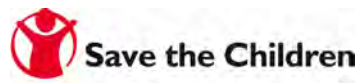
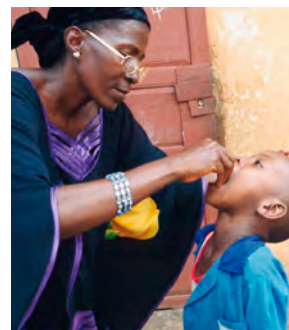


Nutrition Program Design Assistant: A Tool for Program Planners (NPDA)

Workbook

Version 2, Revised 2015



CORE Group

CORE Group fosters collaborative action and learning to improve and expand community-focused public health practices. Established in 1997 in Washington, DC, CORE Group is an independent 501(c)3 organization, and home of the Community Health Network, which brings together CORE Group member organizations, scholars, advocates, and donors to support the health of underserved mothers, children, and communities around the world.

Food and Nutrition Technical Assistance III Project (FANTA)

FANTA works to improve the health and well-being of vulnerable individuals, families, and communities in developing countries by strengthening food security and nutrition policies, programs, and systems. The project provides comprehensive technical support to the U.S. Agency for International Development (USAID) and its partners, including host country governments, international organizations, and nongovernmental organizations. FANTA works at both the country and global levels, supporting the design and implementation of programs in focus countries, and building on field experience to strengthen the evidence base, methods, and global standards for food security and nutrition programming.

Save the Children

Save the Children is the leading independent organization creating lasting change for children in need in the United States and around the world. Save the Children works to ensure the well-being and protection of children in more than 120 countries.



The original tool was made possible by the generous support of the American people through the support of the Office of Health, Infectious Diseases, and Nutrition, Bureau for Global Health, U.S. Agency for International Development (USAID) under terms of Cooperative Agreement No. GHS-A-00-05-00006-00 managed by the CORE Group and Cooperative Agreement No. AID-OAA-A-12-00005 through FANTA, managed by FHI 360.

Version 2 of the tool is made possible by the generous support of the American people through the support of the USAID Office of Health, Infectious Diseases, and Nutrition, Bureau for Global Health under terms of Cooperative Agreement No. AID- OAA-A-12-00005, through FANTA, managed by FHI 360.

The contents are the responsibility of CORE Group and FHI 360 and do not necessarily reflect the views of USAID or the United States Government.

Recommended Citation

CORE Group Nutrition Working Group, Food and Nutrition Technical Assistance III Project (FANTA), and Save the Children. 2015. "Nutrition Program Design Assistant: A Tool for Program Planners." Version 2. Washington, DC: FANTA/FHI 360.

Abstract

The Nutrition Program Design Assistant: A Tool for Program Planners helps program planning teams select appropriate community-based nutrition approaches for specific target areas. The tool has two components: 1) a reference guide that provides guidance on analyzing the nutrition situation, identifying program approaches, and selecting a combination of approaches that best suits the situation, resources, and objectives and; 2) a workbook where the team records information, decisions, and decision-making rationale.

Photos

Top left: Valerie Caldas, Courtesy of Photoshare; **Top right:** Save the Children; **Second left:** Save the Children; **Second right:** Save the Children; **Third left:** Laura Lartigue, Courtesy of Photoshare; **Third right:** Judiann McNulty; **Bottom left:** Save the Children; **Bottom right:** Pradeep Tewari, Courtesy of Photoshare

Table of Contents

ACRONYMS AND ABBREVIATIONS	III
WELCOME TO THE NUTRITION PROGRAM DESIGN ASSISTANT WORKBOOK!	1
Use of Icons	1
STEP 1. GATHER AND SYNTHESIZE INFORMATION ON THE NUTRITION SITUATION	2
Part I. Quantitative Data Collection Tables	3
Part II. Gathering Qualitative Information	15
Part III. Synthesizing Data	18
STEP 2. DETERMINE INITIAL PROGRAM GOAL, PURPOSE, AND SUB-PURPOSE(S)	41
STEP 3. REVIEW HEALTH AND NUTRITION SERVICES	47
STEP 4. PRELIMINARY PROGRAM DESIGN: PREVENTION	54
Section A. Cross-Cutting Approaches to Improve Nutritional Status	55
Section B. Infant and Young Child Feeding	59
Section C. Maternal Nutrition	61
Section D. Micronutrient Status of Children	63
Section E. Underlying Disease Burden	65
STEP 5. PRELIMINARY PROGRAM DESIGN: RECUPERATION	67
STEP 6. PUTTING IT ALL TOGETHER	70
ANNEX 1. NUTRITION PROGRAM APPROACHES: PREVENTION	80
ANNEX 2. NUTRITION PROGRAM APPROACHES: RECUPERATION	92

Acknowledgments

Many people contributed to the revision of this tool, which was coordinated by Lesley Oot and Kristen Cashin, with the Food and Nutrition Technical Assistance III Project (FANTA), and with extensive input from the technical working group, which included: Jennifer Burns, Shannon Downey, Lynette Friedman, Mary Hennigan, Joan Jennings, Justine Kavle, Sonya Kibler, Judiann McNulty, Kathryn Reider, David Shanklin, and Meredith Stakem. Additional technical input was also provided by: Bridget Aidam, Reena Borwankar, Sujata Bose, Rae Galloway, Paige Harrigan, Tara Kovach, Tina Lloren, Jennifer Nielsen, Mary Packard, Sandra Remancus, and Pamela Velez-Vega.

Many people also contributed to the development of the original tool. We want to thank the many CORE members and partners who contributed their input, guidance, and hard work to make this tool a reality. In particular, Joan Jennings developed the conceptual framework for the tool and worked iteratively with the Nutrition Working Group to draft the initial versions. Kristen Cashin, Paige Harrigan, and Lynette Walker wrote the final version with input from a variety of reviewers. The following individuals also contributed to the tool:

Bridget Aidam	Nadra Franklin	Erica Oakley
Judi Aubel	Lynette Friedman	Michel Pacque
Ferdousi Begum	Rae Galloway	Kathryn Reider
Kevin Blythe	Marcia Griffiths	Sandra Remancus
Kathryn Bolles	Mary Hennigan	Marion Roche
Erin Boyd	Justine Kavle	Houkje Ross
Jennifer Burns	Sonya Kibler	Tom Schaetzel
Judy Canahuati	Nazo Kureshy	Kavita Sethuraman
Eunyong Chung	Karen LeBan	David Shanklin
Mercedes de Onis	Tina Lloren	Meredith Stakem
Hedwig Deconinck	Carolyn MacDonald	Marianna Stephens
Shannon Downey	Kathleen MacDonald	Anne Swindale
Erin Dusch	Michael Manske	Caroline Tanner
Leslie Elder	Judiann McNulty	Joan Whelan
Rachel Elrom	Tula Michaelides	Monica Woldt
Heather Finegan	Jennifer Nielsen	Jennifer Yourkavitch

Contributing organizations included: BASICS, Catholic Relief Services, ChildFund International, Concern Worldwide, CORE Group, FANTA, The Grandmother Project, Helen Keller International, International Medical Corps, Manoff Group, Maternal and Child Integrated Program (MCHIP), Save the Children, Technical and Operational Performance Support (TOPS) project, U.S. Agency for International Development, World Health Organization, and World Vision.

In addition to those mentioned, this tool builds on the experiences and lessons learned of many individuals and organizations working with health and nutrition programs around the world. We are indebted to them for their commitment and ingenuity in creating, implementing, and evaluating nutrition programs.

We hope that this tool will enhance your own programming efforts and that you will contribute to our growing understanding of the most effective interventions and approaches for improving maternal, infant, and child nutrition.

Sincerely,

Jennifer Burns, Justine Kavle, and Kathryn Reider
The Nutrition Working Group
CORE Group

Karen LeBan, Executive Director
CORE Group

Acronyms and Abbreviations

BCC	behavior change communication
BMI	body mass index
dl	deciliter(s)
DHS	Demographic and Health Surveys
FANTA	Food and Nutrition Technical Assistance III Project
g	gram(s)
Hb	hemoglobin
HIV	human immunodeficiency virus
KPC	Knowledge, Practice, and Coverage Survey
L	liter(s)
MAM	moderate acute malnutrition
MDD-W	Minimum Dietary Diversity – Women
MICS	Multiple Indicator Cluster Survey
mm	millimeter(s)
MUAC	mid-upper arm circumference
NPDA	Nutrition Program Design Assistant
PD	Positive Deviance
PMTCT	prevention of mother-to-child transmission of HIV
ppm	parts per million
RUTF	ready-to-use therapeutic food
SAM	severe acute malnutrition
UNICEF	United Nations Children’s Fund
USAID	U.S. Agency for International Development
µg	microgram
µmol	micromole(s)

Welcome to the Nutrition Program Design Assistant Workbook!

The Nutrition Program Design Assistant: A Tool for Program Planners (NPDA) is composed of two complementary documents: this Workbook and a Reference Guide. Together, they help program design teams select the most appropriate community-based nutrition approaches for their target area. This Workbook, which provides step-by-step instructions, is where the team records key information, data, decisions, and decision-making rationale. Upon completion, the Workbook provides a record of the design process. The Reference Guide provides an introduction, information on key concepts and terminology, and reference material to guide decision-making.

Both documents include the following steps to guide teams through the design process:

- STEP ONE** **Gather and Synthesize Information on the Nutrition Situation**
- STEP TWO** **Determine Initial Program Goal, Purpose, and Sub-Purpose(s)**
- STEP THREE** **Review Health and Nutrition Services**
- STEP FOUR** **Preliminary Program Design: Prevention**
- STEP FIVE** **Preliminary Program Design: Recuperation**
- STEP SIX** **Putting It All Together**

USE OF ICONS



Write your inputs



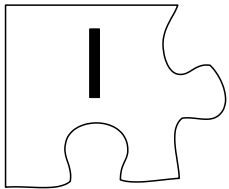
An example is given



Go to the next section

STEP 1

Overview



Gather and Synthesize Information on the Nutrition Situation

The end goals of this step are to: 1) determine whether implementation of a community-based nutrition program is warranted in the setting; 2) identify potential causes of undernutrition and key intervention areas; and 3) decide whether the program will focus on prevention-only or prevention and recuperation. To meet these goals, your team will review data on:

- Nutritional status (anthropometry)
- Infant and young child feeding
- Maternal nutrition
- Micronutrient status of children
- Underlying disease burden

Step 1 is composed of three parts.

Part I. Gathering Quantitative Information

Part I in the Workbook is centered on the Quantitative Data Collection Tables.

Quantitative data used for decision making in Step 1 is collected in this section before being transferred to Tables A-E in Step 1, Part III of the Workbook. This section is designed to both assist in original data collection, and serve as a reference for your team to remember where data came from (source and date) and how you defined the numerator and denominator.

Part II. Gathering Qualitative Information

Part II in the Workbook is centered on the Food Consumption Summary Table. Program planners should record additional qualitative data in a separate notebook.

Information gathered in this part will be used in Step 3 to document health and nutrition services and Steps 4 and 5 to consider potential approaches.

Part III. Synthesizing Data

This section is designed to facilitate data synthesis and decision-making for the five intervention areas.

STEP 1

PART I

QUANTITATIVE DATA COLLECTION TABLES

Complete as much of the tables as you are able, focusing especially on numbered indicators. We anticipate that NPDA users will have some sources of secondary data available to draw from, but in some cases primary data collection will be necessary as part of a rapid survey to help inform program design.

The indicators selected for the tables are the result of an extensive consultative process that took into account the recommendations and consensus from a range of nutrition experts. Standardized indicator titles and definitions are used, and they were selected from those indicators used in the U.S. Agency for International Development's (USAID's) Demographic and Health Surveys (DHS) and Knowledge, Practice, and Coverage (KPC) surveys, and UNICEF's Multiple Indicator Cluster Survey (MICS). The numbered indicators have corresponding decision-making guidance in Step 1, Part III of the Workbook and Reference Guide when the data is synthesized. Non-numbered indicators are additional indicators that may be useful for your team to consider, but do not have corresponding guidance.

It may look daunting at first, but it will be useful to have many of the key nutrition indicator results in one place and it will aid decision making and in developing a monitoring and evaluation plan.

INSTRUCTIONS FOR GATHERING QUANTITATIVE INFORMATION

1. **Review Step 1 in the Reference Guide** on Gathering Quantitative Information
2. Use the Quantitative Data Collection Tables to:
 - a. **Determine the key indicators that your project will gather.** The numbered indicators in each table represent those that will be used throughout the Workbook and have complementary guidance in Step 1, Part III of the Reference Guide. Alternate indicators can be substituted if the indicators listed are not available. In many cases, other useful or complementary indicators are listed for each section. These indicators will not be analyzed in this tool, but represent additional information that may be useful to your team.
 - b. **Note the exact formulation of the indicator you are using.** The indicators in this section are primarily standard indicators taken from the MICS, DHS, and KPC. Your team may gather data from other sources that use slightly different forms of these same indicators (e.g., a different age range) or the funding source for your project may have different indicator requirements.
 - c. **Note the general trend of the indicator you are using.** Note if the trend is either increasing or decreasing. If there are any relevant comments to include about the trend of the indicator, please include in them in the next column (e.g., the level of trend data available/used—national, regional, or provincial; information on geographic or regional differences; magnitude of change; etc.).
 - d. **Note the source of the data** (e.g., DHS, Ministry of Health, World Food Programme, nongovernmental organization monitoring data) **and the date** the data was originally collected or compiled (e.g., DHS from 2007). This information will be helpful for communication among the design team members when many people are involved in the program design process.

- e. **Determine the level of disaggregation** useful to your project and record the data accordingly. It can be very informative to separate data and review trends. This document includes columns to enable disaggregating of data by various parameters including geographic area, sex, age, and income level. Your team is encouraged to use the Microsoft Excel version of this table to manipulate the columns as you see fit to add or subtract these parameters. There are several columns provided for disaggregation by geographic level. Please adjust the titles of these columns to make the data most useful to your project area. If you have not already determined a geographic target area, these columns can be used to collect data across several areas (e.g., districts) to determine the location of greatest need.
- f. **Record** the data.



QUANTITATIVE DATA COLLECTION TABLE A NUTRITIONAL STATUS (ANTHROPOMETRY)

INTERVENTION AREA	GEOGRAPHIC			SOCIO-ECONOMIC LEVEL Lowest Wealth Quintile	SEX		OTHER PERTINENT DISAGGREGATION	Data Trend Direction Increase or Decrease	Comments or Notes on Trends ¹	Data Source(s) and Dates
	% National Level	% Province	% District		M	F				
A. NUTRITIONAL STATUS (ANTHROPOMETRY)²										
A1. Stunting: % of children __ - __ months of age that are stunted (height-for-age < -2 z-scores)										
A2. Underweight: % of children __ - __ months of age that are underweight (weight-for-age < -2 z-scores)										
A3. Moderate acute malnutrition (MAM): % of children ____ to ____ months of age that are moderately wasted (weight-for-height < -2 and ≥ -3 z-scores) Alternate indicator: % of children 6–59 months with mid-upper arm circumference (MUAC) < 125 mm and ≥ 115 mm										
A4. Severe acute malnutrition (SAM): % of children __ - __ months of age with SAM (weight-for-height < -3 z-scores, bilateral pitting edema, or MUAC < 115 mm) ³										
Other:										

¹ In this column note level of trend data (i.e., national, regional, provincial) and other relevant information on the trend of the indicator such as geographic differences or magnitude of change.

² In this table the age range has been left intentionally blank. Although the 0–23 month age range is considered critical, you may have a different target age group depending on the project. Additionally, the data available to you at an early programming stage may be for an age group different from your project’s target age group. Be sure to indicate the age ranges that that data actually represents.

³ Severe wasting is often used to determine population-level prevalence of SAM, because wasting data is more likely to be available at the population level than MUAC or bilateral pitting edema. The age range for measuring MUAC in children is 6 months and older.



QUANTITATIVE DATA COLLECTION TABLE B

INFANT AND YOUNG CHILD FEEDING

INTERVENTION AREA	GEOGRAPHIC			SOCIO-ECONOMIC LEVEL Lowest Wealth Quintile	SEX		OTHER PERTINENT DISAGGREGATION	Data Trend Direction Increase or Decrease	Comments or Notes on Trends ⁴	Data Source(s) and Dates
	% National Level	% Province	% District		M	F				
B. INFANT AND YOUNG CHILD FEEDING⁵										
B1. % of children born in the last 24 months who were put to the breast within one hour of birth										
B2. % of children 0–23 months of age who received a pre-lacteal feeding ⁶										
B3. % of infants 0–5 months of age who are fed exclusively with breast milk										
B4. % of children 12–15 months of age who are fed breast milk										
B5. % of infants 6–8 months of age who receive solid, semi-solid, or soft foods										
B6. % of breastfed and non-breastfed children 6–23 months of age who receive solid, semi-solid, or soft foods ⁷ the minimum number of times ⁸ or more										
B7. % of children 6–23 months of age who receive foods from four or more of seven food groups (grains, roots, and tubers; legumes and nuts; dairy products; meat, fish, and poultry; eggs; vitamin-A rich fruits and vegetables; and other fruits and vegetables)										
B8. % of children 6–23 months of age who receive a minimum acceptable diet (apart from breast milk) ⁹										
B9. % of sick children 0–23 months of age who received increased fluids and continued feeding during diarrhea in the two weeks prior to the survey (Note: fluid is breast milk only in children under 6 months of age)										

⁴ In this column note level of trend data (i.e., national, regional, provincial) and other relevant information on the trend of the indicator such as geographic differences or magnitude of change.

⁵ Indicator definitions can be found in the World Health Organization’s “[Indicators for Assessing Infant and Young Child Feeding Practices Part 1: Definitions](#).” Additional publications on how to measure the indicators and country profiles are also available in [Part II: Measurement](#) and [Part III: Country Profiles](#).

⁶ Pre-lacteal feeds include any food or liquid other than breast milk given to a child in the first 3 days of life.

⁷ Includes milk feeds for non-breastfed children.

⁸ Minimum is based on age and breastfeeding status: 2 times for breastfed child 6–8 months; 3 times for breastfed child 9–23 months; and 4 times for non-breastfed child 6–23 months.

⁹ The indicator is a composite of minimum dietary diversity and minimum meal frequency.

INTERVENTION AREA	GEOGRAPHIC			SOCIO-ECONOMIC LEVEL Lowest Wealth Quintile	SEX		OTHER PERTINENT DISAGGREGATION	Data Trend Direction	Comments or Notes on Trends ⁴	Data Source(s) and Dates
	% National Level	% Province	% District		M	F		Increase or Decrease		
B. INFANT AND YOUNG CHILD FEEDING⁵										
B10. % of children 6–23 months of age with diarrhea in the last two weeks who were offered the same amount or more food during the illness										
OTHER USEFUL INDICATORS										
Median duration of continued breastfeeding among children under 36 months of age										
% of children 6–23 months of age who ate vitamin A-rich foods in the past 24 hours										
% of children 6–23 months of age who ate iron-rich foods in the past 24 hours										
Other:										



QUANTITATIVE DATA COLLECTION TABLE C

MATERNAL NUTRITION

INTERVENTION AREA	GEOGRAPHIC			SOCIO-ECONOMIC LEVEL Lowest Wealth Quintile	SEX		OTHER PERTINENT DISAGGREGATION	Data Trend Direction Increase or Decrease	Comments or Notes on Trends ¹⁰	Data Source(s) and Dates
	% National Level	% Province	% District		M	F				
C. MATERNAL NUTRITION										
C1. % of newborns with low birth weight (< 2,500 g) ¹¹ Alternate indicator: % of newborns with low birth weight (mother's report of baby being "very small at birth")										
C2. % of non-pregnant women of reproductive age (15–49 years of age) with low BMI (< 18.5)										
C3. % of children 0–23 months of age stunted (height-for-age < -2 z-scores) ¹²										
C4. % of women of reproductive age (15–49 years) with vitamin A deficiency (serum retinol values ≤ .70 µmol/l) ¹³ Alternate indicator: % of mothers of children 0–23 months of age reporting night blindness during last pregnancy Alternative Indicator: % of pregnant women with night blindness										
C5. % of mothers of children 6–59 months of age who received high-dose vitamin A supplement within 8 weeks postpartum (6 weeks if not exclusively breastfeeding) ¹⁴										
C6. % of women of reproductive age (15–49 years) with anemia (Hb < 11 g/dl for pregnant women; < 12 g/dl for non-pregnant women)										

¹⁰ In this column note level of trend data (i.e., national, regional, provincial) and other relevant information on the trend of the indicator such as geographic differences or magnitude of change.

¹¹ Depending on the percentage of children delivered in health facilities, this Ministry of Health data may underestimate the prevalence of low birth weight. This first indicator is preferred, but the alternate indicator may provide useful information where most babies are delivered at home. If possible, use both indicators to get as clear a picture as possible.

¹² This indicator is included here as there is a direct link between maternal nutrition and childhood stunting; insert data from Indicator A1 in Table A, noting that the age groups may be different.

¹³ This main indicator is preferred, however if information for this indicator does not exist or is insufficient, use the alternate indicator.

¹⁴ According to 2011 World Health Organization guidelines, "Vitamin A Supplementation in Postpartum Women," vitamin A supplementation in postpartum women is not recommended as a public health intervention for the prevention of maternal and infant morbidity and mortality, but adequate dietary intake of vitamin A-rich foods should be promoted in the postpartum period. However, as some countries still do postpartum supplementation, it will be important to check the country guidelines to see if they have adopted the 2011 guidelines.

INTERVENTION AREA	GEOGRAPHIC			SOCIO-ECONOMIC LEVEL Lowest Wealth Quintile	SEX		OTHER PERTINENT DISAGGREGATION	Data Trend Direction Increase or Decrease	Comments or Notes on Trends ¹⁰	Data Source(s) and Dates
	% National Level	% Province	% District		M	F				
C. MATERNAL NUTRITION										
C7. % of women 15–49 years of age with a birth in the 5 years preceding the survey who took iron tablets/syrup for 90 or more days during pregnancy for most recent birth or iron/folic acid during pregnancy for the most recent birth										
C8. % of households consuming adequately iodized salt (20–40 ppm)										
C9. Median urinary iodine concentration for pregnant women (<i>for this indicator please note the median instead of the percent and notate that this is not a percentage</i>)										
C10. Median urinary iodine concentration of children under 2 years of age, women, and lactating women (<i>for this indicator please note the median instead of the percent and notate that this is not a percentage</i>)										
C11. % of women of reproductive age in the project area who are consuming minimum dietary diversity (5 of 10 food groups). Food groups include: 1) all starchy staple foods, 2) beans and peas, 3) nuts and seeds, 4) dairy, 5) flesh foods, 6) eggs, 7) vitamin A-rich dark green leafy vegetables, 8) other vitamin A-rich vegetables and fruits, 9) other vegetables, and 10) other fruits.										
OTHER USEFUL INDICATORS										
Rates of anemia in women of reproductive age (15–49 years) based on severity: <ul style="list-style-type: none"> Mild (Hb 10.0–11.0 g/dl for pregnant women; 10.0–12.0 g/dl for non-pregnant women) Moderate (Hb 7.0–9.9 dl for pregnant and non-pregnant women) Severe (Hb < 7.0 g/dl for pregnant and non-pregnant women) 										
% of mothers of children 0–23 months of age who took iron/folic acid supplements while pregnant with youngest child										
% of women that consumed at least 1 additional serving of staple food during last pregnancy										

INTERVENTION AREA	GEOGRAPHIC			SOCIO-ECONOMIC LEVEL Lowest Wealth Quintile	SEX		OTHER PERTINENT DISAGGREGATION	Data Trend Direction Increase or Decrease	Comments or Notes on Trends ¹⁰	Data Source(s) and Dates
	% National Level	% Province	% District		M	F				
C. MATERNAL NUTRITION										
% of women that consumed at least 1–2 additional servings of staple food during last lactation										
% of mothers of children 0–59 months of age who took deworming medication during the pregnancy										
% of mothers of children 0–59 months of age who received intermittent preventive treatment for malaria during the pregnancy for their last live birth										
% of non-pregnant women of reproductive age (15–49 years) with high BMI (overweight or obese) (≥ 25.0)										



QUANTITATIVE DATA COLLECTION TABLE D

MICRONUTRIENT STATUS OF CHILDREN

INTERVENTION AREA	GEOGRAPHIC			SOCIO-ECONOMIC LEVEL	SEX		OTHER PERTINENT DISAGGREGATION	Data Trend Direction	Comments or Notes on Trends ¹⁵	Data Source(s) and Dates
	% National Level	% Province	% District	Lowest Wealth Quintile	M	F		Increase or Decrease		
D. MICRONUTRIENT STATUS OF CHILDREN¹⁶										
D1. % of children 6–59 months of age with vitamin A deficiency (serum retinol values $\leq .70 \mu\text{mol/l}$) Alternate indicator: % of children 24–71 months of age with night blindness										
D2. % of children 6–59 months of age who have received vitamin A supplementation in previous 6 months										
D3. % of children 6–59 months of age with anemia (Hb $< 11 \text{ g/dl}$)										
D4. % of children 6–23 months of age receiving iron supplements or micronutrient powders yesterday										
D5. % of children 12–59 months of age receiving deworming medication in the previous 6 months										
D6. % of households consuming adequately iodized salt (20–40 ppm)										
D7. Median urinary iodine concentration in children 0–59 months ($\mu\text{g/l}$)										
OTHER USEFUL INDICATORS										
% of children 12–59 months of age receiving twice-yearly deworming medication										
% of children 6–59 months of age given iron supplements in the past 7 days										
Other:										

¹⁵ In this column note level of trend data (i.e., national, regional, provincial) and other relevant information on the trend of the indicator such as geographic differences or magnitude of change.

¹⁶ Note that data are not gathered on the use of zinc, as there are not established tests for zinc deficiency, nor protocols for zinc supplementation. Use of zinc in the treatment of diarrhea would be part of an intervention for the control of diarrheal disease.



QUANTITATIVE DATA COLLECTION TABLE E

UNDERLYING DISEASE BURDEN

INTERVENTION AREA	GEOGRAPHIC			SOCIO-ECONOMIC LEVEL Lowest Wealth Quintile	SEX		OTHER PERTINENT DISAGGREGATION	Data Trend Direction Increase or Decrease	Comments or Notes on Trends ¹⁷	Data Source(s) and Dates
	% National Level	% Province	% District		M	F				
E. UNDERLYING DISEASE BURDEN										
E1. % of children 0–23 months of age with diarrhea in last 2 weeks										
E2. % of children 0–23 months of age with diarrhea in last 2 weeks who received oral rehydration solution and/or recommended home fluids										
E3. % children under 5 years of age who had diarrhea in the 2 weeks preceding the survey, who received zinc supplements as treatment										
E4. % of children 0–23 months of age with chest-related cough and fast or difficult breathing in the last 2 weeks										
E5. % of children 0–23 months of age with chest-related cough and fast or difficult breathing in the last 2 weeks who were taken to an appropriate health provider										
E6. % of children with fever in the past 2 weeks (in malaria zones)										
E7. % of children 0–23 months of age with a fever during the last 2 weeks, and treated with an effective anti-malarial drug within 24 hours										
E8. % of children 0–23 months of age who are HIV positive ¹⁸										

¹⁷ In this column note level of trend data (i.e., national, regional, provincial) and other relevant information on the trend of the indicator such as geographic differences or magnitude of change.

¹⁸ Notes on HIV data:

- Availability of data on HIV varies among countries and communities, and depends on availability and participation in HIV testing. When there is a lack of accurate quantitative data, nutrition program planners can speak with health officials and health care providers, as well as staff at National AIDS Control Programs to find out whether they consider HIV to be a problem in the program area.
- Because data on HIV prevalence of children are unlikely to be available in most areas, program designers can consider using data on the percent of pregnant women who are HIV positive. Be aware that this may result in an overestimation of HIV in the general population.
- Accurate data for adults may be available through voluntary counseling and testing or antenatal care services. (If a high percentage of adults are HIV positive, a high percentage of children are likely to be at risk.)
- The gender ratio of infected adults may help determine the proportion of children affected by HIV. (If more women than men are infected, children are likely at higher risk.)
- In areas where people do not know their HIV status, chronic illness or tuberculosis infection may serve as a proxy for HIV infection. Additionally, high prevalence of chronic illness among adults will put the children they care for at risk.

INTERVENTION AREA	GEOGRAPHIC			SOCIO-ECONOMIC LEVEL Lowest Wealth Quintile	SEX		OTHER PERTINENT DISAGGREGATION	Data Trend Direction Increase or Decrease	Comments or Notes on Trends ¹⁷	Data Source(s) and Dates
	% National Level	% Province	% District		M	F				
E. UNDERLYING DISEASE BURDEN										
Alternate indicators:										
<ul style="list-style-type: none"> • % of children with mothers who are HIV positive; or • % of pregnant women who are HIV positive; or • % of women 15–49 years of age who are HIV positive; or • % of children 6–23 months of age who are enrolled in prevention of mother-to-child transmission of HIV (PMTCT) services 										
E9. % of children 12–23 months of age fully immunized by 12 months according to country guidelines										
OTHER USEFUL INDICATORS										
% of mothers of children 0–23 months of age who received at least 2 tetanus toxoid vaccines before the birth of the youngest child										
% of children 0–23 months of age whose births were attended by skilled personnel										
% of children 12–23 months of age who received DPT3 according to vaccination card										
% of children 12–23 months of age who received DPT3 according to mother’s recall										
% of children 12–23 months of age who received measles vaccine										
% of households with children 0–23 months of age that treat water effectively										
% of mothers of children 0–23 months of age who live in a household with soap at the location for handwashing										
% of households with access to safe water (or improved water source)										
% of households with access to improved sanitation										
% of children delivered by:										
Doctor										
Other health professional										
Traditional birth attendant										
Other										

INTERVENTION AREA	GEOGRAPHIC			SOCIO-ECONOMIC LEVEL	SEX		OTHER PERTINENT DISAGGREGATION	Data Trend Direction	Comments or Notes on Trends ¹⁷	Data Source(s) and Dates
	% National Level	% Province	% District		Lowest Wealth Quintile	M				
E. UNDERLYING DISEASE BURDEN										
% of deliveries at:										
Health facility										
Home										
Other										
% of households with at least one insecticide-treated bednet										
% of children under 5 years of age who slept under an insecticide-treated bednet the night before the interview										
% of pregnant women 15–49 years of age who slept under an insecticide-treated bednet the night before the interview										
% of mothers of children 0–59 months of age who received intermittent preventive treatment for malaria during the pregnancy for their last live birth										
Other:										



Proceed to Step 1, Part II. Gathering Qualitative Information

STEP 1

PART II

GATHERING QUALITATIVE INFORMATION

INSTRUCTIONS FOR GATHERING QUALITATIVE INFORMATION

1. **Review the information** on gathering qualitative information, starting on page 22 of the Reference Guide.
2. **Collect and record data specifically related to food consumption** in the Food Consumption Summary Table in the Workbook below.
3. **Determine your needs for additional qualitative data gathering** based on the information provided in “Qualitative Data to Collect” on pages 22–23 of the Reference Guide.
4. **Collect the additional pertinent qualitative data and record the results** in a separate notebook or data file.
5. **Keep the qualitative information** available as you proceed through the rest of this program design tool. Share your findings and impressions with other members of the program design team to compare your preliminary findings and learn from their experiences.

Food Consumption Summary Table

It is important to have as much information as possible about what the target populations are eating (and not eating) on a regular basis and the factors influencing why.

There is extensive and specialized guidance and experience in collecting and analyzing data related to food consumption (intake),¹⁹ its availability (both locally produced and available in local markets), and accessibility (e.g., can the target population afford these types of foods; have food prices recently gone up dramatically; are there discrimination patterns in the household that make it more difficult for certain household members, usually women and/or young children, to consume these foods). The following below presents **one way** to summarize the information and NPDA users are encouraged to modify this table using the Microsoft Excel file found at <http://coregroup.org/NPDA2015>. The food group categories are organized according to those in Module 6 of the [Knowledge, Practices, and Coverage survey](#) and also line up with the Essential Nutrition Actions.

¹⁹ Swindale, A. and Ohri-Vachaspati, P. 2005. *Measuring Household Food Consumption: A Technical Guide*. Washington, DC: FANTA.



FOOD CONSUMPTION SUMMARY TABLE

Food Groups	Percentage of children 6–24 months consuming these types of food in the last 24 hours ²⁰	Are these foods available in local markets? ²¹ Y/N (Note seasonal patterns)	Are these foods accessible, especially to those living in the lowest wealth quintile? Y/N (Note seasonal patterns)	Is this food generally consumed by women?	Is it generally fed to children?	Are there any beliefs associated with this type of food?	Other comments/ notes:
Foods made from grains (millet, sorghum, maize, rice, wheat, other local grains, noodles, bread, etc.); <i>(note it is expected that these foods are not fortified; these are recorded below)</i>							
Fortified commercially available baby food (for complementary feeding of children 6–24 months)				N/A			
Vitamin A-rich fruits and vegetables							
Other fruits and vegetables							
Food made from roots and tubers							
Food made from legumes and nuts							
Animal-source foods: meat, fish, poultry, liver, kidneys, eggs, and/or unique wild animals such as insects, mice, small birds, etc.							
Cheese, yogurt, and other milk products							

²⁰ This column includes information that would come from a DHS and/or KPC survey. Such information may not always be available to NPDA users. A 24-hour recall is indicated here, but not all food consumption data will be presented according to a 24-hour recall period. If you have quantitative food consumption data that covers different time frames, e.g., the last week or past 15 days, use that data to help understand the dietary patterns in the program area. Sometimes the information available to program design teams may relate to the entire household or select members of the household, and it is important to make distinctions. In the case of DHS surveys, the data relates to feeding practices of children 6–24 months. While collecting detailed household-level food consumption data generally goes beyond the scale of what is needed in preliminary program design, it is highly recommended to conduct focus groups and other forms of local qualitative data collection to get a better understanding of the dietary patterns in the target population(s), with the understanding that substantially more formative research would follow. Based on the information that is available, the program design team may choose to adapt the table. For example, a simpler way to present and summarize the information may be to ask: *Is this type of food consumed in the household every day (Yes or No)?* and work from there.

²¹ Knowing seasonal patterns and factors related to overall food availability, such as when particular foods are plentiful (and not plentiful) during the year in local markets, in what months/times do foods become more expensive, and the harvest schedules, etc., will help in program design.

Food Groups	Percentage of children 6–24 months consuming these types of food in the last 24 hours ²⁰	Are these foods available in local markets? ²¹ Y/N (Note seasonal patterns)	Are these foods accessible, especially to those living in the lowest wealth quintile? Y/N (Note seasonal patterns)	Is this food generally consumed by women?	Is it generally fed to children?	Are there any beliefs associated with this type of food?	Other comments/ notes:
Any other foods fortified with vitamin A, iron, or other micronutrient(s)							
Foods made with oil, fat, or butter							
Sugary foods (candies, sweets, biscuits, etc.)							
Tea and/or coffee							
Other liquids (including soft drinks)							
Commercially prepared infant formula (for infants and young children)				N/A			



Proceed to Step 1, Part III. Synthesizing Data

STEP 1

PART III

SYNTHESIZING DATA

In Step 1, Part III, the team will review the quantitative and qualitative data gathered and synthesize the data.

INSTRUCTIONS FOR SYNTHESIZING DATA

1. **Fill in the columns labeled “Data” in Tables A–E in Sections A–E.** Copy the indicator value from the Quantitative Data Collection Tables in Step 1, Part 1 for each indicator for the target geographic area.
2. **Record any pertinent observations in the column titled “Comments on Data.”** Observations could include differences in data for males and females, trends over time, seasonality, data quality, or insights based on the qualitative information the team has gathered.
3. **Review Step 1, Part III. Synthesizing Data in the Reference Guide,** which provides guidance for understanding the data provided for each section.
4. **In the Workbook, rank the level of public health concern for each indicator** based on the guidance provided. The cutoffs represent a suggested framework; they are not firm. Where the data is on the borderline of a cutoff point, discuss the situation as a team and use your professional judgment in making your assessments of the level of public health concern.
5. **Discuss and answer the questions** provided after each table in the Workbook in Sections A–E to better understand the implications of the data.
6. **Determine if the data for each intervention area indicate that it is a key public health concern.**
7. **Mark your decision in the conclusion box and explain your rationale in the summary box** at the end of Sections A–E in the Workbook.



An example with all tables and questions completed for Section B is provided on pages 29–32 of the Reference Guide.

Section A. Synthesizing the Data on Nutritional Status (Anthropometry)



TABLE A

ANALYZING DATA ON NUTRITIONAL STATUS (ANTHROPOMETRY)

INDICATORS	DATA (Fill in from Quantitative Data Collection Table)	COMMENTS ON DATA	LEVEL OF PUBLIC HEALTH CONCERN	REFERENCE FOR PUBLIC HEALTH CONCERN
A1. Stunting: % of children ____ to ____ months of age that are stunted (height-for-age < -2 z-scores)				<ul style="list-style-type: none"> • < 20%: Low • 20–29%: Medium • 30–39%: High • ≥ 40%: Very High
A2. Underweight: % of children ____ to ____ months of age that are underweight (weight-for-age < -2 z-scores)				<ul style="list-style-type: none"> • < 10%: Low • 10–19%: Medium • 20–29%: High • ≥ 30%: Very High
A3. Moderate acute malnutrition (MAM): % of children ____ to ____ months of age that are moderately wasted (weight-for-height < -2 and ≥ -3 z-scores) ²² Alternate indicator: % of children 6–59 months with MUAC < 125 mm and ≥ 115 mm				<ul style="list-style-type: none"> • < 5%: Low • 5–9%: Medium • 10–14%: High • ≥ 15%: Very High
A4. Severe acute malnutrition (SAM): % of children ____ to ____ months of age with SAM (weight-for-height < -3 z-scores, bilateral pitting edema, or MUAC < 115 mm) ²³				<ul style="list-style-type: none"> • > 0.5%: Medium • ≥ 1%: High

²² The reference for public health concern is for weight-for-height < -2 z-scores and not just moderate wasting, so please also add the prevalence from A4 to obtain the public health significance level. The reference is also not reflective of MUAC as there are currently no public health significance cut-offs for MUAC.

²³ Severe wasting is often used to determine population-level prevalence of SAM because wasting data is more likely to be available at the population level than MUAC or bilateral pitting edema. The SAM cut-offs listed here are not internationally established. They are a programmatic guideline to indicate that if there is a significant number of cases, or indication that cases might increase, organizations should consider taking action to support the health system to handle the caseload. The age range for measuring MUAC in children is 6 months and older.



SYNTHESIS OF DATA ON NUTRITIONAL STATUS (ANTHROPOMETRY)

Are there any patterns among the indicators? Are you aware of any other considerations, such as seasonal variations in food security, trends over time, aggravating factors (e.g., conflict, weather, disease outbreaks), or the potential for increased risk in the immediate future?

Do any of the indicators concern you more than others? If so, which and why?

Looking at the detailed Quantitative Data Collection tables in Step 1, is there any additional information to take into consideration when designing nutrition activities?

Are there any marginalized or vulnerable groups that might need extra attention or specific strategies to reach them? If so, describe who they are and why they are vulnerable.

How do community or household gender issues and cultural or religious factors (such as fasting) affect the overall nutrition situation (see Reference Guide pages 16–17)?

How do other factors (if present) such as alcoholism, maternal depression, domestic violence, etc. affect the overall nutrition situation?

Other thoughts?



QUESTIONS ON THE IMPLICATIONS OF NUTRITIONAL STATUS (ANTHROPOMETRY)

<p>Is a preventive community-based nutrition program indicated?</p> <p>1. Is stunting prevalence medium (20–29%), high (30–39%), or very high ($\geq 40\%$)? _____</p> <p>2. Is underweight prevalence medium (10–19%), high (20–29%), or very high ($\geq 30\%$)? _____</p>	<p>If yes to 1 or 2, focus on prevention for both women and children (priority intervention areas are identified in sections B–E)</p>
<p>Are recuperative approaches indicated in addition to preventive approaches?</p> <p>1. Is underweight prevalence very high ($\geq 30\%$)? _____</p> <p>2. Is acute malnutrition (MAM + SAM) prevalence high (10–14%) or very high (≥ 15) in your target area?²⁴ _____</p> <p>3. Is prevalence of SAM high ($\geq 1\%$)? _____</p> <p>4. Is MAM + SAM prevalence medium (5–9%) or prevalence of SAM medium ($> 0.5\%$) with any of the following aggravating factors?²⁵</p> <ul style="list-style-type: none"> <input type="checkbox"/> Large-scale population movement and/or sudden large surge of new SAM cases <input type="checkbox"/> Food crisis <input type="checkbox"/> Epidemic/outbreak (e.g., measles, whooping cough, diarrheal disease, malaria) <input type="checkbox"/> Crude death rate $> 1/10,000/\text{day}$ <input type="checkbox"/> High prevalence of maternal mortality <input type="checkbox"/> High prevalence of child mortality <input type="checkbox"/> SAM rates above seasonal norms 	<p>If yes to 1, 2, 3, or 4, recuperation is indicated along with prevention. (considerations for the design of recuperative interventions are addressed in Step 5)</p> <p>Aggravating factors may indicate need for a recuperative approach despite lower levels of public health concern.</p>

²⁴ For this question combine the prevalence of A3 and A4.

²⁵ For this question combine the prevalence of A3 and A4.

Consider all of the information above to determine if this is a priority intervention area. Mark your conclusion next and explain your rationale.



CONCLUSION ON THE SYNTHESIS OF DATA ON NUTRITIONAL STATUS (ANTHROPOMETRY)

Is a preventive community-based nutrition program indicated? Check all areas that apply:

Stunting Underweight

Is a recuperative approach indicated in addition?

Severe acute malnutrition (SAM) Moderate acute malnutrition (MAM) Underweight

Your program's focus:

Prevention Prevention + Recuperation



SUMMARY OF RATIONALE FOR THE CONCLUSION ON THE SYNTHESIS OF DATA ON NUTRITIONAL STATUS (ANTHROPOMETRY)



If you have determined that a preventive or preventive + recuperative community-based nutrition program is necessary, record your rationale and answer in the Conclusion Box in Section A of the Workbook and proceed to Section B. Infant and Young Child Feeding Practices. If you have determined that a community-based program nutrition program is not necessary, then the team may stop here and look at other priority areas for improving child health.

Section B. Synthesizing the Data on Infant and Young Child Feeding



TABLE B

ANALYZING DATA ON INFANT AND YOUNG CHILD FEEDING

	DATA (Fill in from Quantitative Data Collection Table)	COMMENTS ON DATA	LEVEL OF PUBLIC HEALTH CONCERN	REFERENCE FOR PUBLIC HEALTH CONCERN
INDICATOR: BREASTFEEDING				
B1. % of children born in the last 24 months who were put to the breast within one hour of birth				< 80% is generally a priority. Discuss high, medium, and low designations as a group.
B2. % of children 0–23 months of age who received a pre-lacteal feeding				> 20% is generally a priority. Discuss high, medium, and low designations as a group.
B3. % of infants 0–5 months of age who are fed exclusively with breast milk				< 80% is generally a priority. Discuss high, medium, and low designations as a group.
INDICATOR: YOUNG CHILD FEEDING				
B4. % of children 12–15 months of age who are fed breast milk				< 80% is generally a priority. Discuss high, medium, and low designations as a group.
B5. % of infants 6–8 months of age who receive solid, semi-solid, or soft foods				< 80% is generally a priority. Discuss high, medium, and low designations as a group.
B6. % of breastfed and non-breastfed children 6–23 months of age who receive solid, semi-solid, or soft foods (but also including milk feeds for non-breastfed children) a minimum number of times or more (two times for breastfed infants 6–8 months, three times for breastfed children 9–23 months, and four times for non-breastfed children 6–23 months)				< 80% is generally a priority. Discuss high, medium, and low designations as a group.
B7. % of children 6–23 months of age who receive foods from four or more of seven food groups (grains, roots, and tubers; legumes and nuts; dairy products; meat, fish, and poultry; eggs; vitamin-A rich fruits and vegetables; and other fruits and vegetables).				< 80% is generally a priority. Discuss high, medium, and low designations as a group.

	DATA (Fill in from Quantitative Data Collection Table)	COMMENTS ON DATA	LEVEL OF PUBLIC HEALTH CONCERN	REFERENCE FOR PUBLIC HEALTH CONCERN
B8. % of children 6–23 months of age who receive a minimum acceptable diet (apart from breast milk). The indicator is a composite of minimum dietary diversity and minimum meal frequency.				< 80% is generally a priority. Discuss high, medium, and low designations as a group.
INDICATOR: FEEDING OF SICK CHILDREN				
B9. % of sick children 0–23 months of age who received increased fluids and continued feeding during diarrhea in the two weeks prior to the survey (note: fluid is breast milk only in children under 6 months)				< 80% is generally a priority. Discuss high, medium, and low designations as a group.
B10. % of children 6–23 months of age with diarrhea in the last two weeks who were offered the same amount or more food during the illness				< 80% is generally a priority. Discuss high, medium, and low designations as a group.



SYNTHESIS OF DATA ON INFANT AND YOUNG CHILD FEEDING

Are there any patterns among the indicators? Are you aware of any other considerations, such as seasonal variations in food security, trends over time, aggravating factors (e.g., conflict, weather, disease outbreaks), or the potential for increased risk in the immediate future?

Do any of the indicators or practices concern you more than others? If so, which and why? (Qualitative information may be useful here as well)

- Among recommended breastfeeding practices?
- Among recommended complementary feeding practices? (Note: any available information on quality and consistency/texture/thickness of complementary foods would be useful here, too)
- Among recommended practices for feeding of the sick child?

Looking at the detailed Quantitative Data Collection Table and the qualitative data you gathered in Parts 1 and 2, is there any additional information to take into consideration when understanding the nutrition situation related to infant and young child feeding?

Are there any marginalized or vulnerable groups that might need extra attention or specific strategies to reach them? If so, describe who they are and why they are vulnerable.

How do community or household gender issues and cultural or religious factors affect the overall nutrition situation related to infant and young child feeding? (see Reference Guide pages 16–17)

How do other factors (if present) such as alcoholism, maternal depression, domestic violence, etc. affect the overall nutrition situation related to infant and young child feeding?

Other thoughts?

Consider all of the information above to determine if this is a priority intervention area. Mark your conclusion next and explain your rationale.



CONCLUSION ON THE SYNTHESIS OF DATA ON INFANT AND YOUNG CHILD FEEDING

Which interventions in infant and young child feeding are indicated? Check all areas that apply:

Breastfeeding: Immediate initiation Preventing use of pre-lacteals Exclusive breastfeeding Continued breastfeeding

Complementary feeding: Timely introduction Diversity Frequency

Feeding of sick children: Offered more fluids during illness Offered same or more food during illness Offered more after illness

Notes on other considerations/additional info needed?

If there are many (or all) selected above, are there any specific practices that your program might wish to prioritize additional or extra efforts toward behavior change? If yes, note below:



SUMMARY OF RATIONALE FOR THE CONCLUSIONS ON THE SYNTHESIS OF DATA ON INFANT AND YOUNG CHILD FEEDING



Proceed to Section C. Maternal Nutrition

Section C. Synthesizing the Data on Maternal Nutrition



TABLE C

ANALYZING DATA ON MATERNAL NUTRITION

	DATA (Fill in from Quantitative Data Collection Table)	COMMENTS ON DATA	LEVEL OF PUBLIC HEALTH CONCERN	REFERENCE FOR PUBLIC HEALTH CONCERN
INDICATOR: ANTHROPOMETRY				
C1. % of newborns with low birth weight (< 2,500 g) Alternate indicator: % of newborns with low birth weight (mother's report of baby being "very small at birth")				≥ 15%: Concern
C2. % of non-pregnant women of reproductive age (15–49 years) with low BMI (< 18.5)				<ul style="list-style-type: none"> • 5–9.9%: Low • 10–19.9%: Medium • 20–39.9%: High • ≥ 40%: Very High
C3. % of children 0–23 months of age stunted (height-for-age < -2 z-scores)				<ul style="list-style-type: none"> • < 20%: Low • 20–29%: Medium • 30–39%: High • ≥ 40%: Very High
INDICATOR: VITAMIN A				
C4. % of women of reproductive age (15–49 years) with vitamin A deficiency (serum retinol values ≤ .70 μmol/l) Alternate indicator: % of mothers of children 0–23 months of age reporting night blindness during last pregnancy Alternative Indicator: % of pregnant women with night blindness				<ul style="list-style-type: none"> • < 2%: Normal • 2.0–9.9%: Low • 10.0–19.9%: Medium • ≥ 20%: High Alternate indicators: <ul style="list-style-type: none"> • ≥ 5%: Concern

	DATA (Fill in from Quantitative Data Collection Table)	COMMENTS ON DATA	LEVEL OF PUBLIC HEALTH CONCERN	REFERENCE FOR PUBLIC HEALTH CONCERN
C5. % of mothers of children 6–59 months of age who received high-dose vitamin A supplement within 8 weeks postpartum (6 weeks if not exclusively breastfeeding) ²⁶				< 80% is generally a priority. Discuss high, medium, and low designations as a group
INDICATOR: IRON				
C6. % of women of reproductive age (15–49 years) with anemia (Hb < 11 g/dl for pregnant women; < 12 g/dl for non-pregnant women)				<ul style="list-style-type: none"> • ≤ 4.9%: Normal • 5.0–19.9%: Low • 20.0–39.9%: Medium • ≥ 40%: High
C7. % of women 15–49 years of age with a birth in the 5 years preceding the survey who took iron tablets/syrup for 90 or more days during pregnancy for most recent birth or iron/folic acid during pregnancy for the most recent birth				< 80% is generally a priority. Discuss high, medium, and low designations as a group.
INDICATOR: IODINE				
C8. % of households consuming adequately iodized salt (20–40 ppm)				< 90%: Concern
C9. Median urinary iodine concentration for pregnant women				> 150 ug/l
C10. Median urinary iodine concentration of children under 2 years of age, women, and lactating women				< 100 ug/l

²⁶ According to 2011 World Health Organization guidelines, “Vitamin A Supplementation in Postpartum Women,” vitamin A supplementation in postpartum women is not recommended as a public health intervention for the prevention of maternal and infant morbidity and mortality, but adequate dietary intake of vitamin A-rich foods should be promoted in the postpartum period. However, as some countries still do postpartum supplementation, it will be important to check the country guidelines to see if they have adopted the 2011 guidelines.

	DATA (Fill in from Quantitative Data Collection Table)	COMMENTS ON DATA	LEVEL OF PUBLIC HEALTH CONCERN	REFERENCE FOR PUBLIC HEALTH CONCERN
INDICATOR: Minimum Dietary Diversity – Women (MDD-W)				
<p>C11. MDD-W captures the proportion of women of reproductive age in a specific geographic area who are consuming a minimum dietary diversity. A woman of reproductive age is considered to consume minimum dietary diversity if she consumed at least 5 of 10 specific food groups in the previous 24 hours. Food groups include: 1) all starchy staple foods, 2) beans and peas, 3) nuts and seeds, 4) dairy, 5) flesh foods, 6) eggs, 7) vitamin A-rich dark green leafy vegetables, 8) other vitamin A-rich vegetables and fruits, 9) other vegetables, and 10) other fruits.</p>				<p>This indicator reflects consumption of at least 5 of 10 food groups; women consuming foods from 5 or more of the food groups listed have a greater likelihood of meeting their micronutrient needs than women consuming foods from fewer food groups.</p>



SYNTHESIS OF DATA ON MATERNAL NUTRITION

Are there any patterns among the indicators? Are you aware of any trends (e.g., increases or decreases over time) in the prevalence of low birth weight, maternal underweight, or other considerations?

Do any of the indicators or trends concern you? If so, which and why?

Looking at the detailed Quantitative Data Collection Table, and any relevant qualitative data you collected, is there any additional information to take into consideration when designing nutrition activities?

Are there any marginalized or vulnerable groups that might need extra attention or specific strategies to reach them? If so, describe who they are and why they are vulnerable.

How do community or household gender issues affect the maternal nutrition situation?

Are there any other complicating or aggravating factors? (For example, if maternal anemia is a public health concern, what are the patterns of use of iron/folic acid supplements? Is there a high rate of malaria or hookworm infection in the population?)

How do community or household gender issues and cultural or religious factors (such as fasting) affect the maternal nutrition situation (see Reference Guide pages 16–17)?

How do other factors (if present) such as alcoholism, maternal depression, domestic violence, etc. affect the maternal nutrition situation?

Other thoughts?

Consider all of the information above to determine if this is a priority intervention area. Mark your conclusion next and explain your rationale.



CONCLUSION ON THE SYNTHESIS OF DATA ON MATERNAL NUTRITION

Are maternal interventions indicated? Check all areas that apply:

- Dietary practices Vitamin A Iron Iodine MDD-W

Notes on other considerations/additional information needed?



SUMMARY OF THE RATIONALE FOR THE CONCLUSION ON THE SYNTHESIS OF DATA ON MATERNAL NUTRITION



Proceed to Section D. Micronutrient Status of Children

Section D. Synthesizing the Data on Micronutrient Status of Children



TABLE D

ANALYZING DATA ON MICRONUTRIENT STATUS OF CHILDREN

	DATA (Fill in from Quantitative Data Collection Table)	COMMENTS ON DATA	LEVEL OF PUBLIC HEALTH CONCERN	REFERENCE FOR PUBLIC HEALTH CONCERN
INDICATOR: VITAMIN A				
D1. % of children 6–59 months of age with vitamin A deficiency (serum retinol values $\leq .70 \mu\text{mol/l}$) Alternate indicator: % of children 24–71 months of age with night blindness				<ul style="list-style-type: none"> • < 2%: Normal • 2.0–9.9%: Low • 10–19.9%: Medium • $\geq 20\%$: High Alternate indicator: <ul style="list-style-type: none"> • $\geq 5\%$: Concern
D2. % of children 6–59 months of age who have received vitamin A supplementation in previous 6 months				< 80% is generally a priority. Discuss high, medium, and low designations as a group.
INDICATOR: IRON				
D3. % of children 6–59 months of age with anemia (Hb < 11 g/dl) ²⁷				In general population: <ul style="list-style-type: none"> • $\leq 4.9\%$: Normal • 5.0–19.9%: Low • 20.0–39.9%: Medium • $\geq 40\%$: High
D4. % of children 6–23 months of age receiving iron supplements or micronutrient powders yesterday				< 80% is generally a priority. Discuss high, medium, and low designations as a group.
D5. % of children 12–59 months of age receiving deworming medication in the previous 6 months				< 80% is generally a priority. Discuss high, medium, and low designations as a group.
INDICATOR: IODINE				
D6. % of households consuming adequately iodized salt (20–40 ppm)				< 90%: Concern
D7. Median urinary iodine concentration in children 0–59 months of age ($\mu\text{g/l}$)				< 100 $\mu\text{g/l}$

²⁷ The reference for public health concern refers to the percentage of anemia in the general population instead of specifically for children 6–59 months, however, use this table to rate the public health significance related to children.



SYNTHESIS OF DATA ON MICRONUTRIENT STATUS OF CHILDREN

Are there any patterns among the indicators? Are you aware of any other considerations, such as seasonal variations in micronutrient-rich food availability, trends over time, aggravating factors (e.g., disease that depletes micronutrient stores), or cultural practices?

Do any of the indicators concern you more than others? If so, which and why?

Looking at the detailed Quantitative Data Collection Table and qualitative data gathered in Step 1, Parts 1 and 2, is there any additional information to consider when designing nutrition activities?

Are there any marginalized or vulnerable groups that might need extra attention or specific strategies to reach them? If so, describe who they are and why they are vulnerable.

How do community or household gender issues and cultural or religious factors affect the micronutrient status of children (such as fasting, family planning/birth spacing, women's decision making ability within the household, etc.)? (see Reference Guide pages 16–17)

How do other factors (if present) such as alcoholism, maternal depression, domestic violence, etc. affect the micronutrient status of children?

Other thoughts?

Consider all of the information above to determine if this is a priority intervention area. Mark your conclusion below and explain your rationale.



CONCLUSION ON THE SYNTHESIS OF DATA ON MICRONUTRIENT STATUS OF CHILDREN

Are interventions in micronutrients indicated? Check all areas that apply:

- Vitamin A for children Iron for children Iodine for children Dietary practices

Notes on other considerations/additional info needed?



SUMMARY OF RATIONALE FOR THE CONCLUSION ON THE SYNTHESIS OF DATA ON MICRONUTRIENT STATUS OF CHILDREN



Proceed to Section E. Underlying Disease Burden

Section E. Synthesizing the Data on Underlying Disease Burden



TABLE E

ANALYZING DATA ON UNDERLYING DISEASE BURDEN

	DATA (Fill in from Quantitative Data Collection Table)	COMMENTS ON DATA	LEVEL OF PUBLIC HEALTH CONCERN ²⁸
INDICATOR: DIARRHEA			
E1. % of children 0–23 months of age with diarrhea in last 2 weeks			
E2. % of children 0–23 months of age with diarrhea in last 2 weeks who received oral rehydration solution and/or recommended home fluids			
E3. % children under 5 years of age who had diarrhea in the 2 weeks preceding the survey, who received zinc supplements as treatment			
INDICATOR: ACUTE RESPIRATORY INFECTION			
E4. % of children 0–23 months of age with chest-related cough and fast or difficult breathing in the last 2 weeks			
E5. % of children 0–23 months of age with chest-related cough and fast or difficult breathing in the last 2 weeks who were taken to an appropriate health provider			
INDICATOR: MALARIA			
E6. % of children with fever in the past 2 weeks (in malaria zones)			
E7. % of children 0–23 months of age with fever during the last 2 weeks treated with an effective anti-malarial drug within 24 hours			

²⁸ No international standards exist to determine at what level of prevalence a nutrition program should be adapted for or include interventions to address illness. Teams will need to work together and, based on knowledge and experience, decide the level of importance of each of these underlying health conditions in their program area.

	DATA (Fill in from Quantitative Data Collection Table)	COMMENTS ON DATA	LEVEL OF PUBLIC HEALTH CONCERN ²⁸
INDICATOR: HIV			
<p>E8. % of children 0–23 months of age who are HIV positive</p> <p>Alternate indicators:</p> <ul style="list-style-type: none"> • % of children with mothers who are HIV positive; or • % of pregnant women who are HIV positive; or • % of women 15–49 years of age who are HIV positive; or • % of children 6–23 months of age who are enrolled in PMTCT services 			
INDICATOR: IMMUNIZATION COVERAGE			
<p>E9. % of children 12–23 months of age fully immunized by 12 months of age, according to country guidelines</p>			



SYNTHESIS OF DATA ON UNDERLYING DISEASE BURDEN

Are there any patterns among the indicators? Are you aware of any trends or seasonal variations?

Does the prevalence of one of these diseases concern you more than the others? What concerns you about the prevalence of different diseases in the program area?

Are there water, hygiene, or sanitation issues to consider such as handwashing practices, access to clean water, sanitary disposal of human feces, and sanitary places for children to play?

Is there any additional information to consider based on the Quantitative Data Collection Table or the qualitative information you have gathered?

Are there any marginalized or vulnerable groups that might need extra attention or specific strategies to reach them? If so, describe who they are and why they are vulnerable.

How do community or household gender issues and cultural or religious factors affect the underlying disease burden (see Reference Guide pages 16–17)?

How do other factors (if present) such as alcoholism, maternal depression, domestic violence, etc. affect the underlying disease burden?

Other thoughts?

Consider all of the information above to determine if this is a priority intervention area. Mark your conclusion next and explain your rationale.



CONCLUSION ON THE SYNTHESIS OF DATA ON UNDERLYING DISEASE BURDEN

Are interventions in underlying disease burden indicated? Check all areas that apply:

- Diarrhea Acute respiratory infections Malaria HIV Immunizations Water and Sanitation Hygiene
 Other _____

Notes on other considerations/additional information needed?

If there are many (or all) selected above, are there any specific practices that your program might wish to prioritize additional or extra efforts toward behavior change? If yes, please note below:



SUMMARY OF RATIONALE FOR THE CONCLUSION ON THE SYNTHESIS OF DATA ON UNDERLYING DISEASE BURDEN

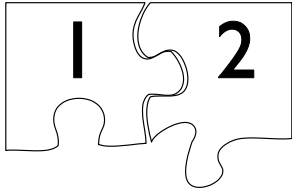
A large, empty rectangular box with a thin blue border, intended for the user to write a summary of rationale for the conclusion on the synthesis of data on underlying disease burden.



Proceed to Step 2.

STEP 2

Determine Initial Program Goal, Purpose, and Sub-Purpose(s)



In Step 2, you will draft the initial program goal, purpose, and sub-purpose(s) based on the data synthesis in Step 1 and the answers to the following questions. The goal, purpose, and sub-purpose(s) developed here will be refined in Step 6, and the additional components of the Logical Framework (LogFrame) will be added.

INSTRUCTIONS FOR DETERMINING INITIAL PROGRAM GOAL, PURPOSE, AND SUB-PURPOSE(S)

1. **Review the guidance and examples** on developing a Theory of Change and LogFrame in Step 2 of the Reference Guide.
2. **Answer the questions in the following boxes** regarding priority interventions, level of funding anticipated, donor priorities, other activities, and organizational technical strengths and expertise.
3. **Draft your initial program goal, purpose, and sub-purpose(s) based on need** and record them in the Workbook. Since your goal, purpose, and sub-purpose(s) are in draft form please wait to input them into the Excel LogFrame template until Step 6 when they are finalized.



A Theory of Change conceptual model is provided on page 39 and an example LogFrame, outlining program goals, purposes, and sub-purposes is provided on pages 43–44 of the Reference Guide.



WHAT ARE THE PRIORITY INTERVENTION AREAS IDENTIFIED IN STEP 1?

Prevention

- Underweight
- Stunting

Prevention + Recuperation

- Underweight
- Stunting
- MAM
- SAM

Infant and Young Child Feeding

- Immediate initiation
- Preventing use of pre-lacteals
- Exclusive breastfeeding
- Continued breastfeeding
- Timely introduction of complementary feeding
- Diversity
- Frequency
- Offered more fluids during illness
- Offered same or more food during illness
- Offered more after illness

Micronutrients in children

- Dietary practices
- Vitamin A
- Iron
- Iodine

Maternal Nutrition

- Dietary practices
- Vitamin A
- Iron
- Iodine
- MDD-W

Underlying disease burden

- Diarrhea
- Acute respiratory infections
- Malaria
- HIV
- Immunizations
- Hygiene
- Water and sanitation
- Other



BASED ON THE ABOVE PRIORITY INTERVENTION AREAS, WHO IS/ARE YOUR TARGET POPULATION(S) AND WHY?



WHAT IS THE ANTICIPATED LEVEL OF FUNDING AVAILABLE FOR THIS PROGRAM?



WHAT ARE THE DONOR PRIORITIES?



UPON WHAT OTHER ACTIVITIES OR DELIVERY PLATFORMS COULD YOU BUILD A NUTRITION PROGRAM (E.G., INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS, NATIONAL NUTRITION PROGRAMS, HIV CARE AND SUPPORT)?



WHAT ARE YOUR ORGANIZATION'S TECHNICAL STRENGTHS AND EXPERTISE RELATED TO HEALTH AND NUTRITION?



WHAT IS THE BROAD PROGRAM GOAL?



WHAT IS YOUR PROGRAM PURPOSE?

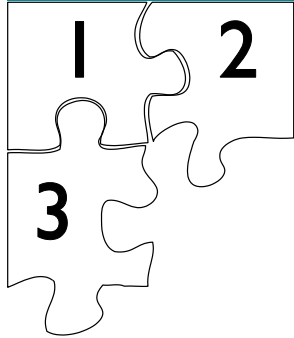


WHAT IS/ARE YOUR INTIAL SUB-PURPOSE(S)?



Proceed to Step 3. Review Health and Nutrition Services

STEP 3



Review Health and Nutrition Services

In Step 3, the team will map the existing capacity of local health and nutrition services at the community and facility levels, which will inform later program design decisions. This section includes questions on the national policy environment followed by a review of local services and materials. The format does not have to be strictly followed and can be adapted. The Workbook can be used to take brief notes on existing policies and services, or a notebook can be used during interviews and then critical information summarized here.

INSTRUCTIONS FOR REVIEWING HEALTH AND NUTRITION SERVICES

1. **Review the information for Step 3 in the Reference Guide** on gathering data on health and nutrition policies and services.
2. **Review the questions in Step 3** on the following pages.
3. **Gather the necessary information** from policy documents and key informant interviews with experienced health or nutrition staff from other organizations active in the area, those in charge of health services locally, and some health staff that provide services locally.
4. **Record the information** on the following pages or in a separate notebook.



HEALTH AND NUTRITION POLICIES AND STRATEGIES RELATED TO MATERNAL AND CHILD NUTRITION

Summarize key aspects of national nutrition policies and strategies and aspects of quality that may affect how a community-based nutrition program targeted to women and children is designed. If an additional notebook was used to record qualitative data, summarize the information in the following table.

Type of policy/strategy	Name and key aspects of policy/strategy	Government office responsible for policy/strategy	Comments on strengths, gaps, coverage, barriers, etc.
Nutrition and health policies and strategies such as a National Nutrition Policy			
<i>Is there multi-sectoral coordination and planning (agriculture and other sectors) at the national level to improve nutrition and food availability and access?</i>			
<i>Is there coordination at the district or provincial levels?</i>			
Multi-sectoral nutrition policies, strategies, or plans (e.g. WASH, FP, agriculture and mental health)			
HIV and nutrition policies or strategies			
Specific child nutrition and health policies and strategies: infant and young child feeding, micronutrient supplementation, international code for marketing of breast milk substitutes, etc.			

Type of policy/strategy	Name and key aspects of policy/strategy	Government office responsible for policy/strategy	Comments on strengths, gaps, coverage, barriers, etc.
Specific maternal nutrition and health policies and strategies: antenatal care, micronutrient supplementation, deworming, PMTCT, etc.			
Food fortification policies and strategies, including salt iodization and oil and flour fortification			
<p>Are all the Essential Nutrition Actions covered by a policy/strategy (see page 14 of the Reference Guide)? Note those that are covered and those that are not, with a possible explanation for why they are not covered in a policy/strategy.</p>			



PROGRAMS AND SERVICES RELATED TO MATERNAL AND CHILD NUTRITION

For the priority intervention areas you listed in Step 2 (page 42), summarize key aspects of nutrition programs and services, delivery channels, and aspects of quality that may affect how a community-based nutrition program targeted to women and children is designed.

Intervention Area	Summary of current relevant programs and/or services	Who is engaged to implement/deliver services? (Ministry of Health, nongovernmental organization, community volunteers, etc.) What is the access, demand, and coverage in your target area?	Comments on strengths, weaknesses, barriers, etc., in general and in your target area	Is there an associated protocol? (Yes or No) If a protocol exists, note if it is up to date, if it is accessible, and other relevant information
Baby-Friendly Hospitals				
Growth monitoring and promotion (note if nutrition counseling is included and if community or facility-based)				
Rehabilitation of acute malnutrition (SAM or MAM), such as CMAM programs or other facility-based services (note if for children, pregnant and lactating women, etc.)				
Integrated management of acute malnutrition/ community-integrated management of acute malnutrition				
Community case management of diarrhea, malaria, or pneumonia				

Intervention Area	Summary of current relevant programs and/or services	Who is engaged to implement/deliver services? (Ministry of Health, nongovernmental organization, community volunteers, etc.) What is the access, demand, and coverage in your target area?	Comments on strengths, weaknesses, barriers, etc., in general and in your target area	Is there an associated protocol? (Yes or No) If a protocol exists, note if it is up to date, if it is accessible, and other relevant information
Antenatal care (note if nutrition counseling is included)				
Delivery care				
Postpartum care				
PMTCT				
HIV treatment, care, and support				
Nutrition training of formal/informal health care providers				
Expanded program on immunization				

Intervention Area	Summary of current relevant programs and/or services	Who is engaged to implement/deliver services? (Ministry of Health, nongovernmental organization, community volunteers, etc.) What is the access, demand, and coverage in your target area?	Comments on strengths, weaknesses, barriers, etc., in general and in your target area	Is there an associated protocol? (Yes or No) If a protocol exists, note if it is up to date, if it is accessible, and other relevant information
Micronutrient supplementation and deworming (can include vitamin A supplementation, iron supplementation, zinc treatment during diarrhea, etc.)				
Water, sanitation, and hygiene (programs/services that have an impact on nutrition)				
Agriculture (programs/services that have an impact on nutrition)				
Sexual and reproductive health and family planning (programs/services that have an impact on nutrition)				
Mental health and psychosocial support (programs/services that have an impact on nutrition sector)				
Other				



AVAILABILITY OF MATERIALS AND EQUIPMENT

Materials and Equipment for Nutrition Services Available at Health Facilities in the Proposed Target Area

Do facilities have sufficient materials and equipment to provide nutrition services?

- Scales Length boards MUAC tapes
 Growth charts (child health cards) Micronutrient supplies
 Supplementary and/or therapeutic foods
 Record-keeping/monitoring materials
 Other:

Describe any supply limitations:

Behavior Change Communication (BCC) Materials

Are there BCC materials for nutrition counseling? Yes No

On which topics? (Obtain one set of materials, if possible.)

Does staff use the materials? How and when?

How accurate and up to date are the materials?

Is there one set of materials or are there many sets that are being used? Is there a set that is endorsed by the government? If there are many sets, are they harmonized? Describe the variations.

Materials and Equipment for Nutrition Services Available for Existing Community Health or Nutrition Volunteers in the Proposed Target Area

Do volunteers have sufficient materials and equipment to provide nutrition services?

- Scales Length boards MUAC tapes
 Growth charts (child health cards) Micronutrient supplies
 Record-keeping/monitoring materials
 Other:

Describe any supply limitations:

Behavior Change Communication (BCC) Materials

Are there BCC materials for nutrition counseling? Yes No

On which topics? (Obtain one set of materials, if possible.)

Do volunteers use the materials? How and when?

How accurate and up-to-date are the materials?

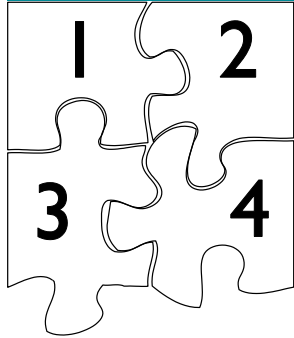
Is there one set of materials or are there many sets that are being used? Is there a set that is endorsed by the government? If there are many sets, are they harmonized? Describe the variations.



Proceed to Step 4. Preliminary Program Design: Prevention

STEP 4

Preliminary Program Design: Prevention



In Step 4, you will list the potential preventive approaches that could be considered based on an analysis of the needs and assets in the target area. The following categories of preventive approaches to reduce undernutrition are included in Step 4:

- Section A: Cross-cutting approaches to improve nutritional status
- Section B: Infant and young child feeding
- Section C: Maternal nutrition
- Section D: Micronutrient status of children
- Section E: Underlying disease burden

Complete each section that you determined was a high priority intervention area in Step 1.

INSTRUCTIONS FOR PRELIMINARY PROGRAM DESIGN: PREVENTION

1. **Summarize key conclusions from Steps 1–3** in the first box in Section A to guide you in deciding on the best focus areas for effective prevention efforts.
2. **Review Step 4, Section A. Cross-Cutting Approaches to Improve Nutritional Status on pages 49–63 of the Reference Guide** and answer the questions in the remaining boxes in Section A of the Workbook. **Make preliminary decisions about potential cross-cutting activities** to incorporate in the program, which will be revisited in each section. Annex 1 in the Workbook provides a summary of the approaches discussed in Step 4 of the Reference Guide for your reference in filling out Sections A–E.
3. **Review Step 4, Sections B–E on pages 63–80 in the Reference Guide** and answer the questions in the corresponding section in the Workbook to determine potential preventive approaches to incorporate in your program. Only fill out sections which you determined were priority intervention areas in Step 1.
4. **Make preliminary decisions about cross-cutting program approaches** that will support multiple intervention areas and **intervention area-specific program approaches**.

STEP 4

SECTION A

CROSS-CUTTING APPROACHES TO IMPROVE NUTRITIONAL STATUS



SUMMARY OF STEPS 1–3 RELATED TO PREVENTION AND CROSS-CUTTING APPROACHES TO IMPROVE NUTRITIONAL STATUS

Summarize the key findings from Steps 1–3 related to prevention. This includes anything that you would like to keep in mind while designing the program and selecting approaches, such as program priorities, key issues, challenges, availability of recuperative services, gaps in service programs, community strengths to build from, policies that may affect programming, an enabling environment, and what you hope the program will achieve.

What approaches have past evaluations or reviews identified as being successful or unsuccessful in this area or for your organization?

Will your program be focusing on prevention only (with referral to recuperative services, as necessary) or on both prevention and recuperation?

Keeping in mind the above summary, discuss with your team the information on cross-cutting approaches to improve nutritional status in the Reference Guide on pages 49–63 and answer the questions on the next page.



DETERMINE RESOURCES, NETWORKS, AND OPPORTUNITIES FOR SOCIAL AND BEHAVIOR CHANGE ACTIVITIES

What programs or platforms already exist through which health and nutrition messages and materials are transmitted? Step 3 in the Workbook provides a list of various potential programs and services. Potential entry points for counseling and messages include: antenatal care visits; delivery and postnatal visits; integrated management of childhood illnesses program; child health weeks/days where immunizations and micronutrient supplements are provided; community-based growth monitoring and promotion; national nutrition or health programs; Positive Deviance (PD)/Hearth program; community-based management of acute malnutrition program; and/or sick-child visits.

What community structures already exist? Existing community structures might be women's groups, peer support groups, village health committees, agricultural groups, or religious groups.

What types of community workers already exist? These could be volunteers or paid workers created by other organizations, programs, the government, or the community. They may include community health workers, community health volunteers, agricultural extension workers, and teachers.

What is the capacity for volunteerism? Consider the cultural acceptability for volunteerism along with the skill sets of potential volunteers (e.g., literacy levels).

What materials already exist for nutrition counseling? Materials might be information, education, and communication materials; counseling guides; or mass media messages (e.g., radio broadcasts, posters, and public service ads). What topics and messages are covered? Do staff use the materials? How and when?

What approaches have past evaluations or reviews identified as being successful in this area or for your organization?



NOTES ON APPROACHES TO CONSIDER IN PROGRAMMING WITH CROSS-CUTTING APPROACHES TO IMPROVE NUTRITIONAL STATUS

A large empty rectangular box with a thin teal border, intended for handwritten notes.

STEP 4

SECTION B

INFANT AND YOUNG CHILD FEEDING



SUMMARY OF STEPS 1–3 RELATED TO PREVENTION AND INFANT AND YOUNG CHILD FEEDING

Summarize the key findings from Steps 1–3 related to infant and young child feeding. This includes anything that you would like to keep in mind while designing the program and selecting approaches, such as program priorities, challenges, key infant and young child feeding practices in the program area, program or community strengths to build from, resources (available or needed), policies that may affect programming, the enabling environment, and what you hope the program will achieve.

What approaches have past evaluations or reviews identified as being successful or unsuccessful in this area or for your organization?

Keeping in mind the above summary, discuss with your team the information on infant and young child feeding approaches in the Reference Guide on pages 63–70. Record your notes on potential approaches to consider in the box on the next page.



NOTES ON APPROACHES TO CONSIDER IN PROGRAMMING WITH INFANT AND YOUNG CHILD FEEDING COMPONENTS (INCLUDE APPROPRIATE CROSS-CUTTING APPROACHES)

A large, empty rectangular box with a thin black border, intended for taking notes on the approaches to consider in programming with infant and young child feeding components.

STEP 4

SECTION C

MATERNAL NUTRITION



SUMMARY OF STEPS 1–3 RELATED TO PREVENTION AND MATERNAL NUTRITION

Summarize the key findings from Steps 1–3 related to maternal nutrition. This includes anything that you would like to keep in mind while designing the program and selecting approaches, such as program priorities, challenges, gaps in service, program or community strengths to build from or strengthen, resources (available or needed), policies that may affect programming, the enabling environment, and what you hope the program will achieve.

What approaches have past evaluations or reviews identified as being successful or unsuccessful in this area or for your organization?

Keeping in mind the above summary, discuss with your team the information on maternal nutrition approaches in the Reference Guide on pages 70–73. Record your notes on potential approaches to consider in the box on the next page.



NOTES ON APPROACHES TO CONSIDER IN PROGRAMMING WITH COMPONENTS THAT ADDRESS MATERNAL NUTRITION (INCLUDE APPROPRIATE CROSS-CUTTING APPROACHES)

A large, empty rectangular box with a thin black border, intended for handwritten notes.

STEP 4

SECTION D

MICRONUTRIENT STATUS OF CHILDREN



SUMMARY OF STEPS 1–3 RELATED TO PREVENTION AND MICRONUTRIENT STATUS OF CHILDREN

Summarize the key findings from Steps 1–3 related to micronutrients. This includes anything that you would like to keep in mind while designing the program and selecting approaches, such as program priorities, challenges, gaps in service, program or community strengths to build from or strengthen, resources (available or needed), policies that may affect programming, the enabling environment, and what you hope the program will achieve.

What approaches have past evaluations or reviews identified as being successful in this area or for your organization?

Keeping in mind the above summary, discuss with your team the information on micronutrient approaches in the Reference Guide on pages 73–77. Record your notes on potential approaches to consider in the box on the next page.



NOTES ON APPROACHES TO CONSIDER IN PROGRAMMING WITH COMPONENTS THAT ADDRESS MICRONUTRIENT STATUS OF CHILDREN (INCLUDE APPROPRIATE CROSS-CUTTING APPROACHES)

A large, empty rectangular box with a thin black border, intended for handwritten notes.

STEP 4

SECTION E

UNDERLYING DISEASE BURDEN



SUMMARY OF STEPS 1–3 RELATED TO PREVENTION AND UNDERLYING DISEASE BURDEN

Summarize the key findings from Steps 1–3 related to underlying disease burden. This includes anything that you would like to keep in mind while designing the program and selecting approaches, such as program priorities, challenges, gaps in service, program or community strengths to build from or strengthen, resources (available or needed), policies that may affect programming, the enabling environment, and what you hope the program will achieve.

What approaches have past evaluations or reviews identified as being successful or unsuccessful in this area or for your organization?

Keeping in mind the above summary, discuss with your team the information on approaches for underlying disease burden in the Reference Guide on pages 78–80. Record your notes on potential approaches to consider in the box on the next page.



NOTES ON APPROACHES TO CONSIDER IN PROGRAMMING WITH COMPONENTS THAT ADDRESS UNDERLYING DISEASE BURDEN (INCLUDE APPROPRIATE CROSS-CUTTING APPROACHES)

A large empty rectangular box with a thin teal border, intended for handwritten notes.



If you have determined that a preventive + recuperative community-based nutrition program is necessary, go to Step 5. If you have determined that only a preventive community-based nutrition program is necessary, skip Step 5 and go directly to Step 6.

STEP 5

Preliminary Program Design: Recuperation

In Step 5, you will list all the potential recuperative nutrition approaches that could be added to the preventive program. This step builds on the conclusions made in Step 4 of this Workbook.

INSTRUCTIONS FOR PRELIMINARY PROGRAM DESIGN: RECUPERATION

1. **Summarize key conclusions from Steps 1–3** in the following box to guide you in deciding on the best focus areas for effective recuperation efforts.
2. **Review Step 5 in the Reference Guide** and Annex 2 in the Workbook, which provides a review of the approaches discussed in Step 5 of the Reference Guide.
3. **Discuss as a team the potential program approaches to consider.**
4. **Make preliminary decisions** about program approaches and record them in the appropriate box.



SUMMARY OF STEPS 1–3 RELATED TO RECUPERATION

Summarize the key findings from Steps 1–3 related to recuperation. This includes anything that you would like to keep in mind while designing the program and selecting approaches, such as program priorities, key issues, challenges, gaps in service programs, community strengths to build from, policies that may affect programming, enabling environment, and what you hope the program will achieve.

What recuperative nutrition approaches have past evaluations or reviews identified as being successful or unsuccessful in this area or for your organization?

Discuss with your team the information on potential recuperative approaches in Step 5 of the Reference Guide, and how these approaches will fit in with the already determined preventative programming. Record your notes in the following box.



NOTES ON POTENTIAL APPROACHES TO CONSIDER IN RECUPERATION PROGRAMMING

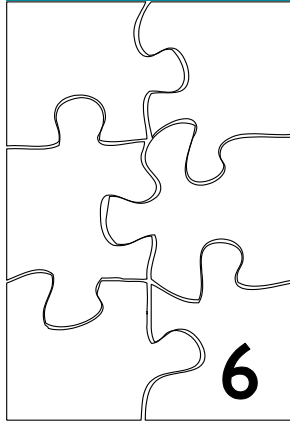
A large, empty rectangular box with a thin teal border, intended for taking notes on potential approaches to consider in recuperation programming.



Proceed to Step 6. Putting It All Together

STEP 6

Putting It All Together



In Step 6 you will make a final decision on the combination of nutrition program approaches to propose for the target area. This step compiles all of the analysis conducted so far in the tool and facilitates the completion of your LogFrame. At this time please utilize the LogFrame Excel template at <http://coregroup.org/NPDA2015> to begin filling in your final decisions.

INSTRUCTIONS FOR PUTTING IT ALL TOGETHER

1. Revisit the team's analysis conducted so far in the Workbook, including:

- a. Main intervention areas of public health concern (summarized in the Workbook in Step 2, page 42)
- b. Initial program goal, purpose, and sub-purpose(s) (Workbook Step 2, pages 45–46)
- c. Other existing activities upon which your program may build (Workbook Step 2, page 44)
- d. Existing health and nutrition policies, strategies, programs, and services (Workbook Step 3, pages 48–52)
- e. Potential preventive nutrition program approaches identified (Workbook Step 4, pages 55–66)
- f. Potential recuperative nutrition program approaches identified (Workbook Step 5, page 69)

2. Answer the questions in the boxes on the following pages, progressively refining your project plan based on your answers.

- a. Refine your initial program goal, purpose, and sub-purposes and fill in your accompanying LogFrame template. Determine your plan for an appropriate combination of approaches to meet these purposes. While doing so, fill out the immediate outcomes and outputs sections of your LogFrame. Ideally, your plan will consolidate various approaches you have considered up to this point, seeking the best synergy among them and addressing current gaps in services and programs.
- b. Determine if your plan addresses donor and government priorities or needs to be adjusted accordingly.
- c. Determine if your plan matches your resources. Fill in the inputs section of your LogFrame using the information on costing in the Reference Guide for guidance.
- d. Determine the coverage for the plan.
- e. Identify the target number of beneficiaries.
- f. Identify the final geographic target area.
- g. Determine any pending information needs to finalize your plan.
- h. Identify any potential organizational barriers that will need to be addressed.
- i. Identify key groups with which you will partner

3. Develop the first draft of your nutrition programming plan.



WHAT ARE THE PRIORITY INTERVENTION AREAS YOU WILL ADDRESS IN YOUR PROGRAM?

Prevention

- Underweight
- Stunting

Prevention + Recuperation

- Underweight
- Stunting
- MAM
- SAM

Infant and Young Child Feeding

- Immediate initiation
- Preventing use of pre-lacteals
- Exclusive breastfeeding
- Continued breastfeeding
- Timely introduction of complementary feeding
- Diversity
- Frequency
- Offered more fluids during illness
- Offered same or more food during illness
- Offered more after illness

Micronutrients in children

- Dietary practices
- Vitamin A
- Iron
- Iodine

Maternal Nutrition

- Dietary practices
- Vitamin A
- Iron
- Iodine
- MDD-W

Underlying disease burden

- Diarrhea
- Acute respiratory infections
- Malaria
- HIV
- Immunizations
- Hygiene
- Water and sanitation
- Other



WHAT IS YOUR FINAL PROGRAM GOAL?

(ADD THIS INFORMATION TO YOUR LOGFRAME)



WHAT IS YOUR FINAL PROJECT PURPOSE?

(ADD THIS INFORMATION TO YOUR LOGFRAME)



WHAT IS/ARE YOUR FINAL SUB-PURPOSE(S)?
(ADD THIS INFORMATION TO YOUR LOGFRAME)



WHAT ARE THE MAIN APPROACHES YOU ARE CONSIDERING TO ACHIEVE YOUR PURPOSE AND SUB-PURPOSE(S)?



**HOW WILL YOU COMBINE THESE APPROACHES TO ACHIEVE YOUR PURPOSE AND SUB-PURPOSE(S)?
WHY DID YOU SELECT THIS COMBINATION?**

(COMPLETE THE IMMEDIATE OUTCOMES AND OUTPUTS SECTIONS IN YOUR LOGFRAME AS YOU MAKE THESE DECISIONS) Refer to pages 40–44 on LogFrames in the Reference Guide if needed.



DOES THE PLAN ADDRESS DONOR AND GOVERNMENT PRIORITIES? IF NOT, HOW WILL YOU ADJUST THE PLAN?



SUMMARIZE THE PROPOSED PROGRAM'S GENERAL RESOURCE REQUIREMENTS?
(ADD TO THE INPUTS SECTION OF YOUR LOGFRAME WHERE APPROPRIATE)

See information on costing in the Reference Guide on pages 89–90.

Staffing:

Technical assistance:

Direct program implementation:

Program supplies:



DOES THE PLAN MATCH YOUR RESOURCES? IF NOT, HOW WILL YOU ADJUST THE PLAN?



WHAT IS THE COVERAGE NEEDED?



WHAT WILL BE THE NUMBER OF BENEFICIARIES?



WHICH GEOGRAPHIC AREAS WILL YOU TARGET?



WHAT IMPORTANT INFORMATION DO YOU STILL NEED?



WITHIN YOUR PROGRAM CONTEXT, ARE THERE FACTORS OUTSIDE YOUR PROGRAM DESIGN THAT MAY IMPEDE PROGRESS THAT CAN BE MITIGATED BY YOUR PROGRAM DESIGN?



WHO ARE THE KEY GROUPS WITH WHICH YOU WILL PARTNER?



HOW WILL YOU ENSURE THAT YOUR PROGRAM INVESTMENT LEADS TO A MEANINGFUL, SUSTAINABLE, NUTRITION IMPACT?

Congratulations and Best of Luck!

If you have any feedback, comments, or suggestions for the tool, please contact the CORE Nutrition Working Group at Contact@coregroupdc.org.

Annex 1. Nutrition Program Approaches: Prevention

The following tables provide a summary of the approaches listed in Step 4 of the Reference Guide for easy reference while filling out Step 4 in the Workbook.

Community Mobilization ²⁹	
Brief Summary Description	A process, which includes capacity building, through which community members, groups, or organizations identify, plan, carry out, and monitor and evaluate activities on a participatory and sustained basis to improve their health and other conditions, either on their own initiative or stimulated by others.
Objectives	<ul style="list-style-type: none"> • Build greater community participation, commitment, and capacity for sustainably improving child nutrition • Strengthen civil society
Target Group	<ul style="list-style-type: none"> • Everyone in the community
Criteria	<ul style="list-style-type: none"> • Community members most affected by and interested in child nutrition are involved from the very beginning and throughout the process
Defining Characteristics	<ul style="list-style-type: none"> • Builds on social networks to spread support, commitment, and changes in social norms and behaviors • Builds local capacity to identify and address community needs • Helps to shift the balance of power so that disenfranchised populations have a voice in decision making and increased access to information and services while addressing many of the underlying social causes of poor nutrition and health • Motivates communities to advocate for policy changes to respond better to their real needs • Plays a key role in linking communities to health services, helping to define, improve on, and monitor quality of care, thereby improving the availability of, access to, and satisfaction with health and nutrition services • Uses a variety of communication channels including community performances, interest group meetings, special events, print media, video, and other forms
Needed Elements for Quality Programming	<ul style="list-style-type: none"> • Staff training in community mobilization techniques • Organizational and political commitment and support • Adequate time—it will generally take 2–3 years to begin to see improvements in nutrition and several more years to strengthen community capacity to sustain improvements • Community participation, ownership, and collective action • Organizational values and principles that support empowering people to develop and implement their own solutions to health and other challenges
Resources	<ul style="list-style-type: none"> • Demystifying Community Mobilization -- An Effective Strategy to Improve Maternal and Newborn Health (ACCESS Program Community Mobilization Working Group 2007) • How to Mobilize Communities for Health and Social Change (Health Communication Partnership) • Overview of the Approach for Mobilizing Families and Communities in Ethiopia to Adopt Seven Feeding Actions (Alive & Thrive 2014)

²⁹ Adapted from ACCESS Program Community Mobilization Working Group. 2007. *Demystifying Community Mobilization: An Effective Strategy to Improve Maternal and Newborn Health*.

Counseling at Key Contact Points (Facility Based)

Brief Summary Description	<p>Counseling is provided by a health care provider to a caregiver during the delivery of health services. Counseling messages should be personalized to the needs of the client. ENA guidance emphasizes the promotion of “small, doable actions” with negotiation techniques to support trial and adoption of behaviors, and the use of visual aids such as counseling cards to engage clients. To be effective, counselors need to have both good technical information and strong interpersonal communication skills. Client uptake of practices recommended during counseling will increase if this approach is combined with other communication channels. Contact points for counseling include the following facility-based services:</p> <ul style="list-style-type: none"> • Clinics for prevention of mother-to-child transmission of HIV • Antenatal or prenatal and postpartum care visits • Baby delivery (potentially via traditional birth attendants) • Integrated management of childhood illnesses or sick-child visits • Well-child visits and immunizations • GMP sessions • Child health days • Recuperative feeding sessions • Mobile clinics
Objectives	<ul style="list-style-type: none"> • Improve care and feeding practices for pregnant and lactating women and children under 2 years of age
Target Groups	<ul style="list-style-type: none"> • Pregnant and lactating women • Mothers/caregivers of children 0–23 months or up through 59 months • Influencers of caregivers of children under 5 years of age
Criteria	<ul style="list-style-type: none"> • Time available for counseling • Adequate coverage: community where women access services at the health facility
Defining Characteristics	<ul style="list-style-type: none"> • Messages targeted to the child’s developmental stage when the mother/caregiver seeks the service • Individually-tailored guidance
Needed Elements for Quality Programming	<ul style="list-style-type: none"> • Training on counseling and negotiation skills • Counseling materials developed through formative research, appropriate for a low-literate population, if necessary • Time and space available for counseling • Continuous supportive supervision of counselors • Follow up in home setting by volunteers
Resources	<ul style="list-style-type: none"> • Training Manual for Health and Social Workers in Sub-Saharan Africa: Implementation of Essential Nutrition Actions (BASICS and SARA projects) • ENA Health Worker Training Guide and ENA Health Worker Handouts (CORE Group 2011)

Home and Community-Based Visits

Summary	<p>Home visits conducted by community health workers (including volunteers), auxiliary nurses, or specialized community nutrition volunteers provide an opportunity for one-on-one, personalized counseling, outreach, follow up, and support to pregnant women, lactating women, caregivers of children, and their families. Visits may include checking on the health of a baby, counseling caregivers, or following up with a child who has experienced growth faltering, acute malnutrition, and/or illness. Community-based opportunities for education and support to groups provide opportunities for nutrition education as well as the potential for one-on-one counseling if appropriate. Examples of such opportunities are:</p> <ul style="list-style-type: none"> • School or community meetings for mother and father involvement • Local gathering places such as shops, wells, and marketplaces • Adult education venues such as literacy classes and agricultural training programs
Objectives	<ul style="list-style-type: none"> • Ensure child’s health or growth is improving • Improve care and feeding practices • Help overcome barriers to change • Support family
Target Groups	<ul style="list-style-type: none"> • Pregnant and lactating women • Mothers/caregivers of children 0–23 months or up through 59 months • Caregivers of children under 5 years of age • Influencers of caregivers of children under 5 years of age
Criteria	<ul style="list-style-type: none"> • Willing, available, and trained volunteers • Community where homes are located a short distance from each other
Defining Characteristics	<ul style="list-style-type: none"> • Opportunity to observe household context and behaviors • Opportunity to tailor messages to individual needs and to engage in dialogue to negotiate change • Community members provide support and counseling • Individually tailored guidance and support
Needed Elements for Quality Programming	<ul style="list-style-type: none"> • Counseling materials developed through formative research, appropriate for a low-literate population, if necessary • Training on counseling and negotiation skills • Continuous supportive supervision of counselors • Incentives
Resources	<ul style="list-style-type: none"> • Training Guide for Community Volunteers (CORE Group 2011, currently being updated) • ENA Health Worker Training Guide and ENA Health Worker Handouts (CORE Group 2011) • Community-Based Infant and Young Child Feeding Counseling Packet (UNICEF 2013)

Support Groups	
Brief Summary Description	Support groups provide comfortable, respectful environments where peers can learn from and support each other to practice optimal child care and feeding practices. Support groups may build on existing groups within the community or be organized for specific purposes. Common support groups include breastfeeding support groups, women’s groups, and grandmother’s groups. Support groups may be facilitated by a member of the group and may include nutrition education sessions led by a health care provider or other community member.
Objective	<ul style="list-style-type: none"> • Promote optimal child care and feeding behaviors
Target Groups	<ul style="list-style-type: none"> • Mothers of young children (under 2, 3, or 5 years of age) • Pregnant women • First-time mothers • Adolescent mothers
Criteria	<ul style="list-style-type: none"> • Group members willing and able to meet and share with each other • Community mobilized
Defining Characteristics	<ul style="list-style-type: none"> • Groups are composed of peers • Safe environment for mothers to learn and share • Research shows the level of influence of peers on behavior change is strong³⁰ • Requires minimal outside resources
Needed Elements for Quality Programming	<ul style="list-style-type: none"> • Formative research to identify motivating themes and messages • Group leader must have strong facilitation skills • Training may be necessary • Variation in methodology from very interactive to presentation of topic followed by group discussion • Can link to the non-health sector
Resources	<ul style="list-style-type: none"> • Training of Trainers for Mother-to-Mother Support Groups (LINKAGES Project 2003) • Freedom from Hunger (Freedom from Hunger integrates microfinance with health and life skills services to equip very poor families to improve their incomes, safeguard their health, and achieve lasting food security through a range of group-based models.) • Peer Counselor Programs (La Leche League) • Resources of IYCF Support Groups (Alive & Thrive 2014) • Grandmother Project

³⁰ WHO. 2003. *Community-Based Strategies for Breastfeeding Promotion and Support in Developing Countries*. Geneva: WHO.

Care Groups	
Brief Summary Description	Care groups are an approach for organizing community health volunteers. It is a community-based strategy for improving coverage and behavior change through building teams of women who each represent, serve, and promote health and nutrition among women in 10–15 households in their community. Volunteers (often referred to as “leader mothers”) meet weekly or bi-weekly with a paid facilitator to learn a new health message, report on the incidence of disease, and support each other. Care group members visit the women for whom they are responsible, offering support, guidance, and education to promote behavior change.
Objectives	<ul style="list-style-type: none"> • Improve coverage of health programs • Sustainable behavior change
Target Group	<ul style="list-style-type: none"> • Mothers of children 0–59 months of age
Criteria	<ul style="list-style-type: none"> • Community with houses close enough together so that volunteers can walk between them and to meetings • Sufficient volunteer pool • Training program
Defining Characteristics	<ul style="list-style-type: none"> • Paid promoter trains and mentors through monthly meetings • Trained leader mother volunteers provide support to other mothers • Small number of paid staff reach large population (through leader mothers) • Peer support • Can support multiple health initiatives
Needed Elements for Quality Programming	<ul style="list-style-type: none"> • Time available—leader mothers must have 5 hours per week to volunteer • Long start-up time (due to training); program should be of 4–5 year duration • Comprehensive and ongoing training of leader mothers • Supervisor-to-promoter ratio should be 1:5
Resources	<ul style="list-style-type: none"> • A Guide to Mobilizing Community-Based Volunteer Health Educators: The Care Group Difference (CORE Group) • Care Groups Info (CORE Group) • Care Groups: A Training Manual for Program Design and Implementation (Food Security and Nutrition Network Social and Behavioral Change Task Force 2014)

Mass Media

Brief Summary Description	Mass media refers to various means of communication designed to reach a wide, general audience, including broadcast forms such as radio and TV, print media such as newspapers and comics, and large scale outdoor media like billboards and bus advertising. Mass media can transmit messages to a wide audience and educate and entertain them. Since it is sometimes an expensive strategy, if needed, a program may consider collaborating with others conducting mass media efforts to align messages for greater repetition and support.	
Objective	<ul style="list-style-type: none"> To create awareness of specific behaviors or draw attention to ongoing activities or health issues 	
Target Group	<ul style="list-style-type: none"> Communities in the area—can target all members with broad messages 	
Criteria	<ul style="list-style-type: none"> People need access to the media being used 	
Defining Characteristics	<ul style="list-style-type: none"> Simple messages; can generate discussion High inputs at beginning and then message carried by advertising channel 	<ul style="list-style-type: none"> Can reach many people in little time
Needed Elements for Quality Programming	<ul style="list-style-type: none"> Formative research to identify motivating themes Careful selection of appropriate messages 	<ul style="list-style-type: none"> Pre-testing and refinement of the message Creativity and social marketing expertise
Resources	<ul style="list-style-type: none"> Alive & Thrive 	

“Edutainment” and Community Activities

Brief Summary Description	Edutainment uses popular forms of entertainment such as music and drama to communicate nutrition messages. Other forms of community-based communications that achieve similar aims include festivals, community events, fashion shows, cooking demonstrations, and contests.	
Objective	<ul style="list-style-type: none"> Reach a broad, general audience (particularly people who would not be reached through other channels) with messages Increase appeal and audience engagement Stimulate awareness and conversation in community about key topics 	<ul style="list-style-type: none"> Create value by having popular/admired figures associate with health messages Build positive attitudes and support for behavior change
Target Group	<ul style="list-style-type: none"> General population in community 	
Criteria	<ul style="list-style-type: none"> Available channels to reach the community Audience engagement 	
Defining Characteristics	<ul style="list-style-type: none"> Learning via entertainment channels Opportunity to reach large audiences Can support multiple health initiatives 	<ul style="list-style-type: none"> Community based Simple messages to spark conversations among audience members
Needed Elements for Quality Programming	<ul style="list-style-type: none"> Formative research to identify motivating themes and appropriate messaging Popular entertainment format that lends itself to incorporating public health content 	<ul style="list-style-type: none"> Talented, creative people working in teams Performance venue, group meeting, or special event to work through
Resources	<ul style="list-style-type: none"> Soul City 	

Community-Based Growth Monitoring and Promotion

Brief Summary Description	<p>Approach implemented at the community level to prevent undernutrition and improve child growth through monthly monitoring of child weight gain, (although there is growing consensus that monitoring height/length gain may be more critical), one-on-one counseling and negotiation for behavior change, home visits, and integration with other health services. Action is taken based on whether a child has gained adequate weight, not by a nutritional status cutoff point, and then identifying and addressing growth problems before the child becomes malnourished. A major benefit of high-quality programs includes that caregivers witness their child’s weight gain and thereby receive reinforcement for improving their practices. Additionally, community-based growth monitoring and promotion provides an opportunity for advocacy with community leaders and other persons of influence to become involved in seeking local solutions to the problem of growth faltering and undernutrition.</p>	
Objectives	<ul style="list-style-type: none"> • Improve child growth • Prevent undernutrition • Early detection of growth faltering and undernutrition 	
Target Group	<ul style="list-style-type: none"> • Children 0–23 months 	
Criteria (<i>when to use this approach</i>)	<ul style="list-style-type: none"> • Best used in communities with high prevalence of mild or moderate underweight or stunting • Requires careful training of volunteers in growth charting, interpreting charts, and counseling caregivers 	
Defining Characteristics	<ul style="list-style-type: none"> • Creates community motivation/sensitization to reduce underweight • Uses trained community-selected volunteers • Uses “inadequate weight gain” as early indicator of growth faltering • Referral and counter-referral system with health posts/centers • Uses counseling and negotiation specific to the individual child 	<ul style="list-style-type: none"> • Home visits • Active community involvement in problem solving and planning • Potential contact for measuring mid-upper arm circumference, edema screening, and referral for SAM • Addresses many causes of poor growth, not just the symptoms, and is closely tied to promoting evidence-based interventions
Needed Elements for Quality Programming by Implementers	<p>For the individual child:</p> <ul style="list-style-type: none"> • Routine monthly assessment of growth status • Feedback on growth and assessment of health and feeding • Individualized counseling on feeding and child care practices and negotiating adoption of improved practices • Follow-up and referral following program standards 	<p>Across the whole program:</p> <ul style="list-style-type: none"> • Quality counseling • Analysis of causes of inadequate growth with guidelines for taking actions • A large network of community-based workers or volunteers (2–3 community workers per 20 children) to be effective • Supportive and quality monitoring and supervision • Community participation in planning • Caretaker involvement in monitoring the child’s weight gain • A central location within a reasonable walk for most community members
Resources	<ul style="list-style-type: none"> • Promoting the Growth of Children: What Works. Rationale and Guidance for Programs (The World Bank 1996) • A Cost Analysis of the Honduras Community-Based Integrated Child Care Program (World Bank HNP Discussion Paper 2003) • Growth Monitoring and Promotion: A Review of the Evidence (<i>Maternal and Child Nutrition</i> 2008, Vol. 4, Issue Supplement s1) 	

Food Supplementation/Food Assistance: Prevention

Brief Summary Description	In food-insecure environments, programs may choose to supplement the diets of women, children, and/or households to help them meet their macro and micronutrient needs. Food supplements may be in the form of international food aid (including fortified-blended foods and vitamin A-fortified oil) or locally or regionally purchased foods. The food rations are generally distributed on a monthly basis. To be most effective, food supplementation should be accompanied by essential health and nutrition services and SBC programming. One food supplementation approach, the preventing malnutrition in children under 2 approach (PM2A) is a specific, tested package of actions aimed at preventing undernutrition. Although PM2A has been found to be more effective in reducing chronic malnutrition than recuperative programs, it may not be appropriate in all program contexts. There is also a great deal of experience with the use of food supplementation to meet gaps in the diet in emergency situations; some lessons are applicable in developing contexts.
Objective	<ul style="list-style-type: none"> • Reduce prevalence of chronic malnutrition
Target Groups	<ul style="list-style-type: none"> • All children 6–23 months of age • Pregnant women • Lactating women from delivery until the child is 6 months of age • Households of the participant women and children
Criteria	<ul style="list-style-type: none"> • Food-insecure environment • Evidence that the area can absorb the quantity of food supplementation needed and that the food supplementation will not displace local food production (Bellmon Estimation Studies for Title II is a resource) • Logistical capacity for transport, storage, and management of food commodity • Health services available (or ability to work to strengthen health services) • Child stunting and/or underweight should be high (> 30% or 20%, respectively)
Defining Characteristics	<ul style="list-style-type: none"> • Food is provided to vulnerable people who could not otherwise access it • Opportunity to link with agriculture and livelihood sectors and improve food access while also improving utilization • Food supplementation may also be targeted on a seasonal basis, based on local context and preferences
Needed Elements for Quality Programming	<ul style="list-style-type: none"> • Provision of or access to basic essential health services • Complementary SBC programming focused on maternal nutrition, IYCF, hygiene, and health-seeking behaviors • Close coordination with health, nutrition, and food security programs and services • Formative research to adapt program to local conditions, including a seasonal calendar of when food needs are greatest
Resources	<ul style="list-style-type: none"> • USAID Office of Food for Peace • Impact and Cost-Effectiveness of the Preventing Malnutrition in Children under 2 Approach (FANTA) • World Food Programme

Conditional Cash Transfers³¹

Brief Summary Description	Conditional cash transfer programs provide cash payments to poor households that fulfill program-mandated requirements, such as participation in certain nutrition programs (e.g., behavior change communication, GMP, supplementation, and attending health services). These programs aim to alleviate poverty in the short and long term through simultaneous cash transfers and investments in health, education, social services, and women’s empowerment. The cash payment given to the household encourages participation in health and nutrition programs, reduces resource constraints/improves purchasing power, and encourages long-term investment in human capital. Program evaluations have found that conditional cash transfer programs have improved nutritional status in children (stunting) and school enrollment, and have reduced illness. The programs tend to be large scale and government-run. Results are very dependent on the quality of program implementation and targeting. Administering and monitoring conditional cash transfers can be costly.
Objectives	<ul style="list-style-type: none"> • Break the intergenerational cycle of poverty • Provide incentive to participate in essential health and nutrition services • Promote behavior change
Target Groups	<ul style="list-style-type: none"> • Poor households with children under 2 years of age • Women are generally the recipients of the cash because they are more likely to invest it in the well-being of their family
Criteria	<ul style="list-style-type: none"> • Nutrition and health services/programs that beneficiaries must participate in are in place, accessible, and of good quality • Government/community support of the program • Program takes place in areas where families are unlikely or unable to invest their own resources in children’s long-term human capital (e.g., health services are available and of good quality, but underutilized)
Defining Characteristics	<ul style="list-style-type: none"> • Resource transfer is cash • There are conditions for receiving the cash • Comprehensive program addressing resource constraints, poverty, health-seeking behaviors, and behavior change
Needed Elements for Quality Programming	<ul style="list-style-type: none"> • Close monitoring of program operations, targeting, and conditionality • Strong administrative supervision • Links between all related sectors (health, education, social services) • Formative research to understand reasons why people do or do not participate in health and nutrition services • Health system strengthening to support increased demand from conditional cash transfers
Resources	<ul style="list-style-type: none"> • Can Conditional Cash Transfer Programs Play a Greater Role in Reducing Child Undernutrition? (The World Bank 2008) • Conditional Cash Transfer Programs: An Effective Tool for Poverty Alleviation? (Asian Development Bank 2008) • Nuts and Bolts of the Bolsa Familia Program: Implementing CCTs in a Decentralized Context (World Bank 2007)

³¹ Bassett, L. 2008. *Can Conditional Cash Transfer Programs Play a Greater Role in Reducing Child Undernutrition?* SP Discussion Paper No. 0835, Social Protection and Labor. Washington, DC: The World Bank.

Child Health Weeks/Days

Brief Summary Description	These should occur every 6 months to deliver vitamin A supplements and other preventive health services to children at the community level. In addition to vitamin A, services have included: catch-up immunization, providing iron/folic acid to pregnant women, deworming, iodized salt testing, distribution of long lasting insecticide-treated nets, screening for malnutrition, and promotion of infant and young child nutrition.
Objectives	<ul style="list-style-type: none"> • Increase coverage of vitamin A supplementation • Increase coverage of other nutrition approaches • Provide deworming
Target Group	<ul style="list-style-type: none"> • Children 0–59 months of age
Criteria	<ul style="list-style-type: none"> • Vitamin A program in the country
Defining Characteristics	<ul style="list-style-type: none"> • High coverage rates • Feasible in diverse settings • Community census and social mobilization
Needed Elements for Quality Programming	<ul style="list-style-type: none"> • Best suited for areas with high prevalence of vitamin A deficiency • Requires coordination with district health plan and staff • Need to assure adequate supply • Volunteers and supervisors need to be trained • Substantial social mobilization • Follow-up/record-keeping important • Part of a larger nutrition strategy

Community-Integrated Management of Childhood Illness

Brief Summary Description	Community-based program to address diarrhea, malaria, undernutrition, measles and pneumonia. Four key elements are: facility/community linkages; care and information at the community level; promotion of 16 key family practices; and coordination with other sectors.
Objectives	<ul style="list-style-type: none"> • Reduce morbidity and mortality of children under 5 years of age • Address diarrhea, malaria, undernutrition, measles, and pneumonia • Improve access to curative services
Target Groups	<ul style="list-style-type: none"> • Children 0–59 months of age
Criteria	<ul style="list-style-type: none"> • National integrated management of childhood illnesses policies and protocols • Collaborating health facility implementing integrated management of childhood illnesses for patient referral • Cadre of available community health workers or volunteers • High prevalence of common childhood illnesses: undernutrition, diarrhea, malaria, pneumonia, and/or measles
Defining Characteristics	<ul style="list-style-type: none"> • Integrated approach focuses on whole child, not individual diseases • Community-level prevention and treatment • Linked with health facilities • Evidence-based protocols for prevention and treatment • Addresses interrelationships among illnesses • All ENA messages are part of integrated management of childhood illnesses key family practices • Mostly applied to children who present at health facilities or to community health workers with illness
Needed Elements for Quality Programming	<ul style="list-style-type: none"> • Involvement and commitment of the health sector • Training of health staff • Refresher courses • Supplies • Supervision
Resources	<ul style="list-style-type: none"> • Household and Community IMCI (CORE Group)

Community Case Management	
Brief Summary Description	An approach to deliver community-based, life-saving curative interventions for common, serious childhood infections including: pneumonia, diarrhea, malaria, and newborn sepsis. It relies on trained, supervised community members to provide health services. The interventions are: antibiotics for pneumonia, dysentery, and newborn sepsis; oral rehydration therapy; antimalarials; zinc; and vitamin A.
Objectives	<ul style="list-style-type: none"> • Reduce mortality from common childhood illnesses among children 0–59 months of age • Improve access to curative services • Address pneumonia, diarrhea, newborn sepsis, and malaria
Target Groups	<ul style="list-style-type: none"> • Children 0–59 months of age
Criteria	<ul style="list-style-type: none"> • High mortality from illnesses treated by community case management • Lack of continual access to curative interventions • Low use of health facilities • Policy environment supports community case management (e.g., community health workers able to administer medications) • Treatment protocols available
Defining Characteristics	<ul style="list-style-type: none"> • Uses trained, supervised community members to deliver the services • Designed to respond to local needs; is seldom a national program • Focus on areas with limited access to health facilities • Used to improve access, quality, and demand of treatment at the community level
Needed Elements for Quality Programming	<ul style="list-style-type: none"> • Requires sound training and supervision • Strong links with functional health facilities for training, supervision, and referral • Requires access to supply of curative products: medicines, oral rehydration therapy, vitamin A, and zinc • Promotion of timely care-seeking and improved feeding during illness
Resources	<ul style="list-style-type: none"> • Community Case Management Essentials (CORE Group 2010)

Annex 2. Nutrition Program Approaches: Recuperation

The following tables provide summary of the programs listed in Step 5 of the Reference Guide for easy reference while filling out Step 5 in the Workbook.

PD/Hearth	
Brief Summary Description	PD/Hearth is an approach to rehabilitate underweight children. Positive Deviance Inquiries identify successful practices and strategies of poor local families that have healthy children. In a 2-week intensive behavior change initiative (hearth sessions), volunteers and caregivers prepare and feed a recuperative meal of locally available foods and learn and practice affordable, acceptable, effective, and sustainable PD care practices. The meal ingredients are provided by participating families so that they learn that they can afford the foods, where to acquire them, and how to use them. Families are followed up with home visits after graduating from the hearth session to ensure continued growth.
Objectives	<ul style="list-style-type: none"> • Rehabilitate moderately underweight children³² • Enable families to maintain child’s improved nutritional status • Prevent undernutrition among other children born in the family • Improve care and feeding practices • Avoid community dependence on supplemental food programs
Target Group	<ul style="list-style-type: none"> • Children 6–36 months of age with moderate underweight (weight-for-age < -2 z-scores) • Note: Children under 6 months of age should be exclusively breastfed and if malnourished, need to be referred to a health center
Criteria	<p>Consider PD/Hearth if you can answer yes to the following questions:</p> <ul style="list-style-type: none"> • Are at least 30% of children 6–36 months moderately or severely underweight (weight-for-age < -2 z-scores)? • Is nutrient-rich food available and affordable? • Are homes located within a short distance of each other? • Is there is a community commitment to overcome undernutrition? • Is there access to basic complementary health services such as deworming, immunizations, malaria treatment, micronutrient supplementation, and referrals? • Is there a system (or can a system be created) for identifying and tracking malnourished children?
Defining Characteristics	<ul style="list-style-type: none"> • Caregivers contribute local foods • Community-level rehabilitation • Uses locally available foods and feasible practices • Engages community in addressing undernutrition • Recuperation and prevention of future undernutrition • Follow-up home visits • Intensive behavior change
Needed Elements for Quality Programming	<ul style="list-style-type: none"> • Positive Deviance Inquiries done in every community • Growth monitoring or screening mechanism to identify malnourished children • SBC strategies for hearth participants and larger community • Health services to address common childhood diseases • Community mobilization • Qualitative skill sets to engage community in conducting and analyzing Positive Deviance Inquiries • Skills in anthropometric measurement • Ability to identify children with SAM for referral • Ability to identify children who are stunted only, who are less likely to benefit from the program, and screen them out • Technical assistance from someone skilled in the PD/Hearth approach • Good supervision skills • Access to basic complementary health services (immunization, deworming, and micronutrients)
Resources	<ul style="list-style-type: none"> • Positive Deviance/Hearth Essential Elements: A Resource Guide for Sustainably Rehabilitating Malnourished Children (CORE Group 2005)

³² Evidence indicates that PD/Hearth is most effective in rehabilitation where underweight is reflecting wasting rather than stunting.

Community-Based Management of Acute Malnutrition (CMAM)

Brief Summary Description	Community-based approach for managing SAM cases, which includes outpatient care for SAM without medical complications, inpatient care for SAM with medical complications and infants under 6 months, and community outreach. Community workers are trained to use MUAC and assess edema to actively seek and refer SAM cases to the CMAM program. Based on a medical evaluation and using routine medication and RUTF, CMAM treats the majority of SAM cases at home. SAM cases with medical complications are referred to inpatient care for stabilization before being released to outpatient care for full recovery. CMAM programs may also include a component to manage MAM with routine medications and supplementary feeding, often with fortified-blended foods or ready-to-use supplemental foods.
Objectives	<ul style="list-style-type: none"> • Treat acute malnutrition • Reduce morbidity and mortality of children with acute malnutrition
Target Groups	<ul style="list-style-type: none"> • Children 6–59 months of age with SAM (MUAC < 115 mm, weight-for-height < -3 z-scores, and/or bilateral pitting edema) • Children 6–59 months of age with MAM (MUAC < 125 but > 115 mm, weight-for-height < -2 z-scores but > -3 z-scores) and children under 6 months with MAM may be included in the national program protocols • Children under 6 months of age with SAM
Criteria	<ul style="list-style-type: none"> • Availability of national protocols for the management of acute malnutrition • Availability of RUTF, therapeutic milk (F75/F100), and routine medication • Availability of trained staff • Prevalence of SAM in children under 5 exceeds 1% of population of children 6–59 months • Communities with > 10% wasting among children 6–59 months • May be considered for use in post-emergency communities or with frequent periodic emergencies in addition to development contexts
Defining Characteristics	<ul style="list-style-type: none"> • Community-based approach for treating acute malnutrition on an outpatient basis • Use of RUTF instead of milk-based formulas for cases of SAM with no medical complications and children over 6 months of age • Community outreach for active case-finding and referral to catch children with SAM or MAM as early as possible
Needed Elements for Quality Programming	<ul style="list-style-type: none"> • Active community case-finding using MUAC and assessment of edema • SBC strategies for sustainable prevention • Health services to address common childhood diseases • Trained community members who can identify cases of acute malnutrition for referral • Resources (financial, in-kind) for a supply of RUTF and medications • Trained clinical staff to conduct anthropometric measurements, classify nutritional status, conduct medical evaluation, identify medical complications, refer cases, and treat cases • Inpatient services available
Resources	<ul style="list-style-type: none"> • The CMAM Forum (a central repository for information on CMAM) • Training Guide for Community-Based Management of Acute Malnutrition (FANTA, Concern Worldwide, UNICEF, and Valid International 2008)

Food Supplementation/Food Assistance: Recuperation

Brief Summary Description	In a recuperative food supplementation program, children (usually 6–59 months of age, but target ages vary) with MAM receive a supplementary food ration along with health services and behavior change communication for a set period of time or until recovery. Supplementary feeding programs are often established in emergencies to fill dietary gaps, protect lives, and protect nutritional status of women and children.
Objectives	<ul style="list-style-type: none"> • Manage MAM • Manage moderate underweight
Target Groups	<ul style="list-style-type: none"> • Children 6–59 months of age with MAM • Lactating mothers of malnourished children under 6 months of age
Criteria	<ul style="list-style-type: none"> • Food-insecure environment • Evidence that food supplementation will not displace local production • Logistical capacity for transport, storage, and management of food commodity • High prevalence of MAM and SAM, together (> 10% or > 5% with aggravating factors)
Defining Characteristics	<ul style="list-style-type: none"> • Opportunity to link with agriculture and livelihood sectors and improve food access while also improving utilization • Food supplementation may also be targeted on a seasonal basis, when food needs are greatest • Food is provided to children 6–59 months of age with MAM
Needed Elements for Quality Programming	<ul style="list-style-type: none"> • Provision of or access to basic essential health services (and treatment of SAM if appropriate) • Complementary preventive SBC programming focused on maternal nutrition, IYCF, hygiene, and health-seeking behaviors • Close programmatic coordination with health, nutrition, and food security programs and services • Formative research to adapt program to local conditions, including seasonal calendar of when food needs are greatest
Resources	<ul style="list-style-type: none"> • USAID Office of Food for Peace • World Food Programme

