys with representative sampling methods (MICS, DHS, SMART)	Health;Nutrition
Nut	N-22	Prevention and Control of Micronutrients Deficiencies	Iron-folic acid supplementation in pregnant women	Proportion of pregnant women having received iron-folic acid contained supplementation daily in previous 6 months/during preganancy	%	%	Number of pregnant women who bought or received iron-folic acid contained supplementation daily in the previous 6 months during pregnancy	Geographical area	No	Baseline; Outcome	Yes			preparatory; Phase III and IV			WHO recommendation: 30-60 mg elemental iron and 400 ?g folic acid (apps.who.int/iris/bitstream/10665/77770/1/9789241501996_eng.pdf);	Population survey with representative sampling methods (eg, MICS, DHA, SMART)	Health;Nutrition
Nut	N-23	Prevention and Control of Micronutrients Deficiencies	Iodised salt consumption	Proportion households using adequately iodized salt in previous 6 months	%	%	Number of households using adequately iodized salt (20-40 ppm) in previous 6 months	Geographical area	No	Baseline	Yes		Indicator should be equal to or greater than 90% (reference?) -Number of households using adequately iodized salt (20-40 ppm) in previous 6 months	preparatory; Phase III and IV	Adequately iodized salt is salt containing 15 to 40 ppm of iodine at the household level. Reference: Assessment of iodine deficiency disorders and monitoring their elimination : a guide for programme managers. 3 3rd ed., WHO, 2008		Use of "using" rather than "having regularly consumed in previous 6 months" based on recommended assessment methods, which is measuring iodine level in salt in households at a time of assessment and not collecting retrospective data (as the level of iodine in salt consumed cannot be assessed and many people do not know if salt is / was iodised). Alternative formulation: "Proportion of households using adequately iodized salt" - see reference. Apparently not a food		Health;Food Security;Nutrition
Nut	N-24	Prevention and Control of Micronutrients Deficiencies	Prevalence rate of vitamin A deficiency	Proportion of children below five years of age with sub-clinical vitamin A deficiency Proportion of women of reproductive age with clinical vitamin A deficiency	%	%	Number of children below five years of age with vitamin A deficiency (serum retinol values <0.70 ?mol/l) % of women of reproductive age (15-49 years of age) with Vitamin A deficiency (serum retinol values<0.70 ?mol/l)	Geographical area	Yes	Baseline	No		Public Health Significance: <2% normal; 2-9.9% Low; 10-19.9% Medium; >20% High (ref: WHO 1996)	Preparatory	FOR CHILDREN - Serum or plasma retinol levels measured in capillary or venous samples is an invasive test that is expensive if HPLC is used. Newer methods for dry blood spots with the capillary method are emerging.FOR WOMEN - Information can be ascertained verbally. Since the question is targeted at a specific subset of women, the indicator fails to capture the full range of women of reproductive ages. There is a need to standardise the phrasing of the question.		Inserted based on discussion 8th July to be reviewed & agreed; WHO guideline: who.int/vmnis/retinol.pdf	primary data - National Surveys, Local studies, DHS, MICS; secondary data - VMNIS	Health;Nutrition
Nut	N-25	Prevention and Control of Micronutrients Deficiencies	Prevalence rate of anaemia	Proportion of children below five yeasr of age with Hb concentration of <11 g/dL Proportion of women in reproductive age with Hb concentration of <12 g/dL	%	%	Number of children below five years of age with Hb concentration of <11 g/dL Number of women of reproductive age with anemia (Hb<11g/dl for pregnant women; <12 g/dl for non pregnant women)	Geographical area	No	Baseline	No		Public Health Significance: <4.9% Normal/Adequate; 5-19.9% Low; 20-39.9% Medium; >40% High (ref: WHO 2001).	Preparatory	The finger-prick blood sample test is easy to administer in the field. The test could be easily integrated in regular health or prenatal visit to capture all women in reproductive ages. Cost of equipment may be		Inserted based on discussion 8th July to be reviewed & agreed; WHO guideline: who.int/indicators/haemolobin.pdf;	primary data - National Surveys, Local studies, DHS, MICS; secondary data - VMNIS	Health;Nutrition
Nut	N-26	Prevention and Control of Micronutrients Deficiencies	Prevalence rate of iodine deficiency	Median urinary iodine concentration (?g/L) in children aged 6-12 years	%	%	Median urinary iodine concentration (?g/L) in children aged 6-12 years	Geographical area	Yes	Baseline	No		For children under-5, Public Health significance if <100 ?g/l but I don't know for children 6-12 years of age (ref: WHO, UNICEF, ICCIDD 2007)	Preparatory	A median urinary iodine concentration in a population of < 100 ?g/l indicates that the iodine intake is insufficient. A non-invasive method of measurement, the cost of sporturine samples tests is affordable. School age children 6-12 years can be easily tested in population-based surveys.		WHO guideline: apps.who.int/iris/bitstream/10665/85972/1/WHO_NMH_NHD_EPG_13.1_eng.pdf; According to WHO ideally one should also assess PLW	primary data - National Surveys, Local studies; secondary data - VMNIS	Health;Nutrition
Nut	N-27	Child health	Measles vaccination coverage	Measles coverage refers to the percentage of children who have received at least one dose of measles-containing vaccine in a given year, i.e. prevalence rate (%) of children under 9-59 months with confirmed (oral and by card) measles vaccination; This indicator is used for estimating the vaccine coverage of the total EPI strategy. To avoid overestimation, measles vaccination coverage is often used as a proxy since it is usually lower than DPT3 coverage.	%	%	Number of children 9-59 months with confirmed (oral and by card) measles vaccination	Geographical area	Yes	Baseline	No			preparatory; Phase III and IV	See health cluster	See health cluster	This information is usually available through the Health Cluster, but nutrition surveys may provide updates representative information	Population survey with representative sampling methods (eg, MICS, DHA, SMART)	Health;Nutrition
Nut	N-28	Prevention and Management of Acute Malnutrition	Morbidity	2 week recall of illness	%	%	Number of children 0-59 months whose caregiver reported an illness in the previous 2 weeks	Geographical area	Yes	Baseline	Yes		No threshold	preparatory; Phase I and II; Phase II and IV	survey data		This information may be available through the Health Cluster, but nutrition surveys may provid eupdates representative information	SMART surveys, Disease early warning systems	Health;Nutrition
Nut	N-29	Prevention and Management of Acute Malnutrition	US Mortality	US Mortality rate	Rate	Rate		Geographical area	No	Baseline	No			preparatory; Phases 1I, II III and IV	survey data and h/facility and community records		These data should be taken from Health Cluster or specific mortality surveys, representative surveys and also calculated through health facility and commnity records in early phases of emergency.	Reptresentative survey and or from h/facility / community records	Health;Nutrition
Nut	N-30	Infant and Young Child Feeding	Early initiation of breastfeeding	Proportion of children 0-23 months who were put to the breastwithin one hour of birth.	%	%	Number of women with a live birth in the X years prior to the survey who put the newborn infant to the breast within one hour of birth (Note: DHS data are based on the three years or five years prior to survey and MICS data are based on the two years prior to survey)	Geographical area	No	Baseline	No		No standard; < 80% is generally a priority. Discuss high, medium and low designations as a group	For Phases III-IV, an adapted indicator should be used where the same methodology is used but the denominator is infants born since onset of the emergency. (Proportion of children born since the onset of the emergency who were put to the breastfed within one hour of birth). In Phase 1 and 11, the denominator used should be infants born since onset of the emergency. In these phases opportunistic sampling will be necessary, e.g. at facilities providing obstetric services/newborn support.	WHO IYCF core indicator.	For preparatory phase, the WHO core indicator should be used as a baseline where the denominator is children born in the last 24 months (Proportion of children born in the last 24 months who were put to the breastfed within one hour of birth).		Preparatory, Phase III and IV: representative IYCF survey. Phase I and II: use key informant interviews and opportunisitic sampling to give an ALERT indication	Health;Nutrition
Nut	N-31	Infant and Young Child Feeding	Exclusive breastfeeding under 6 months	Proportion of infants 0-5 months of age who are fed exclusively with breast milk	%	%	Infants 0-5 months of age who received only breast milk during the previous day	Geographical area, sex, age: 0-1, 2-3, 4-5 months if available	Yes	Baseline	Yes		No standard; < 80% is generally a priority. Discuss high, medium and low designations as a group	For Phases III and IV, core WHO indicator should be measured. In Phases 1 and 11, it is not possible to accurately assess the exclusive breastfeeding rate in the population. Baseline information and N-40 (not breastfed) will be key information in Phases I and II.	WHO IYCF core indicator.	For preparatory phase, core WHO indicator should be measured		Preparatory, Phase III and IV: representative IYCF survey. Phase I and II: use key informant interviews and opportunisitic sampling to give an ALERT indication	Health;Nutrition
Nut	N-32	Infant and Young Child Feeding	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	%	%	Infants 12-15 months of age and 20-23 months of age who receive any breastmilk	Geographical area	No	Baseline	No			preparatory; Phase III and IV	The WHO IYCF core indicator reports continued breastfeeding at 1 year. In emergencies, it is important to also monitor continued breastfeeding rate at 2 years (WHO IYCF optional indicator) as children 1-2 years are also at signficant risk of increased morbidity and mortality if not breastfed in this context.			representative IYCF survey	Health;Nutrition

Nut	N-33	Infant and Young Child Feeding	Children ever breastfed	Proportion of children born in the last 24 months who were ever breastfed	%	%	Number of infants 0-23 months of age who ever received breastmilk	Geographical area	Yes	Baseline	Yes		No standard; < 80% is generally a priority. Discuss high,mediumand low designations as a group	For measurement in Phases 1-IV, an adapted indicator should be used where the denominator should be infants born since onset of the emergency. In phases 1 and 2, opportunistic sampling will be necessary, e.g. piggy backed onto reproductive health sampling or anthropometric screening or food security assessment.	WHO IYCF core indicator.	For preparatory phase, the core WHO Indicator should be used as a baseline where the denominator is infants born in the last 24 months.		Preparatory, Phase III and IV: representative IYCF survey. Phase I and II: use key informant interviews and opportunisitic sampling to give an ALERT indication	Health;Nutrition
Nut	N-34	Infant and Young Child Feeding	Predominant breastfeeding under 6 months	Proportion of infants 0-5 months of age who are predominantly breastfed	%	%	Number of infants 0-5 months of age who are predominantly breastfed	Geographical area	No	Baseline	No		No standard; < 80% is generally a priority. Discuss high,mediumand low designations as a group		preparatory; Phase III and IV	WHO IYCF optional indicator			representative IYCF survey	Health;Nutrition
Nut	N-35	Infant and Young Child Feeding	Bottle feeding	Proportion of children 0-23 months of age who are fed with a bottle	%	%	Number of infants 0-23 months who are fed with a bottle	Geographical area	Yes	Baseline	Yes				preparatory; Phases I, II, III and IV	WHO IYCF optional indicator. This indicator determines the use of bottles which carry risk; is not an indicator of use of infant formula or breastmilk substitutes, since it records any item fed using a bottle including breastmilk, water, semi-solids, etc).			Preparatory, Phase III and IV: representative IYCF survey. Phase I and II use key informant interviews and opportunisitic sampling to give an ALERT indication	Health;Nutrition
Nut	N-36	Infant and Young Child Feeding	Minimum dietary diversity	Proportion of children 6-23 months of age who receive foods from 4 or more food groups	%	%	Number of children 6-23 months who receive food from 4 or more food groups	Geographical area	No	Baseline	Yes		No standard; < 80% is generally a priority. Discuss high, medium and low designations as a group		preparatory; Phase III and IV	This indicator is adapted from the WHO IYCF core indicator for children 6-23 months.			representative IYCF survey	Health;Nutrition
Nut	N-37	Infant and Young Child Feeding	Minimum meal frequency	Proportion of children 6-23 mos who received solid, semi-solid or soft foods the minimum number of times or more.	%	%	Number of children 6-23 months who received solid, semi-solid or soft foods for the minimum number of times or more	Geographical area	No	Baseline	No		No standard; < 80% is generally a priority. Discuss high, medium and low designations as a group		preparatory; Phase III and IV	WHO IYCF core indicator			representative IYCF survey	Health;Nutrition
Nut	N-38	Infant and Young Child Feeding	Minimum acceptable diet	Proportion of children 6-23 months of age who receive a minimum acceptable diet (apart from breast milk)	%	%	Number of children 6-23 months who receive a minimum acceptable diet	Geographical area	Yes	Baseline	No		No standard; < 80% is generally a priority. Discuss high, medium and low designations as a group		preparatory; Phase III and IV	WHO IYCF core indicator			representative IYCF survey	Health;Nutrition
Nut	N-39	Infant and Young Child Feeding	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	%	%	Number of infants 5-8 months who received solid, semi-solid or soft foods during the previous day	Geographical area	No	Baseline	No		No standard; < 80% is generally a priority. Discuss high, medium and low designations as a group		preparatory; Phase III and IV	WHO IYCF core indicator. Need guidance on sample size			representative IYCF survey	Health;Nutrition
Nut	N-40	Infant and Young Child Feeding	Not breastfed	Proportion of infants 0<12 months and 12<24 months not breastfed	%	%	Number of infants 0-12 months and 12-24 months not breastfed	Geographical area; 0-<12 months, 12-<24 months	Yes	Baseline	Yes			Calculate this indicator based on standardised data collected. In phases 1 and 11, an indication of the proportion of non-breastfed infants should be estimated based on key informant interviews and opportunistic sampling.	This is not a standard indicator. However it is possible to calculate this indicator using standardised data collected to produce WHO IYCF core indicators.	Preparatory: calculate this indicator based on standardised data collected. In phases 1 and 11, an indication of the proportion of non-breastfed infants should be estimated based on key informant interviews and opportunistic sampling.	Need to raise this with WHO to see how we might develop this as a standard indicator to report in emergency prone contexts.	Preparatory, Phases 111 and IV: Indicator produced from data collected from MICS/DHS. Phase I and II will use key informant interviews and opportunisitic sampling to give an ALERT indication.	Health;Nutrition
Nut	N-41	Infant and Young Child Feeding	Any 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		any report	NA	Geographical area	Yes	Baseline	Yes		zero tolerance	Phases 1,11, 111 and IV.	This is an alert to problems. Any general distribution of these products to the affected population is a concern as there is a risk of spillover to infants and young children.			Key informant interviews (include logistics and any agencies involved in distribution, as well as health and nutrition staff and caregivers). Distribution reports. Observations.	Health;Nutrition
Nut	N-42	Infant and Young Child Feeding	Any 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		any report	NA	Geographical area	Yes	Baseline	Yes		zero tolerance	Phases 1,11, 111 and IV.	This is an alert to problems. Inappropriate distribution is where distribution is not in accordance with the Operational Guidance on IFE in meeting criteria for assessment of need, skilled support available, guaranteed continuity of supplies, individual follow up, availability of storage and preparation facilities, appropriate labelling, and monitoring for spillover to breastfed infants.			Key informant interviews (include logistics and any agencies involved in distribution, as well as health and nutrition staff and caregivers). Distribution reports. Observations.	Health;Nutrition