

**Nutrition in emergencies checklist for the nutrition cluster**

**Part II. Wasting management**

The nutrition in emergencies checklist is a tool designed to help each in country nutrition sector or cluster review and reflect on the service delivery aspect of the nutrition in emergency response. The checklist is to be used at least once a year by the nutrition sector or cluster coordination country team – or any in-country nutrition in emergency mechanism- to self-assess the quality of the service delivery aspect of the nutrition response before, during and/or after a crisis.

The checklist is organized by nutrition in emergency themes, the four main themes are Part I. Infant and Young Child Feeding in Emergencies, Part II. Wasting Management, Part III. Nutrition Information Systems and Part IV. Micronutrients Supplementation. Under each theme, a set of questions are asked in the left column to prompt reflection, elements of the answer and examples from other countries are under the right-hand column. The questions under each theme span the humanitarian program cycle. Please use it with the corresponding Excel tool.

This below checklist is specifically in relation to part II. Wasting management, it is designed to support nutrition cluster and/or in country wasting TWG in the review of the capacity under this theme.

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| **Acute malnutrition management** | |
| During emergencies, communities and families go through shocks that often disrupts their normal day to day lives. In many cases, daily access to three diversified and nutritious meals is compromised. Nutrition status of populations significantly deteriorates during emergencies. Groups that are most at risk in this situation are older people, adults suffering from a chronic illness, children under five years, pregnant and lactating women, and infants. Ensuring that acutely malnourished individuals have access to treatment is one of the top priorities for the nutrition cluster. | |
| **Before the emergency** | |
| **Policies and guidance** | |
| * Are there national policies aligned with global guidance on management of acute malnutrition including in health facilities and in the community? Note that policies are formal statements issued by the state. | Each country should have an up-to-date national policy on management of acute malnutrition including in health facilities and in the community. During non-emergency response times, it is important to advocate for a national policy that includes acute malnutrition management. This is particularly important when such a policy does not exist in country, is incomplete or is obsolete.  During an emergency, Technical Working Groups (TWG) find themselves wrapped up in updating the national policy and this takes away from the time they need to dedicate to the response. For this reason, it is recommended that TWGs can rely on a hired consultant who can do this longer-term work of putting together a national policy. If an emergency is declared, interim guidance can be quickly set up until longer term review and agreed upon national policies are in place. Next section provides more information specifically on guidelines. |
| * Are there clear national operational procedures or guidelines for management of acute malnutrition including in health facilities and in the community? Note that procedures are step-by-step instructions for implementation and guidelines are designed to advise on processes for implementation. | Whether for staff part of the national government or non-governmental organizations, the policy needs to be translated into contextualized, practical, and well-articulated operational procedures or guidelines for managing acute malnutrition in emergencies. In the event this document does not exist, in non-emergency times the nutrition cluster and or the acute malnutrition TWG should advocate for this work to be initiated and completed and abide by the latest global guidance developed by UNICEF and the World Health Organization (WHO). The [WHO guideline updates on the management of severe acute malnutrition in infants and children](https://www.who.int/publications/i/item/9789241506328) are a reference with which the country guidelines need to align. |
| * Are there temporary and interim protocols in place to face with the constraints brought by the COVID19 pandemic in country? Are interim protocols in place to face other infectious disease outbreaks in country, such as Ebola? | A number of briefs and programmatic adaptations can be found under [the global nutrition cluster technical alliance (GNC-TA) website](https://gtam.nutritioncluster.net/node/34) under the prevention and treatment of wasting section of the covid19 page. The key guidance and notes that have been issued are (1) the [prevention, early detection and treatment of wasting in children 0-59 months through national health systems in the context of covid-19](https://www.nutritioncluster.net/node/19161), (2) a [toolkit for community health workers community-based treatment of uncomplicated wasting for children 6-59 months in the context of covid-19](https://mcusercontent.com/fb1d9aabd6c823bef179830e9/files/a7f85a4b-074c-4f7c-b0bf-f4d793db9f21/CHW_community_based_treatment_toolkit_COVID_FULL.pdf), as well as 5 information notes detailing programmatic adaptations for the following constraints: (3) [when RUF is unavailable,](https://www.nutritioncluster.net/Resources_Wasting_COVID-19_Programme_Adaptations_Information_Note_1) (4) [when standard screening or family MUAC is not possible](https://www.nutritioncluster.net/Resources_Wasting_COVID-19_Programme_Adaptations_Information_Note_2), (5) [remote supervision of CHWs](https://www.nutritioncluster.net/Resources_Wasting_COVID-19_Programme_Adaptations_Information%20_Note_003), (6), [remote training of CHWs](https://www.nutritioncluster.net/Resources_Wasting_COVID-19_Information_Note_004) (7) [community based management of at risk mothers and infants under 6 months](https://www.nutritioncluster.net/node/19046). |
| **Contingency plans** | |
| * Is there an inter-agency contingency plan that includes a comprehensive section on the management of acute malnutrition? | It saves lives to plan and pre-agree on how to respond to the different emergency scenarios that are likely to occur in your country ahead of time[. A contingency plan](https://www.unicef.org/emergencies/files/UNICEF_Preparedness_Guidance_Note_29_Dec__2016_.pdf), discussed and agreed upon by all nutrition cluster partners, that looks and addresses how the emergency will impact acutely malnourished vulnerable population groups is an important preparedness measure. It is important to unpack how the emergency will impact older people, chronically ill and undernourished adults, adolescents, pregnant and lactating women, and children under five years old. Delineating the different likely scenarios will also help plan differently for an outbreak within a displacement context versus an earthquake for example. Preparing as well for an infectious disease or a pandemic would also need to be part of the plan. |
| **Capacity building** | |
| * Is there an in-country repository for acute malnutrition management operational guidance and tools in national and/or local language(s)? | Having acute malnutrition management guidance and tools available and accessible by all nutrition partners in-country will facilitate their use and the partner’s adherence to the guidance. It is recommended you set up a repository whether online (on <https://www.humanitarianresponse.info/>) if connection is available or through other storage options if not (usb key for example)-so that all partners have access to the guidance, tools and templates they need for the response. |
| * Are there training materials in acute malnutrition management ready in the national and/or local language(s)? | Translating agreed-upon guidelines into training material into the local language for the health care personnel will facilitate the dissemination and uptake. A number of training courses are available at the global level such as [WHO’s training course on the management of severe malnutrition](https://www.who.int/nutrition/publications/severemalnutrition/training_inpatient_MSM/en/), and FANTA III’s [training guide for community based management of acute malnutrition](https://www.fantaproject.org/focus-areas/nutrition-emergencies-mam/cmam-training), as well as short online modules such as UNICEF’s [acute malnutrition in emergencies preparedness and response](https://agora.unicef.org/course/view.php?id=28662) or longer courses such as MSF’s [basics of the nutrition programme](https://tembo.msf.org/course/info.php?id=506) |
| * Is there a pool of trained health and nutrition personnel in acute malnutrition management in country? | Training in acute malnutrition management a pool of health and nutrition workers and providing on-the-job ongoing mentoring will improve the quality of the response. This would require that training materials in the local language are up to date and available. |
| * Are there pre-determined trainers on acute malnutrition management in country? | Training a pool of health and nutrition personnel as trainers in acute malnutrition management will facilitate the roll out of trainings in country. If this measure is planned and implemented during non-emergency times, this pool of trainers can support the roll out of trainings to specific personnel of areas hit by an emergency. |
| **Data** | |
| * Do you have routine and recent data on key acute malnutrition indicators in country? | Routinely collecting data on key acute malnutrition management indicators will allow monitoring of the nutrition situation and have a baseline to compare changes during and after an emergency. A country or an area with an above threshold percentage of Global Acute Malnutrition for children below 5 years old is a warning sign that this population is at an even greater risk when an emergency occurs, and steps need to be taken in the cluster to ensure provision of services in this area.  The following recommended key indicators are listed in the [nutrition humanitarian needs analysis document](https://www.nutritioncluster.net/resource_NutHumanitarianAnalysis):   * Prevalence of Global Acute Malnutrition (GAM) based on weight for height Z-score (WHZ)<-2 and/or bilateral pitting oedema among children 0-59 months (if no data, use 6-59 months) * Prevalence of Global Acute Malnutrition (GAM) based on Mid-Upper Arm Circumference (MUAC) <125mm and/or bilateral pitting oedema among children 6-59 months * Prevalence of Global Acute Malnutrition (GAM) based on Mid-Upper Arm Circumference (MUAC)<210-230mm (depending on the contexts) and/or bilateral pitting oedema among PLW * Prevalence of stunting based on height-for-age Z-score (HAZ)<-2 among children 0-59 months |
| * Is data from different areas of the country available? | Variation might exist between different parts of a large country, especially if different populations or livelihood zones exist. It is important to attempt to have data from different major livelihood zones in a large country. |
| * Do you have up-to-date data on the coverage of the acute malnutrition management interventions in country? | Understanding the gaps in service coverage will allow better planning to address the gaps with partners during non-emergency time and it will allow having the necessary knowledge of the current status of operations in order to plan for scale up when an emergency hits. |
| * Are monitoring indicators and tools pre-agreed upon and harmonized? | Cluster partners have their own monitoring and evaluation guidelines within their own organization. Yet, it is important to collate data from the different partners to monitor the collective response and to do so, there is a need to jointly agree on indicators to be used by all partners. This harmonization of indicators for acute malnutrition management may require lengthy, back and forth discussions and adjustments. Hence there is an opportunity to start harmonization of indicators before an emergency as a preparedness measure. |
| * In the event of an emergency, does the government and/or nutrition sector or cluster partners have the capacity to undergo an initial rapid assessment? Do they have the capacity to implement a [SMART assessment](https://smartmethodology.org/) 4 to 6 months after the emergency onset? | When an emergency hits, a multisector initial rapid assessment will take place. It is important to evaluate whether the nutrition partners have the capacity to support this exercise and start building their capacity if not. One way to do so is by organizing a training for the partners. Discussing and pre-approving a list of indicators for the initial rapid assessment before an emergency hits is a very useful preparedness activity. Similarly, since it is recommended to have a SMART assessment implemented 4-6 months after the onset of an emergency, the nutrition cluster partners’ capacity to implement such an assessment would need to be evaluated and their capacity built to support the exercise. This can be jointly organized with the support of the [nutrition information systems technical working group (NIS TWG)](https://www.nutritioncluster.net/node/4869) if available in country. |
| **Supplies** | |
| * Are pathways to purchase medical supplies needed for the management of acute malnutrition such as Ready to Use Foods, antibiotics, and anti-helminths clear? | Ideally before the emergency hits, a supply management plan would be written with all partners involved including the ministry of health and shared for all to be aware and plan accordingly. |
| * Are other supplies needed for setting up acute malnutrition management space available or included in the interagency contingency plan? | In case the health facilities are destroyed during an earthquake or a conflict, there may be a need to plan for weight scales, height boards, MUAC tapes, tents, foldable tables and chairs and other supplies needed to quickly set up a provision of service points. |
| * Are the supplies amount and location known by main actors and accessible in case of an emergency? | The amount and location of the supplies available should be known by all actors working in nutrition in emergencies in country. Due to turn-over, this information is often missed. It is important to set up a regular information bulletin to inform all partners and have a regularly updated website where partners can go to for information. |
| **Capacity Mapping** | |
| * Has there been a mapping of the capacity of local and international partners to respond to acute malnutrition management needs during a crisis? | Mapping the capacity of partners to respond to CMAM is the first step to a relevant capacity building plan. It also allows to understand how much the cluster should rely on in country capacities and how much on external support such as regional capacity, the [Global Nutrition Cluster](http://nutritioncluster.net/) and the [Global Nutrition Custer Technical Alliance](https://ta.nutritioncluster.net/) |
| * Is there a focal organization that partners can rely on or go to for expert acute malnutrition management advice? | In line with the point above, an expert agency in country can be requested to train and/or orient other partners on CMAM and key interventions. |
| **Technical Working Group (TWG)** | |
| * Is there an acute malnutrition TWG established prior to the emergency? | The preparedness work delineated above can be done by a technical working group on acute malnutrition management. Establishing a TWG is a first step to starting to prepare for an acute malnutrition management response. In the ideal scenario, the Ministry of Health (MoH) would need to be onboard and leading or co-leading the creation of this working group. |
| * Does the acute malnutrition TWG have ToRs? | Generic Terms of references have been developed to fast-track creating an acute malnutrition management TWG in country. These customizable ToRs can be found [here](https://www.nutritioncluster.net/node/11351) in English, French and Spanish. After determining the key actors and convening for a meeting to create an acute malnutrition TWG, an important agenda point during that first meeting would be to review and validate the ToRs of the group. The generic ToRs can be discussed and customized. |
| * Does the TWG have chairs in place? | In an ideal scenario, the acute malnutrition TWG group has two co-chairs chosen on rotational basis for a year, each chair is responsible for leading the group for 6 months. Every 6 months, the chairs will rotate in order to keep the group active. The chairs are chosen upon an interview with the Nutrition Cluster Coordinator whereby the technical knowledge, leadership skills and the time commitment to the TWG needs to be assessed.  A ToR with the tasks of the chair(s) can be agreed upon and shared with the chair agency supervisor. The ToR should include engaging partners, calling for the meeting, setting the agenda, preparing or consolidating the documents that need to be reviewed, ensuring minutes are taken at every meeting, following up on the action points, reminding deliverables, engage with the NCC on the acute malnutrition TWG deliverables. The role of the chair is also to ensure a needs assessment is done in acute malnutrition management and a workplan is put together collectively for the TWG to address the needs, it is important that this is done with impartiality, humanity, neutrality and independence. It is the role of the chair to identify challenges and request for support. The chair is responsible to report back to the nutrition cluster on an agreed basis and to provide a handover report before leaving the group or the position. |
| * Has an evaluation of the chair’s work been done once a year? | An evaluation of the chair’s work would need to take place once a year or every 6 months- this could include but is not limited to an online survey sent to the TWG members on the deliverables and the governance of the group. |
| * Does the TWG have a workplan? | This checklist can be used to assess the situation in country and determine some of the main gaps in wasting management. A workplan to address those gaps would keep the technical working group moving in the right direction and allow the group to focus on a long-term plan -along with the inevitable ad hoc requests throughout the year. The TWG should have a yearly workplan addressing the main prioritized needs in this thematic area. The workplan can span over 6 months at a time or two years depending on what is suitable in your context. |
| * Does the TWG monitor its progress against set targets once every 3 months | A workplan will allow the group to evaluate their own performance against the set workplan deliverables. It is recommended that the group evaluates their performance as per the set targets in the workplan every 3 months. |
| * Do the TWG members meet every month? | In other words: is the TWG active? In order to work on acute malnutrition management, the group would need to communicate regularly to ensure the needs are being addressed and the set deliverables attained. |
| **At the onset of and during the emergency response** | |
| **Need assessment and analysis** |  |
| * Was a quick secondary data review done? | In order to better understand the context prior to the emergency, it is important to review the data on acute malnutrition and practices prior to the emergency. |
| * Have you gathered information on existing policies, guidance, training materials, trained personnel, contingency plans, prepositioned supplies, acute malnutrition management TWG that were present before the emergency? | At the onset of the emergency, a number of shifts and changes will occur. Information might get lost. In order to build on what was done in the past and allow the nutrition cluster to better assess the gaps in those areas, seek information from nutrition cluster partners who were present before the emergency onset on existing acute malnutrition management policies, guidance, training materials, trained personnel, contingency plans, prepositioned supplies, CMAM/Wasting TWG and activities that were present before the emergency. |
| * Has an initial rapid assessment that includes acute malnutrition indicators taken place in the first weeks and months following the crisis? | It is not advisable to implement a SMART survey immediately at the onset of an emergency, it is only advisable to start planning for a full-fledged survey 4 to 6 months after the onset of the emergency. If an inter-sector initial assessment is taking place, or if another sector is conducting an assessment, it is an opportunity for the nutrition cluster to include indicators on acute malnutrition to the assessment. |
| * How is the access to data from the relevant sectors such as food security, health, WASH, and protection to support analysis of acute malnutrition needs? | To better inform the response, data from other sectors such as the availability of quality drinking water, the access to markets and health care, Mental Health and Psychosocial Support (MHPSS) situation, will be essential to better understand the context and support the PLW and/or caregivers to optimally feed their young children. |
| * Are communities consulted and involved in the assessment of needs? | If nutrition cluster partners are already undergoing assessments, focus group discussions with caregivers of young children, pregnant mothers and other groups as needed can help identify the specific challenges and identify the needs of this population more accurately. This exercise is highly recommended as it supports proper design of effective life-saving interventions. The nutrition sector and/or cluster should encourage and coordinate sharing these assessments among the nutrition partners. |
| * Does the Humanitarian Needs Overview (HNO) provide specific and to the point information on the acute malnutrition situation before the emergency for rapid onset emergencies and how the emergency affected nutrition status? For protracted emergencies, does the HNO discuss the current nutrition status of the population? | As a nutrition cluster, it is important to ensure that data on key acute malnutrition indicators in country prior to the emergency are shared in the HNO. How the emergency affected the way the infants are fed is a very important information to add to the HNO. Current nutrition status needs to be described for protracted emergencies. If data is missing, it is important to mention it in the HNO and address this gap in the cluster plan. |
| **Strategic Planning** |  |
| * Does the Humanitarian Response Plan (HRP) and the nutrition cluster strategic plan address the acute malnutrition needs raised in the HNO, are the two documents aligned? | The two documents need to be linked: the HRP is constructed to address the needs articulated in the HNO. Since the HRP is often limited in the number of words allowed, it is recommended to put together a cluster strategy in order to be better able to unpack certain sections.  Partners and UN agencies should be encouraged to also look for ways to align their internal plans such as UNICEF’s Humanitarian Action for Children (HAC) to the HRP. |
| * Does the Humanitarian Response Plan (HRP) and the nutrition cluster strategic plan cover aspects on acute malnutrition management planned interventions including considerations on whether the population is static or on the move? | The acute malnutrition management needs of the population need to be well articulated in the HNO and the analysis needs to be broken down by different populations (static or on the move, host or IDPs or refugees for example). Articulating the different interventions clearly will enhance the specificity and hence the quality of the response.  The needs of populations on the move are quite different from those populations that are static. The plan needs to consider and articulate how the interventions will differ for different populations |
| * Does the HRP and the nutrition cluster strategic plan provide a clear strategy on how to address the coverage gaps in acute malnutrition management services? | The gap in the service coverage needs to be clearly delineated in the HNO in order to be addressed in the HRP. In the HRP, the nutrition cluster should ideally explain how the gap in coverage of acute malnutrition management services will be reduced in the next year. UNICEF’s [management of severe acute malnutrition: working towards results at scale](https://www.humanitarianresponse.info/en/operations/latin-america-and-caribbean/document/management-severe-acute-malnutrition-children) provides guidance on how to plan a scale up. |
| * Does the HRP and the nutrition cluster strategic plan include a section on how the quality of the acute malnutrition management interventions in country will be enhanced? | In the HRP or the nutrition cluster strategy, the nutrition cluster should ideally explain how the quality of the acute malnutrition management services will be enhanced. Is there a process in place for monitoring quality? How is that being monitored? What corrective measures have been taken to improve the quality of interventions? Is a capacity building strategy in place? |
| * Are different community groups and members views taken into consideration as the plan is put together? | In the same way that the HNO needs to involve the communities affected by the emergency, the HRP needs to also take into consideration the views of those in need for a nutrition intervention. Nutrition sector and/or cluster partners can explain and gather feedback on the nutrition plan as it is being discussed through focus group discussions and key informant interviews. |
| * Has the HRP and the nutrition cluster strategic plan been converted into an operational yearly workplan? | To make progress on the acute malnutrition management strategy, the cluster would need an operational workplan with clear deadlines and entity responsible for each set of deliverables. A monitoring plan would also help keep track of progress. |
| **Implementation and Monitoring** |  |
| Policies and guidance | |
| * Are all partners adhering to the interim or the national acute malnutrition management protocol? | How is the monitoring of the intervention taking place? Joint nutrition cluster and/or sector partners monitoring to ensure partners are adhering to protocols are one way to monitor the quality of the intervention and adherence to the national acute malnutrition protocol |
| Technical Working Groups | See the section above on Technical Working Group (TWG) |
| Capacity |  |
| * Has there been any discussion on the minimum capacity required for nutrition activities and capacity mapping? Is the capacity of partners to deliver acute malnutrition management programme been assessed? | There is [a tool on how to do capacity mapping](https://www.nutritioncluster.net/resource_CM) for all nutrition activities that you can adapt to guide you in that exercise and discussion with partners. Once you understand the capacity of partners to deliver acute malnutrition management specialized services and more importantly, once you understand the gaps in that capacity, then you can plan to request support accordingly. It is important to be objective and neutral in that assessment and constantly bring back the focus on what benefits the collective.  The exercise on mapping the capacity of partners to deliver nutrition in emergency interventions needs to include an assessment on the capacity of partners to deliver different aspects of the acute malnutrition management. |
| * Does the sector have a capacity building strategy for acute malnutrition management, and if yes, is this being implemented? | The capacity building strategy need to address the gaps in the capacity mapping in acute malnutrition management. The strategy would need to then be declined into an operational plan with person responsible and timeline. A follow up on the plan would need to take place frequently to ensure that the targets are reached within the timeline set. |
| * Is a training schedule for acute malnutrition management training planned? | An essential part of the operational plan is a training schedule for rolling out acute malnutrition management knowledge and skills across the health personnel and community frontline workers of the affected areas. |
| Service Delivery |  |
| * In addition to the nutrition cluster strategy, is there an acute malnutrition management strategy and approach standardized across all partners? | The acute malnutrition management intervention strategy would need to be built with the cluster partners and be adhered to by the partners for optimum results. In some cases, the NCC may need additional support and therefore a request to a partner with acute malnutrition expertise or the GNC technical alliance may be necessary to support the acute malnutrition TWG with a strategy. |
| * Are training curricula and Information Education and Communication materials for acute malnutrition in the national and/or local language standardized and distributed/used? | Acute malnutrition materials should be up to date, relevant, and reflect official WHO and UNICEF’s global guidance. Ideally, the materials should be available online and accessible to all partners. |
| * Is an acute malnutrition programme taking place systematically at all levels of health and nutrition service provision –community, outreach, health facility including at the hospital and/or the stabilization center (SC)? | It is important to note whether the intervention is taking place at all the levels of the health system, namely the community, health facilities and hospitals to be effectively reaching the population in need. |
| * Is there a good linkage between health and nutrition programmes to promote continuum of care and referral systems from the community to health facilities including stabilization centers? | Community mobilization and screening require an effective referral system to health centers, and from health centers to hospitals when needed. These linkages need to be in place and functioning properly for optimum results. |
| * Is the delivery and quality of acute malnutrition management activities the same for all partners? | It is clear that the quality of the acute malnutrition management interventions will not be the same for all partners, it is important however to be able to identify those partners that need additional technical support and reach out to the [GNC technical alliance](https://ta.nutritioncluster.net/) for in country support to those partners. |
| * Are the acute malnutrition management activities of community volunteers standardized across all partners? | Through the initiative of the acute malnutrition TWG, a community booklet, and key messages should be standardized and [adapted](https://www.unicef.org/nutrition/index_58362.html) to the context for volunteers and all nutrition stakeholders. |
| * Are there systems for effectively avoiding duplication of services? | Acute malnutrition management services from different partners might be overlapping in one area when other areas are underserved, it is the responsibility of the nutrition cluster to ensure that duplication is not an issue and that double counting does not occur. Are operational programme delivery issues being routinely discussed at the nutrition sector and/or cluster meeting? |
| **Supplies** |  |
| * Is there an effective supply needs and requirements monitoring in place? | Following the initial rapid assessment, an estimation of the supplies needs to take place during the initial rapid assessment stage and again during the emergency. This should take into account the supplies that partners already have in their warehouses.  Once the supplies are purchased and targeted distribution is underway, it is important to ensure a very strict monitoring of the quantities delivered to implementing partners. This monitoring will allow to avert pipeline breaks and plan ahead of time for purchases.  It is also critical to monitor how the distribution is taking place at the field level, a joint cluster monitoring team can be put together to ensure that targeted distribution is taking place with proper instructions to caregivers |
| * Do partners face challenges in accessing supplies ( those include all supplies needed for SAM and MAM treatment, for example RUTF, RUSF, CSB, CSB+, etc.)? | Challenges faced by partners in accessing supplies need to be identified and addressed. Documenting challenges and successes will also help the entire nutrition community learn, evolve and jointly respond better next time. |
| Coverage |  |
| * Are the partners implementing the complete agreed package of acute malnutrition management interventions in a given area? | Clusters should agree together on an identified ‘comprehensive acute malnutrition management package’ relevant for the emergency context. Once a set of actions are agreed, the package should be reflected in the HRP, acute malnutrition management strategy and workplan. The 4W reporting template can be adapted to manage coverage and duplication. |
| * Is the coverage of the package of nutrition specific interventions adequate? | Are partners only covering a small percentage of the population in need of acute malnutrition management services? If so, then this needs to be identified and quick action need to be put in place to increase the coverage if the areas are accessible.  If the areas are not accessible, remote management and training the mothers could be part of the last resort solution. It is important that the [simplified approached and interventions](https://docs.google.com/document/d/16TZQbBj65GT6bjmzxkhISVjzxK-EM-LTUztsO69DA-M/edit) are scaled up in this case. |
| Interface with other sectors |  |
| * Interface with the wash sector: have the different ways nutrition and WASH sectors can support and collaborate been mapped out? For example, do outreach services/OTPs and SC have separate latrines for men and women as well as clean water points? Outside the facilities, are water points available in villages and latrines in communities with elevated percentages of GAM? | If no clean water is available in an area, this alone can put all infants at risk. Hence, the quality of the nutrition in emergency response depends on integration with the WASH sector. Ensuring collaboration with WASH colleagues includes the awareness of the nutrition needs and risks such as clean water points, washing areas, segregated latrines, and the presence of clean water and good hygiene practices in the community. Certain nutrition interventions can act as a vector to the WASH interventions. Intersectoral collaboration is therefore essential. |
| * Interface with the food security sector: have the different ways nutrition and FS sectors can support and collaborate been mapped out? are there implementation plans jointly prepared with the Food Security sector? For example, is the FSC able to provide foods that are appropriate to 6-23 months old? | It is useful to explore whether diets of pregnant women and children 6-59 months meet standard indicators including in amounts and diversity. The food security sector may provide food baskets/cash/vouchers during an emergency, ideally nutrition counseling by nutrition partners would also be part of this support. Jointly planning to improve the status of the population is key. Intersectoral collaboration is therefore essential. |
| * Interface with the health sector: have the different ways nutrition and health sectors can support and collaborate been mapped out? For example: are referrals to other health services such as skilled attendant’s delivery services, pre- and post-natal care and immunization mapped out and established? | The nutrition and health sectors should jointly discuss the different ways by which they can mutually support one another. For example mapping the different referral mechanisms with the health sector to ensure smooth and interconnected provision of services throughout the continuum of care for maternal nutrition, infants, young children, adolescents, chronically ill adults and old people. Intersectoral collaboration is therefore essential. |
| * Are linkages with protection and MHPSS services mapped out and established? | The nutrition and protection clusters should establish referral mechanisms for Gender Based Violence (GBV), Disability, as well as Mental Health and Psychosocial Support (MHPSS). To facilitate and support this task, contact protection cluster focal points in country and they will help orient and train nutrition cluster partners on considerations for nutrition programming such as training front line nutrition personnel for unsolicited disclosure of violence from the people in need and or attending the nutrition services. |
| Monitoring |  |
| * Are the 4 Ws mapped? | Mapping the acute malnutrition management interventions is crucial to understanding where coverage gaps are and how to address them. The GNC Information Management Officer Helpdesk can provide support on how to do this mapping. |
| * Are the indicators discussed and agreed upon by partners? Are reporting and data collection tools harmonized and are all partner using the same reporting format? | See section on [Data](#bookmark3) above. |
| * Are qualitative indicators used to monitor the quality of acute malnutrition management interventions or are only output indicators used? | As an example: beyond monitoring only ‘the number of community health workers trained’ (output), there is a need to monitor the quality of the training by monitoring knowledge retention or ‘the average score on the post training quiz’ |
| * Is reporting timely? How many centers are reporting? Is the humanitarian response website updated regularly? | This question is to self-reflect on the timeliness and coverage of the collective reporting and whether the current reporting system is useful to better direct the interventions. |
| * Are the performance indicators routinely analyzed and action is taken to address the shortfalls? | * The performance indicators can be found in the management of malnutrition section of the [sphere standard](https://handbook.spherestandards.org/en/sphere/#ch007)s, for instance the performance indicators for the management of severe acute malnutrition are: Proportion of discharges from therapeutic care who have died, recovered or defaulted   + Died: <10 per cent   + Recovered: >75 per cent   + Defaulted: <15 per cent |
| * Is there any cross learning between partners delivering nutrition specific services? | Visits to centers where acute malnutrition management stakeholders are performing optimally can be proposed to partners to improve performance. |
| * Is a bulletin issued frequently to inform progress and inform where the key documents are? | A bulletin issued on a monthly or quarterly basis would be useful to keep every actor in the humanitarian sphere abreast of the progress towards the workplan targets of the acute malnutrition TWG and informed on the available acute malnutrition documentation in country. |
| **Operational Peer Review and Evaluation** |  |
| * Is there a plan to map capacities of partners, develop joint training plans develop joint supervision tools and establish on-the-job coaching techniques? | Agreed upon joint supervision tools and on the job mentoring are a good starting point to ongoing evaluations. |
| * Is there a plan to jointly monitor the quality of the response and address gaps that are flagged? | One way to evaluate the cluster performance in acute malnutrition could be through forming a group of nutrition cluster members to jointly visit programs with an observation checklist and return to discuss their finding with the nutrition cluster. These joint- evaluation need to be well framed and thought through but could be an effective way to identify gaps and jointly plan to address them. |
| **After the emergency** | |
| * Have the Ministry of Health and other relevant governmental bodies been leading and validating the humanitarian response? | The nutrition in emergency mechanisms need to be embedded if possible, in the government structure for a sustainable mechanism. Jointly develop a handover plan that ensure acute malnutrition management sustainability such as capacity building, resource planning, and policy support. |
| * Is acute malnutrition management integrated in routine health services in country? | Integrating the acute malnutrition management interventions in the health services is an essential step to a sustainable system. |
| * Are the nutrition acute malnutrition management indicators integrated in the Health Monitoring Information System (HMIS)? | The government lead Health Monitoring Information System would need to similarly integrate the acute malnutrition management indicators, a government-led system would need to analyze and react to the numbers by implementing corrective measure when needed. |
| * Are the medical and therapeutic food supplies budgeted and purchased as part of the national health system ongoing programs? | Although every aspect of the acute malnutrition management interventions would ideally need to be integrated within a sustainable in country system led by the government’s Ministry of Health, the possibility of handing over supply purchases will depend on the context. It is hence worth discussing with partners about the possible options in relation to transitioning to a more sustainable system. |
| Technical Working Groups |  |
| * Is the established acute malnutrition TWG led and chaired by the government? (see section above on TWG) | The government leading the TWG is one way to ensure the sustainability of the system in place. |