Nutrition Program Design Assistant: A Tool for Program Planners

Workbook

April 2010








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WORKBOOK

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

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April 2010

CORE Group

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Food and Nutrition Technical Assistance II Project (FANTA-2)

FANTA-2 works to improve nutrition and food security policies, strategies and programs through technical support to the United States Agency for International Development (USAID) and its partners, including host country governments, international organizations and NGO implementing partners. Focus areas for technical assistance include maternal and child health and nutrition, HIV and other infectious diseases, food security and livelihood strengthening, and emergency and reconstruction. FANTA-2 develops and adapts approaches to support the design and quality implementation of field programs, while building on field experience to improve and expand the evidence base, methods, and global standards for nutrition and food security programming. The project is funded by USAID, managed by the Bureau for Global Health (GH) and implemented by the AED.

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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.

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Joan Jennings developed the conceptual framework for the tool and worked iteratively with the Nutrition Working Group to draft the initial versions.

Kristen Cashin (AED/FANTA-2), **Paige Harrigan** (Save the Children), and **Lynette Walker** (Consultant) wrote the final version of this document with solicited input from a variety of reviewers.

Kathryn Bolles (Save the Children), **Paige Harrigan** (Save the Children), and **Mary Hennigan** (Catholic Relief Services) shepherded this tool from its initial conception to the final product as co-chairs of the CORE Nutrition Working Group.

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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 methods for improving maternal, infant and child nutrition.

Sincerely,
Paige Harrigan, Co-Chair
The Nutrition Working Group
CORE Group

Karen LeBan, Executive Director
CORE Group

World Vision's contribution to the printing costs is appreciated.

Acronyms and Abbreviations

ARI	Acute respiratory infections
BCC	Behavior change communication
BFHI	Baby-Friendly Hospital Initiative
BMI	Body mass index
CBGMP	Community-based growth monitoring and promotion
CCM	Community case management
CCT	Conditional cash transfer
CHV	Community health volunteer
CHW	Community health worker
C-IMCI	Community Integrated Management of Childhood Illnesses
CMAM	Community-Based Management of Acute Malnutrition
CNV	Community nutrition volunteer
CRS	Catholic Relief Services
CSHGP	USAID Child Survival and Health Grants Program
dl	Decileter(s)
DHS	Demographic and Health Surveys
EBF	Exclusive breastfeeding
ENA	Essential Nutrition Actions
FANTA-2	Food and Nutrition Technical Assistance II Project
FBA	Food based approaches
g	Gram(s)
GAM	Global acute malnutrition
GMP	Growth monitoring and promotion
Hb	Hemoglobin
HFA	Height-for-age
HIV	Human immunodeficiency virus
HMIS	Health management information system
IEC	Information, education and communication
IFA	Iron/folic acid
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent preventive treatment of malaria
IYCF	Infant and young child feeding
kcal	Kilocalorie(s)
kg	Kilogram(s)
KPC	Knowledge, Practice and Coverage Survey
l	Liter(s)
LNS	Lipid-based nutrient supplement
m	Meter(s)
MAM	Moderate acute malnutrition
MAMI	Management of Moderate Acute Malnutrition in Infants Project
MICS	Multiple Indicator Cluster Survey
mm	Millimeter(s)
MOH	Ministry of Health
MUAC	Mid-upper arm circumference
NGO	Nongovernmental organization
NNP	National Nutrition Policy
NPDA	Nutrition Program Design Assistant
NWG	Nutrition Working Group
ORC Macro	Opinion Research Corporation Macro International, Inc
ORS	Oral rehydration solution
ORT	Oral rehydration therapy
PD	Positive Deviance
PDI	Positive Deviance Inquiry
PM2A	Preventing Malnutrition in Children Under 2 Approach
PMTCT	Prevention of mother to child transmission of HIV
ppm	Parts per million
PRA	Participatory Rapid Appraisal
PVO	Private voluntary organization
RRA	Rapid Rural Appraisal
RUTF	Ready-to-use therapeutic food
SAM	Severe acute malnutrition
SBC	Social and behavior change
SBCC	Social and behavior change communication
SFP	Supplementary feeding programs
SPA	DHS Service Provision Assessment
TRM	Technical Reference Material
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WFA	Weight-for-age
WFH	Weight-for-height
WHO	World Health Organization
µmol	Micromole(s)

Welcome to the Nutrition Program Design Assistant Workbook!

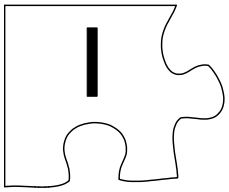
The Nutrition Program Design Assistant: A Tool for Program Planners (NPDA) is composed of two complementary documents: this Workbook and a Reference Guide. Together, they help program design teams select the most appropriate community-based nutrition approaches for their target area. This Workbook, which 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 and Objectives**
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

Icon	Indicates
	Information is given about where to find guidance in the Reference Guide.
	Write your inputs.
	An example is given.
	Go to the next section.



STEP 1. 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 around 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. Refer to page 14 of the Reference Guide for guidance on data collection.

Part II. Gathering Qualitative Information

Part II in the Workbook is centered around 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. Refer to page 16 in the Reference Guide for guidance on collecting qualitative data related to food consumption.

Part III. Synthesizing Data

This section is designed to facilitate data synthesis and decision-making for the five intervention areas. Guidance for synthesizing data begins on page 19 of the Reference Guide.

STEP 1 • PART I. QUANTITATIVE DATA COLLECTION TABLES

Complete as much of the tables as you are able, focusing especially on numbered indicators for which there is guidance in the reference guide. 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 are selected from those indicators used in USAID's DHS and KPC surveys and UNICEF's MICS. The numbered indicators have corresponding decision-making guidance in the Reference Guide and Workbook. 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 pages 14-16 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 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. **Insert the definitions of the numerator and denominator** you will be using for each indicator so that you have a record of how the indicator was formed (e.g., numerator = children under 5 with SAM, denominator = all children under 5).

d. **Note the source of the data** (e.g., DHS, MOH, WFP, NGO 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 MS 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	SEX		OTHER PERTINENT DISAGGREGATION	DEFINITION OF		Data Source (s) and Dates
A. NUTRITIONAL STATUS: ANTHROPOMETRY[1]	% National Level	% Province	% District	Lowest Wealth Quintile	M	F		Numerator	Denominator	
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. Wasting: % of children __ – __ months of age that are wasted (weight-for-height <-2 Z-scores)										

[1] In Table A, Data on Moderate and Severe Undernutrition, 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.

INTERVENTION AREA	GEOGRAPHIC			SOCIO-ECONOMIC LEVEL	SEX		OTHER PERTINENT DISAGGREGATION	DEFINITION OF		Data Source (s) and Dates
A. NUTRITIONAL STATUS: ANTHROPOMETRY[1]	% National Level	% Province	% District	Lowest Wealth Quintile	M	F		Numerator	Denominator	
A4. Severe Acute Malnutrition: % of children __ - __ months of age with severe acute malnutrition (weight-for-height <-3 Z-scores, bilateral pitting edema, or MUAC < 115 mm[2])										
Other:										

QUANTITATIVE DATA COLLECTION TABLE B. INFANT AND YOUNG CHILD FEEDING

INTERVENTION AREA	GEOGRAPHIC			SOCIO-ECONOMIC LEVEL	SEX		OTHER PERTINENT DISAGGREGATION	DEFINITION OF		Data source (s) and Dates
B. INFANT AND YOUNG CHILD FEEDING[3]	% National Level	% Province	% District	Lowest Wealth Quintile	M	F		Numerator	Denominator	
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[4]										
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										

[2] The age range for measuring MUAC in children is 6-59 months of age.
[3] Indicator definitions can be found in "Indicators for assessing infant and young child feeding practices,Part 1: Definitions" WHO, 2008. *http://whqlibdoc.who.int/publications/2008/9789241596664_eng.pdf* An additional publication on how to measure the indicators is forthcoming.
[4] pre-lacteal feeds include any food or liquid other than breast milk given to a child in the first three days of life

INTERVENTION AREA	GEOGRAPHIC			SOCIO-ECONOMIC LEVEL	SEX		OTHER PERTINENT DISAGGREGATION	DEFINITION OF		Data source (s) and Dates
B. INFANT AND YOUNG CHILD FEEDING[3]	% National Level	% Province	% District	Lowest Wealth Quintile	M	F		Numerator	Denominator	
B6. % of breastfed and non-breastfed children 6-23 months of age who receive solid, semi-solid or soft foods[5] the minimum number of times[6] or more										
B7. % of children 6-23 months of age who receive foods from four or more food groups[7]										
B8. % of children 6-23 months of age who receive a minimum acceptable diet[8]										
B9. % of children 0-23 months of age with diarrhea in the last 2 weeks who were offered more fluids during the illness (note: fluid is breast milk only in children under 6 months of age)										
B10. % of children 6-23 months of age with diarrhea in the last 2 weeks who were offered the same amount or more food during the illness										
OTHER USEFUL INDICATORS NOT ADDRESSED IN THE REFERENCE GUIDE										
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:										

[5] Includes milk feeds for non-breastfed children
[6] Minimum is based on age and breastfeeding status: 2 times – breastfed child 6-8 months; 3 times – breastfed child 9-23 months; 4 times – non-breastfed child 6-23 months
[7] Note: the food groups are based on seven specific food groups describe in "Indicators for assessing infant and young child feeding practices,Part 1: Definitions" WHO, 2008. http://whqlibdoc.who.int/publications/2008/9789241596664_eng.pdf An additional publication on how to measure the indicators is forthcoming.
[8] The Minimum Acceptable Diet is a summary infant and young child feeding indicator that indicates the proportion of children who receive a minimum acceptable diet by combining the dietary diversity and meal frequency indicators.

QUANTITATIVE DATA COLLECTION TABLE C: MATERNAL NUTRITION

INTERVENTION AREA	GEOGRAPHIC			SOCIO-ECONOMIC LEVEL	SEX		OTHER PERTINENT DISAGGREGATION	DEFINITION OF		Data source (s) and Dates
C. MATERNAL NUTRITION	% National Level	% Province	% District	Lowest Wealth Quintile	M	F		Numerator	Denominator	
C1. % of newborns with low birth weight (<2,500 grams) [9] **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 kg/ m^2)										
C3. % of children 0-59 months of age stunted (height-for-age < -2 Z-scores)[10]										
C4. % of women of reproductive age (15-49 years of age) with vitamin A deficiency (serum retinol values ≤ .70µmol/l) [11] **Alternate indicator:** % of mothers of children 0-23 months of age reporting night blindness during last pregnancy										
C5. % of mothers of children age 6-59 months of age who received high-dose vitamin A supplement within 8 weeks post-partum (6 weeks if not exclusively breastfeeding)										
C6. % of women of reproductive age (15-49 years of age) with anemia (Hb < 11 g/dl for pregnant women; < 12 g/dl for non pregnant women)										
C7. % of mothers of children 0-23 months of age who bought or received iron / folic acid supplements while pregnant with youngest child										

[9] Depending on the percentage of children delivered in health facilities, this MOH 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.
[10] Note: Insert data from Indicator 3 in Table A ***could be different age group*
[11] This main indicator is preferred, however if information for this indicator does not exist or is insufficient, use the alternate indicator.

INTERVENTION AREA	GEOGRAPHIC			SOCIO-ECONOMIC LEVEL	SEX		OTHER PERTINENT DISAGGREGATION	DEFINITION OF		Data source (s) and Dates
C. MATERNAL NUTRITION	% National Level	% Province	% District	Lowest Wealth Quintile	M	F		Numerator	Denominator	
C8. % of households consuming adequately iodized salt (20-40 ppm)										
OTHER USEFUL INDICATORS NOT ADDRESSED IN THE REFERENCE GUIDE										
Rates of anemia in women of reproductive age (15-49 years of age) based on severity: o Mild (Hb10.0-11.0 g/dl for pregnant women; 10.0-12.0 g/dl for non-pregnant women) o Moderate (Hb 7.0-9.9 dl for pregnant and non-pregnant women) o 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 who took 90+ daily iron supplements during last pregnancy										
% of women that consumed at least 1 additional serving of staple food during last pregnancy										
% 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										
Other:										

QUANTITATIVE DATA COLLECTION TABLE D. MICRONUTRIENT STATUS OF CHILDREN

INTERVENTION AREA	GEOGRAPHIC			SOCIO-ECONOMIC LEVEL	SEX		OTHER PERTINENT DISAGGREGATION	DEFINITION OF		Data source (s) and Dates
D. MICRONUTRIENT STATUS OF CHILDREN[12]	% National Level	% Province	% District	Lowest Wealth Quintile	M	F		Numerator	Denominator	
D1. % of children 6-59 months of age with vitamin A deficiency (serum retinol values ≤ .70µmol/l)[13] **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 supplement in previous 6 months										
D3.% of children 6-59 months of age with anemia (Hb< 11 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										
D7. Median urinary iodine concentration in children 0-59 months years of age (µg/l)										
OTHER USEFUL INDICATORS NOT ADDRESSED IN THE REFERENCE GUIDE										
% 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:										

[12] 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.
[13] This first indicator is preferred; however, if information for this indicator does not exist or is insufficient, use the alternate indicator.

QUANTITATIVE DATA COLLECTION TABLE E. UNDERLYING DISEASE BURDEN

INTERVENTION AREA	GEOGRAPHIC			SOCIO-ECONOMIC LEVEL	SEX		OTHER PERTINENT DISAGGREGATION	DEFINITION OF		Data source (s) and Dates
E. UNDERLYING DISEASE BURDEN	% National Level	% Province	% District	Lowest Wealth Quintile	M	F		Numerator	Denominator	
E1. % of children 0-23 months of age with diarrhea in last two weeks										
E2. % of children 0-23 months of age with diarrhea in last two weeks who received ORS and/or recommended home fluids										
E3. % of children 0-23 months of age with chest-related cough and fast or difficult breathing in the last two weeks										
E4. % of children 0-23 months of age with chest-related cough and fast or difficult breathing in the last two weeks who were taken to an appropriate health provider										
E5. % of children with fever in the past two weeks (in malaria zones)										
E6. % of children 0-23 months of age with a fever during the last two weeks, and treated with an effective anti-malarial drug within 24 hours										
E7. % of children 0-23 months of age who are HIV positive[14]										

[14] **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 is HIV positive, a high percentage of children is 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.)
- Prevalence of chronic illness and/or tuberculosis: In areas where people do not know their HIV status, chronic illness 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	SEX		OTHER PERTINENT DISAGGREGATION	DEFINITION OF		Data source (s) and Dates
E. UNDERLYING DISEASE BURDEN	% National Level	% Province	% District	Lowest Wealth Quintile	M	F		Numerator	Denominator	
Alternate indicators: o % of children with mothers who are HIV positive; or o % of pregnant women who are HIV positive; or o % of women 15-49 years of age who are HIV-positive; or o % of children 6-23 months of age who are enrolled in PMTCT services										
E8. % of children 12-23 months fully immunized by age 12 months according to country guidelines										
OTHER USEFUL INDICATORS NOT ADDRESSED IN THE REFERENCE GUIDE										
% of mothers of children 0-23 months of age who received at least two 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 hand washing										
% of households with access to safe water (or improved water source)										

INTERVENTION AREA	GEOGRAPHIC			SOCIO-ECONOMIC LEVEL	SEX		OTHER PERTINENT DISAGGREGATION	DEFINITION OF		Data source (s) and Dates
E. UNDERLYING DISEASE BURDEN	% National Level	% Province	% District	Lowest Wealth Quintile	M	F		Numerator	Denominator	
% of households with access to improved sanitation										
% of children delivered by: Doctor										
Other health professional										
Traditional birth attendant										
Other										
% of deliveries at: Health facility										
Home										
Other										
% of households with at least one ITN										
% of children under 5 who slept under an ITN the night before the interview										
% of pregnant women 15-49 years of age who slept under an ITN 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 on pages 16-19 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 page 16 of the in the Reference Guide.
4. **Collect the additional pertinent qualitative data and record the results** in a separate notebook or datafile.
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),[15] 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 table below presents **one way** to summarize the information and NPDA users are encouraged to modify this table, using the MS Excel file (found at www.coregroup .org or www.fanta-2.org) or other formats. The food group categories are organized according to those in Module 2 of the KPC[16] and also line up with the ENA practices.

[15] Swindale, Anne and Punam Ohri-Vachaspati. 2005. *Measuring Household Food Consumption: A Technical Guide*. Washington, D.C.: Food and Nutrition Technical Assistance (FANTA) Project, Academy for Educational Development (AED).
[16] http://www.childsurvival.com/kpc2000/kpc2000_new_summary.cfm

FOOD CONSUMPTION SUMMARY TABLE

Food Groups	Percentage of children 6-24 months of age consuming these types of foods in the last 24 hours[17]	Are these foods Available in local markets?[18] 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) – *(note it is expected that these foods are not fortified, there are categories for fortified foods below).*							
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 meat foods: meat, fish, poultry, liver, kidneys, eggs and/or unique wild animals such as insects, mice, small birds							

[17] Note: 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 aged 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 chose 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.

[18] 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 of age consuming these types of foods in the last 24 hours[17]	Are these foods Available in local markets?[18] 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:
Cheese, yogurt and other milk products							
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 out the columns labeled "Data" in Tables A-E**. Copy the indicator value from the Quantitative Data Collection Tables for each indicator for the target geographic area. Note: Guidance for completing the column in Tables A - E on the level of public health concern will be provided in Step 1 • Part III.

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 • Section III. Synthesizing the Data on pages 19-28 of the Reference Guide**, which provides guidance for understanding the data provided for each section (A. Nutritional Status: Anthropometry, B. Infant and Young Child Feeding, C. Maternal Nutrition, D. Micronutrient Status of Children, E. Underlying Disease Burden).

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. **Answer the questions provided after each table** in the Workbook to better understand the implications of the data.

6. **Discuss the implications of the data and record your assessment** in the Synthesis of Data section for Sections A – E.

7. **Determine if the data for each intervention area indicate that it is a key public health concern.**

8. **Mark your decision in the Conclusion checkbox and explain your rationale** at the end of each section in the Workbook.

Section A. Synthesizing the Data on Nutritional Status: Anthropometry

Guidance for this section begins on page 19 of the Reference Guide.

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 (HFA < -2 Z-scores)				▪ < 20%: Low ▪ 20-29%: Medium ▪ 30-39%: High ▪ ≥ 40%: Very High
A2. Underweight: % of children ____ to ____ months of age that are underweight (WFA < -2 Z-scores)				▪ < 10%: Low ▪ 10-19%: Medium ▪ 20-29%: High ▪ ≥ 30%: Very High
A3. Wasting: % of children ____ to ____ months of age that are wasted (WFH < -2 Z-scores)				▪ < 5.0%: Low ▪ 5 to 9%: Medium ▪ 10 to 14%: High ▪ ≥ 15%: Very High
A4. Severe Acute Malnutrition: % of children ____ to ____ months of age with SAM (WFH < -3 Z-scores, bilateral pitting edema, or MUAC < 115 mm)				▪ > .5%: Medium ▪ ≥ 1%: High

OTHER FACTORS TO CONSIDER REGARDING NUTRITIONAL STATUS: ANTHROPOMETRY

What are the patterns of malnutrition (ex. seasonality, trends over time, aggravating factors) in your area?

SYNTHESIS OF DATA ON NUTRITIONAL STATUS: ANTHROPOMETRY

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

What further insight does disaggregated data provide? (Note: this detail would be found in the Quantitative Data Collection Tables and is not listed above)

Which are the most vulnerable groups? Why?

Are there gender issues to consider?

Other thoughts?

QUESTIONS ON THE IMPLICATIONS OF NUTRITIONAL STATUS: ANTHROPOMETRY

Further instruction and questions

Is a preventive community-based nutrition program indicated?

1. Is stunting prevalence Medium (20-29%), High (30-39%) or Very High (≥ 40%)? _____

2. Is underweight prevalence Medium (10-19%), High (20-29%) or Very High (≥30%)?

If yes to 1 or 2, focus on prevention for both women and children, and identify priority intervention areas among sections B-E below

Are recuperative approaches indicated in addition to preventive approaches?

1. Is underweight prevalence Very High (≥ 30%)? _____

2. Is wasting prevalence High (≥ 10%) or Very High (≥15) in your target area? _____

3. Is prevalence of SAM high (≥ 1%)? _____

4. Is wasting prevalence Medium (5-9%) or prevalence of SAM Medium (>0.5%) with any of the following aggravating factors?

- ☐ Large-scale population movement and/or sudden large influx of new SAM cases
- ☐ Serious food crisis
- ☐ Epidemic of measles or whooping cough
- ☐ Outbreak of diarrheal disease
- ☐ Crude death rate > 1/10,000/day
- ☐ High prevalence of maternal mortality
- ☐ High prevalence of child mortality
- ☐ SAM rates above seasonal norms

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.

Aggravating factors may indicate a need for a recuperative approach despite lower levels of public health concern.

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 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?

☐ SAM ☐ 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 to other priority areas for improving child health.

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

Guidance for this section, including an example, begins on page 20 of the Reference Guide.

TABLE B. ANALYZING DATA ON INFANT AND YOUNG CHILD FEEDING

INDICATOR: BREASTFEEDING	DATA (Fill in from Quantitative Data Collection Table)	COMMENTS ON DATA	LEVEL OF PUBLIC HEALTH CONCERN	REFERENCE FOR PUBLIC HEALTH CONCERN
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	**DATA (Fill in from Quantitative Data Collection Table)**	**COMMENTS ON DATA**	**LEVEL OF PUBLIC HEALTH CONCERN**	**REFERENCE FOR PUBLIC HEALTH CONCERN**
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 the minimum number of times or more				< 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 food groups				< 80% is generally a priority. Discuss high, medium and low designations as a group.
B8. % of children 6-23 months of age who receive a minimum acceptable diet				< 80% is generally a priority. Discuss high, medium and low designations as a group.

INDICATOR: FEEDING OF SICK CHILDREN	DATA (Fill in from Quantitative Data Collection Table)	COMMENTS ON DATA	LEVEL OF PUBLIC HEALTH CONCERN	REFERENCE FOR PUBLIC HEALTH CONCERN
B9. % of children 0-23 months of age with diarrhea in the last two weeks who were offered more fluids during the illness (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

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

What further insight does disaggregated data provide?

Which are the most vulnerable groups? Why?

Are there gender issues to consider?

Other thoughts?

Consider all of the information above to determine if this is a priority intervention area. Mark your conclusion below, explain your rationale and proceed to Section C. Maternal Nutrition.

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

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

☐ Breastfeeding ☐ Young child feeding ☐ Feeding of sick children

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

Section C. Synthesizing the Data on Maternal Nutrition

Guidance for this section begins on page 24 of the Reference Guide.

TABLE C. ANALYZING DATA ON MATERNAL NUTRITION

INDICATOR: ANTHROPOMETRY	DATA (Fill in from Quantitative Data Collection Table)	COMMENTS ON DATA	LEVEL OF PUBLIC HEALTH CONCERN	REFERENCE FOR PUBLIC HEALTH CONCERN
C1. % of newborns with low birth weight (<2500 g)[19] **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 of age) with low BMI (<18.5 kg/m^2))				▪ 5 – 9.9%: Low ▪ 10 – 19.9%: Medium ▪ 20 – 39.9%: High ▪ ≥ 40%: Very High
C3. % of children 0-59 months of age stunted (height-for-age < -2 Z-scores)				▪ < 20%: Low ▪ 20-29%: Medium ▪ 30-39%: High ▪ ≥ 40%: Very High
INDICATOR: VITAMIN A	**DATA (Fill in from Quantitative Data Collection Table)**	**COMMENTS ON DATA**	**LEVEL OF PUBLIC HEALTH CONCERN**	**REFERENCE FOR PUBLIC HEALTH CONCERN**
C4. % of women of reproductive age (15-49 years of age) with vitamin A deficiency (serum retinol values ≤ .70µmol/l)[20] **Alternate indicator:** % of mothers of children 0-23 months of age reporting night blindness during last pregnancy				▪ < 2%: Normal ▪ 2.0 – 9.9%: Low ▪ 10.0 – 19.9%: Medium ▪ ≥ 20%: High ▪ Alternate Indicator: ≥ 5%: Concern

[19] Depending on the percentage of children delivered in health facilities, this MOH 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.
[20] This first indicator is preferred, however if information for this indicator does not exist or is insufficient, use the alternate indicator.

C5. % of mothers of children 0-23 months of age who received high-dose vitamin A supplement within eight weeks post-partum (six weeks if not exclusively breastfeeding)				< 80% is generally a priority. Discuss high, medium and low designations as a group
INDICATOR: IRON	**DATA (Fill in from Quantitative Data Collection Table)**	**COMMENTS ON DATA**	**LEVEL OF PUBLIC HEALTH CONCERN**	**REFERENCE FOR PUBLIC HEALTH CONCERN**
C6. % of women of reproductive age (15-49 years of age) with anemia (Hb < 11 g/dl for pregnant women; < 12 g/dl for non-pregnant women)				▪ ≤ 4.9%: Normal ▪ 5.0 – 19.9%: Low ▪ 20.0 – 39.9%: Medium ▪ ≥ 40%: High
C7. % of mothers of children 0-23 months of age who bought or received iron / folic acid supplements while pregnant with youngest child				< 80% is generally a priority. Discuss high, medium and low designations as a group.
INDICATOR: IODINE	**DATA (Fill in from Quantitative Data Collection Table)**	**COMMENTS ON DATA**	**LEVEL OF PUBLIC HEALTH CONCERN**	**REFERENCE FOR PUBLIC HEALTH CONCERN**
C8. % of households consuming adequately iodized salt (20-40 ppm)				< 90%: Concern

OTHER FACTORS TO CONSIDER REGARDING MATERNAL NUTRITION

What are the patterns of low birth weight? Has the prevalence of low birth weight remained the same, increased or decreased in the target population?

Has the percentage of women 15-49 years of age with BMI <18.5 kg/m^2 increased recently?

What are the patterns of use of IFA supplements?

If maternal anemia is a public health concern, is there a high rate of malaria or hookworm infection in the population?

SYNTHESIS OF DATA ON MATERNAL NUTRITION

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

What further insight does disaggregated data provide? (Note: this detail would be found in the Quantitative Data Collection Table and is not listed above)

Which are the most vulnerable groups? Why?

Are there gender issues to consider?

Other thoughts?

Consider all of the information above to determine if this is a priority intervention area. Mark your conclusion below, explain your rationale and proceed to Section D. Micronutrient Status of Children.

CONCLUSION ON THE SYNTHESIS OF DATA ON MATERNAL NUTRITION

Are maternal nutrition interventions indicated?

☐ Yes ☐ No

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

Section D. Synthesizing the Data on Micronutrient Status of Children

Guidance for this section begins on page 26 of the Reference Guide.

TABLE D. ANALYZING DATA ON MICRONUTRIENT STATUS OF CHILDREN

INDICATOR: VITAMIN A	DATA (Fill in from Quantitative Data Collection Table)	COMMENTS ON DATA	LEVEL OF PUBLIC HEALTH CONCERN	REFERENCE FOR PUBLIC HEALTH CONCERN
D1. % of children 6 - 59 months of age with vitamin A deficiency (serum retinol values ≤ .70µmol/l)[21] **Alternate indicator:** % of children 24-71 months of age with night blindness				▪ 2.0 – 9.9%: Low ▪ 10 – 19.9%: Medium ▪ ≥ 20%: High ▪ Alternate Indicator: ≥ 5%: Concern
D2. % of children 6 - 59 months of age who have received vitamin A supplement in previous 6 months				< 80% is generally a priority. Discuss high, medium and low designations as a group.
INDICATOR: IRON	**DATA (Fill in from Quantitative Data Collection Table)**	**COMMENTS ON DATA**	**LEVEL OF PUBLIC HEALTH CONCERN**	**REFERENCE FOR PUBLIC HEALTH CONCERN**
D3. % of children 6-59 months of age with anemia (Hb < 11 g/dl)				▪ ≤ 4.9: Normal ▪ 5.0 – 19.9%: Low ▪ 20.0 – 39.9%: Medium ▪ ≥ 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.

[21] This first indicator is preferred, however if information for this indicator does not exist or is insufficient, use the alternate indicator.

INDICATOR: IODINE	DATA (Fill in from Quantitative Data Collection Table)	COMMENTS ON DATA	LEVEL OF PUBLIC HEALTH CONCERN	REFERENCE FOR PUBLIC HEALTH CONCERN
D6. % of households consuming adequately iodized salt (20-40 ppm)				▪ < 90%: Concern
D7. Median urinary iodine concentration in children 0-59 months years of age (µg/l)				▪ <100 µg/l

SYNTHESIS OF DATA ON MICRONUTRIENT STATUS OF CHILDREN

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

What further insight does disaggregated data provide? (Note: this detail would be found in the Quantitative Data Collection Tables and is not listed above)

Which are the most vulnerable groups? Why?

Are there gender issues to consider?

Other thoughts?

Consider all of the information above to determine if this is a priority intervention area. Mark your conclusion below, explain your rationale and proceed to Section E. Underlying Disease Burden.

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 ☐ Zinc for children

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

Section E. Synthesizing the Data on Underlying Disease Burden


Guidance for this section begins on page 27 of the Reference Guide.

TABLE E. ANALYZING DATA ON UNDERLYING DISEASE BURDEN

INDICATOR: DIARRHEA	DATA (Fill in from Quantitative Data Collection Table)	COMMENTS ON DATA	LEVEL OF PUBLIC HEALTH CONCERN[22]
E1. % of children 0-23 months of age with diarrhea in last two weeks			
E2. % of children 0-23 months of age with diarrhea in last two weeks who received ORS and/or recommended home fluids			
INDICATOR: ACUTE RESPIRATORY INFECTION (ARI)	**DATA (Fill in from Quantitative Data Collection Table)**	**COMMENTS ON DATA**	**LEVEL OF PUBLIC HEALTH CONCERN**
E3. % of children 0-23 months of age with chest-related cough and fast or difficult breathing in the last two weeks			
E4. % of children 0-23 months of age with chest-related cough and fast or difficult breathing in the last two weeks who were taken to an appropriate health provider			
INDICATOR: MALARIA	**DATA (Fill in from Quantitative Data Collection Table)**	**COMMENTS ON DATA**	**LEVEL OF PUBLIC HEALTH CONCERN**
E5. % of children with fever in the past two weeks (in malaria zones)			
E6. % of children 0-23 months of age with fever during the last two weeks treated with an effective anti-malarial drug within 24 hours			

[22] 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.

INDICATOR: HIV	DATA (Fill in from Quantitative Data Collection Table)	COMMENTS ON DATA	LEVEL OF PUBLIC HEALTH CONCERN
E7. % of children 0-23 months of age who are HIV positive[23] **Alternate indicators:** o % of children with mothers who are HIV positive; or o % of pregnant women who are HIV positive; or o % of women 15-49 years of age who are HIV positive; or o % of children 6-23 months of age who are enrolled in PMTCT (prevention of mother-to- child transmission of HIV) services			
INDICATOR: IMMUNIZATION COVERAGE	**DATA (Fill in from Quantitative Data Collection Table)**	**COMMENTS ON DATA**	**LEVEL OF PUBLIC HEALTH CONCERN**
E8. % of children 12-23 months of age fully immunized by 12 months of age, according to country guidelines			

OTHER FACTORS TO CONSIDER REGARDING UNDERLYING DISEASE BURDEN

Does the prevalence of one of these diseases stand out as more important than the others? What concerns you about the prevalence of different diseases in the program area?

Explain/describe any seasonal variations in disease prevalence/incidence.

[23] This first indicator is preferred; however, if information is inadequate or unavailable, use one of the alternate indicators.

SYNTHESIS OF DATA ON UNDERLYING DISEASE BURDEN

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

What further insight does disaggregated data provide? (Note: this detail would be found in the Quantitative Data Collection Tables and is not listed above)

Which are the most vulnerable groups? Why?

Are there gender issues to consider?

Other thoughts?

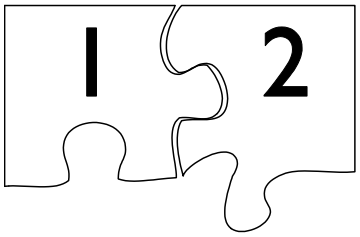
Consider all of the information above to determine if this is a priority intervention area. Mark your conclusion below, explain your rationale and proceed to Step 2.

CONCLUSION ON THE SYNTHESIS OF DATA ON UNDERLYING DISEASE BURDEN

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

☐ Diarrhea ☐ ARI ☐ Malaria ☐ HIV ☐ Immunizations ☐ Water and Sanitation ☐ Hygiene ☐ Other_____

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



STEP 2. Determine Initial Program Goal and Objectives

In Step 2, you will draft the initial program goal and objectives based on the data synthesis in Step 1 and the answers to the following questions. The objectives developed here will be refined in Step 6. Guidance for this step begins in the Reference Guide on page 29.

INSTRUCTIONS FOR DETERMINING INITIAL PROGRAM GOAL AND OBJECTIVES

1. **Review the guidance and examples** on "Forming Program Goals and Objectives" on pages 29-30 of the Reference Guide.
2. **Answer the questions in the boxes below** regarding priority interventions, level of funding anticipated, donor priorities, other activities, and organizational technical strengths and expertise.
3. **Draft your initial program goal and objectives based on need** and record them in the Workbook.

WHAT ARE THE PRIORITY INTERVENTION AREAS IDENTIFIED IN STEP 1: (I.E., WHERE IS THE GREATEST NEED?)

- ☐ **Prevention**
  - ☐ Underweight
  - ☐ Stunting
- ☐ **Prevention + Recuperation**
  - ☐ Underweight
  - ☐ Stunting
  - ☐ Wasting/MAM
  - ☐ SAM
- ☐ **IYCF**
  - ☐ Breastfeeding
  - ☐ Young child feeding
  - ☐ Feeding of sick children
- ☐ **Maternal Nutrition**
  - ☐ Dietary practices
  - ☐ Vitamin A
  - ☐ Iron
  - ☐ Iodine
- ☐ **Micronutrients in children**
  - ☐ Dietary practices
  - ☐ Vitamin A
  - ☐ Iron
  - ☐ Iodine
  - ☐ Zinc
- ☐ **Underlying disease burden**
  - ☐ Diarrhea
  - ☐ ARI
  - ☐ Malaria
  - ☐ HIV
  - ☐ Immunizations
  - ☐ Other

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

WHAT ARE THE DONOR PRIORITIES?

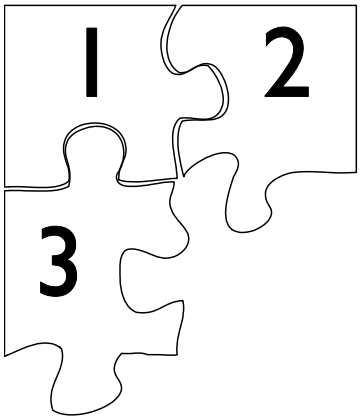
UPON WHAT OTHER ACTIVITIES OR DELIVERY PLATFORMS COULD YOU BUILD A NUTRITION PROGRAM (E.G., INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS [IMCI], NATIONAL NUTRITION PROGRAMS, HIV CARE AND SUPPORT)?

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

WHAT IS THE BROAD PROGRAM GOAL?

WHAT ARE YOUR INITIAL STRATEGIC OBJECTIVES?

Proceed to Step 3. Review Health and Nutrition Services



STEP 3. Review Health and Nutrition Services

Instructions and guidance for this step begin on page 31 of the Reference Guide.

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 in the Reference Guide** on gathering data on health and nutrition policies and services.
2. **Review the questions in Step 3** below.
3. **Gather the necessary information** by gathering policy documents, interviewing key informants and including 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 to collect the needed information.
4. **Record the information** below or in a separate notebook.

REVIEWING HEALTH AND NUTRITION SERVICES RELATED TO OVERALL NUTRTIONAL STATUS

Summarize key aspects of the following nutrition policies and protocols, delivery channels, services, and aspects of quality that may affect how a community-based nutrition program targeted to women and children is designed: Boxes that are shaded are not applicable.

	National Policies and Strategies Related to Overall Nutritional Status	**Delivery Channels, Service Availability, Access and Uptake** ***(What contact points and/or delivery strategies are already in place, need to be strengthened or need to be developed? What is the availability and accessibility of services? Who provides it? What is the coverage?)***	**Comments on actual or perceived quality of the policy, strategy or services?**
Note: If there are supply issues, please note this at the end of this section after the tables.			
Nutrition and health policies, such as a National Nutrition Policy (NNP) or a National Plan to Reduce Stunting *(if sub-section of NNP, please summarize here)*			
Essential Nutrition Actions			
CROSS-CUTTING POLICIES, STRATEGIES AND SERVICES FOR PREVENTION			
Social and behavior change			
Food-based approaches (including dietary diversification, food fortification, supplementation and food production)			

	National Policies and Strategies Related to Overall Nutritional Status	Delivery Channels, Service Availability, Access and Uptake *(What contact points and/or delivery strategies are already in place, need to be strengthened or need to be developed? What is the availability and accessibility of services? Who provides it? What is the coverage?)*	Comments on actual or perceived quality of the policy, strategy or services?
Health and Nutrition Service Integration (including referrals and counter-referrals, follow-up care through health services)			
Community- or facility-based GMP?			
POLICIES, STRATEGIES AND SERVICES FOR RECUPERATION			
Rehabilitation of underweight children			
Rehabilitation of MAM in children			
Rehabilitation of SAM in children (facility-based)			

	National Policies and Strategies Related to Overall Nutritional Status	Delivery Channels, Service Availability, Access and Uptake *(What contact points and/or delivery strategies are already in place, need to be strengthened or need to be developed? What is the availability and accessibility of services? Who provides it? What is the coverage?)*	Comments on actual or perceived quality of the policy, strategy or services?
Community-based Management of Acute Malnutriiton (CMAM)			
Referral services			
Other			

REVIEWING HEALTH AND NUTRITION SERVICES RELATED TO INFANT AND YOUNG CHILD FEEDING

	National Policies Related to Infant and Young Child Feeding	Delivery Channels, Service Availability, Access and Uptake *(What contact points and/or delivery strategies are already in place, need to be strengthened or need to be developed? What is the availability and accessibility of services? Who provides it? What is the coverage?)*	Comments on actual or perceived quality of the services? *(How well are policies, strategies, services, and protocols adhered to and implemented at the community level?)*
Note: If there are supply issues, please note this at the end of this section after the tables.			
IYCF policy *(if this is a sub-section of NNP, please summarize here)*			

	National Policies Related to Infant and Young Child Feeding	**Delivery Channels, Service Availability, Access and Uptake** ***(What contact points and/or delivery strategies are already in place, need to be strengthened or need to be developed? What is the availability and accessibility of services? Who provides it? What is the coverage?)***	**Comments on actual or perceived quality of the services?** ***(How well are policies, strategies, services, and protocols adhered to and implemented at the community level?)***
Is there a policy in place for the International Code for the Marketing of Breastmilk Substitutes?[24]			
"Baby Friendly Hospitals"[25]			
Baby Friendly Communities			
What key IYCF practices are currently being promoted?			
National nutrition programs			
Social and behavior change (SBC)			

[24] A good primer of Frequently Asked Questions on the Code can be found at http://www.who.int/child_adolescent_health/documents/9241594292/en/) and a direct link to the Code is: http://www.who.int/nutrition/publications/infantfeeding/9241541601/en/

[25] The Baby-Friendly Hospital Initiative (BFHI) is a joint UNICEF and WHO program to ensure that maternity wards provide breastfeeding support by designating them "baby-friendly". Hospitals that are "baby-friendly" do not accept free or low-cost breastmilk substitutes or feeding bottles. In addition they have implemented 10 specific steps to support successful breastfeeding. For more information, see: http://www.unicef.org/programme/breastfeeding/baby.htm

	National Policies Related to Infant and Young Child Feeding	**Delivery Channels, Service Availability, Access and Uptake** ***(What contact points and/or delivery strategies are already in place, need to be strengthened or need to be developed? What is the availability and accessibility of services? Who provides it? What is the coverage?)***	**Comments on actual or perceived quality of the services?** ***(How well are policies, strategies, services, and protocols adhered to and implemented at the community level?)***
Support groups (e.g. peer support or group counseling)			
Supplementary feeding programs			
IMCI			
Mass media/social promotion of improved IYCF (this could include the promotion of fortified complementary foods)			
Home visits			
Nutrition counseling			
Other			

REVIEWING HEALTH AND NUTRITION SERVICES RELATED TO MATERNAL NUTRITION

	National Policies Related to Maternal Nutrition	Delivery Channels, Service Availability, Access and Uptake *(What contact points and/or delivery strategies are already in place, need to be strengthened or need to be developed? What is the availability and accessibility of services? Who provides it? What is the coverage?)*	Comments on actual or perceived quality of the services?
Note: If there are supply issues, please note this at the end of this section after the tables.			
Antenatal care			
Delivery care (including late cord clamping)			
Post-partum care (including vitamin A supplementation and breastfeeding support)			
Iron/folic acid (IFA) supplementation of pregnant women			
Prevention of mother-to-child transmission of HIV (PMTCT)			
Intermittent preventive treatment of malaria (IPT) for pregnant women			

	National Policies Related to Maternal Nutrition	Delivery Channels, Service Availability, Access and Uptake *(What contact points and/or delivery strategies are already in place, need to be strengthened or need to be developed? What is the availability and accessibility of services? Who provides it? What is the coverage?)*	Comments on actual or perceived quality of the services?
Deworming for pregnant women			
Food supplementation			
Long-lasting insecticidal nets (LLINs) access			
Training of skilled birth attendants			
Nutrition counseling			
Support groups			
Community-level activities and existing local support networks			
Other			

REVIEWING HEALTH AND NUTRITION SERVICES RELATED TO THE MICRONUTRIENT STATUS OF CHILDREN

	National Policies Related to Micronutrient Status of Children	**Delivery Channels, Service Availability, Access and Uptake** ***(What contact points and/or delivery strategies are already in place, need to be strengthened or need to be developed? What is the availability and accessibility of services? Who provides it? What is the coverage? Consistency?)***	**Comments on actual or perceived quality of the services?**
Note: If there are supply issues, please note this at the end of this section after the tables.			
Vitamin A supplementation for children			
Iron supplementation for children *(Note: recent WHO statements advise against blanket preventive iron supplementation of children in malarious areas)*			
Deworming for children			
Iodized salt			
Multiple micronutrients (including *Sprinkles*)			
Other			

REVIEWING HEALTH AND NUTRITION SERVICES RELATED TO UNDERLYING DISEASE BURDEN

	National Policies Related to Underlying Disease Burden	**Delivery Channels, Service Availability, Access and Uptake** ***(What contact points and/or delivery strategies are already in place, need to be strengthened or need to be developed? What is the availability and accessibility of services? Who provides it? What is the coverage? Consistency?)***	**Comments on actual or perceived quality of the services?**
Note: If there are supply issues, please note this at the end of this section after the tables.			
Facility-based Integrated Management of Childhood Illnesses (IMCI)			
Community Integrated Management of Childhood Illnesses (C-IMCI)			
Preventive services, including: well-baby visits at facility and community level and immunization)			
Malaria prevention			
Vitamin A for measles			
Therapeutic zinc for treatment of diarrhea			
PMTCT programs			

	National Policies Related to Underlying Disease Burden	Delivery Channels, Service Availability, Access and Uptake *(What contact points and/or delivery strategies are already in place, need to be strengthened or need to be developed? What is the availability and accessibility of services? Who provides it? What is the coverage? Consistency?)*	Comments on actual or perceived quality of the services?
Oral rehydration therapy (ORT)			
Community-case management for diarrhea, malaria and pneumonia			
TB DOTS (tuberculosis directly observed treatment, short course)			
HIV and nutrition policies, protocols, programs			
Pediatric HIV services			
Water and sanitation policies			
Other			

AVAILABILITY OF MATERIALS AND EQUIPMENT

Materials and Equipment for Nutrition Services

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 here any supply limitations:

Information, Education and Communication (IEC) and Behavior Change Communication (BCC) Materials
Are there IEC/BCC materials for nutrition counseling? ☐ Yes ☐ No

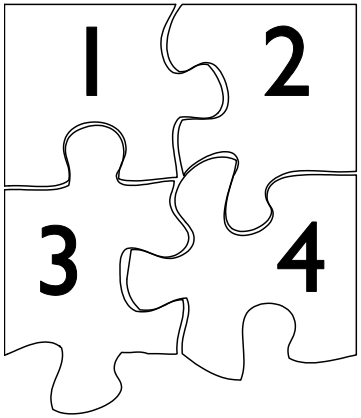
On which topics? (Obtain one set of materials, if possible.)

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? If there are many sets, are they harmonized? Please describe the variations.

Proceed to Step 4. Preliminary Program Design: Prevention



STEP 4. Preliminary Program Design: Prevention

Guidance for this step begins on page 34 of the Reference Guide. Annex 1 on page 73 provides a side-by-side comparison of approaches discussed in Step 4 of the Reference Guide for your reference in filling out the following sections.

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. 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 box below 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** and answer the questions below. **Make preliminary decisions about potential cross-cutting activities** to incorporate in the program, which will be revisited in each section.

3. **Review Step 4 • Sections B-E in the Reference Guide** and answer the questions in the corresponding section 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**.

SECTION A. CROSS-CUTTING APPROACHES TO IMPROVE NUTRITIONAL STATUS

Guidance for this section begins on page 35 of the Reference Guide.

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 35-46 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; at delivery and post-natal visits; the IMCI and community-IMCI program; child health weeks/days where immunizations and micronutrient supplements are provided; within community-based growth promotion, national nutrition or health programs; and PD/Hearth, CMAM and/or sick-child visits.

What community structures already exist? Existing community structures might be, e.g., 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, government or the community. They may include CHWs, CHVs, 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 IEC materials, counseling guides or mass media messages (e.g., radio broadcasts, posters, 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?

Record your notes on potential approaches to consider in the box below.

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

SECTION B. INFANT AND YOUNG CHILD FEEDING

Guidance for this section begins on page 47 of the Reference Guide.

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

Summarize the key findings from Steps 1-3 related to IYCF. This includes anything that you would like to keep in mind while designing the program and selecting approaches, such as program priorities, challenges, key IYCF practices in the program area, programs 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 IYCF approaches in the Reference Guide on pages 47-53. 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)

SECTION C. MATERNAL NUTRITION

Guidance for this section begins on page 54 of the Reference Guide.

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, programs 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 54-57. 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)

SECTION D. MICRONUTRIENT STATUS OF CHILDREN

Guidance for this section begins on page 57 of the Reference Guide.

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, programs 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 page 57-61. 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)

SECTION E. UNDERLYING DISEASE BURDEN


Guidance for this section begins on page 61 of the Reference Guide.

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

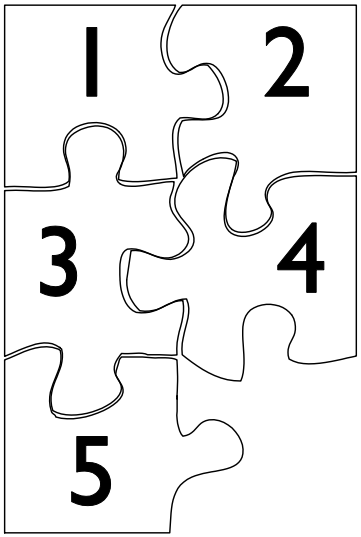
Summarize the key findings from Steps 1-3 related to for underlying disease burden. This includes anything that you would like to keep in mind while designing the program and selecting approaches, such as program priorities, challenges, gaps in service, programs or community strengths to build from or 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 61-63. 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)

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

Guidance for Step 5 begins on page 64 of the Reference Guide.

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 box below to guide you in deciding on the best focus areas for effective recuperation efforts.
2. **Review Step 5 in the Reference Guide** to read about various program approach options.
3. **Discuss as a team the potential program approaches to consider.**
4. **Make preliminary decisions** about program approaches and record them below.

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 or community strengths to build from, policies that may affect programming, enabling environment and what you hope the program will achieve.

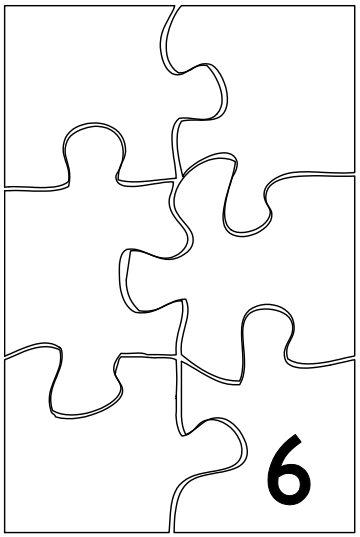
What recuperative nutrition approaches have past evaluations or reviews identified as being successful or unsuccessful in this area or for your organization?

Refer to Step 5 in the Reference Guide to determine potential prevention approaches and potential recuperation approaches to incorporate, as necessary. As you consider different approaches, keep in mind the key points that you summarized in the first question above.

Discuss with your team the information on potential recuperative approaches in Step 5 of the Reference Guide. Record your notes on in the box on the next page.

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. Guidance for this step begins on page 72 of the Reference Guide.

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 the first box in Step 2, page 35)
   b. **Initial program goal and objectives** (Workbook Step 2, page 37)
   c. **Other existing activities upon which your program may build** (Workbook Step 2, page 36)
   d. **Existing health and nutrition services** (Workbook Step 3, pages 39-48)
   e. **Potential preventive nutrition program approaches identified** (Workbook Step 4, pages 51-61)
   f. **Potential recuperative nutrition program approaches identified** (Workbook Step 5, page 62)
2. **Answer the questions in the boxes below**, progressively refining your project plan based on your answers.
   a. **Refine your initial program goal and objectives.**
   b. **Select IRs.**
   c. **Determine your plan for an appropriate combination of approaches** to meet these objectives. 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.
   d. **Determine if your plan addresses donor and government priorities** or needs to be adjusted accordingly.

e. **Determine if your plan matches your resources**. Review the information on costing in the Reference Guide for guidance.

f. **Determine the coverage** for the plan.

g. **Determine the target audience.**

h. **Identify the target number of beneficiaries.**

i. **Identify the final geographic target area.**

j. **Determine any pending information needs** to finalize your plan.

k. **Identify any potential organizational barriers** that will need to be addressed.

l. **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
  - ☐ Wasting/MAM
  - ☐ SAM
- ☐ **IYCF**
  - ☐ Breastfeeding
  - ☐ Young child feeding
  - ☐ Feeding of sick children
- ☐ **Maternal Nutrition**
  - ☐ Dietary practices
  - ☐ Vitamin A
  - ☐ Iron
  - ☐ Iodine
- ☐ **Micronutrients in children**
  - ☐ Dietary practices
  - ☐ Vitamin A
  - ☐ Iron
  - ☐ Iodine
  - ☐ Zinc
- ☐ **Underlying Disease Burden**
  - ☐ Diarrhea
  - ☐ ARI
  - ☐ Malaria
  - ☐ HIV
  - ☐ Immunizations
  - ☐ Other

WHAT IS YOUR FINAL PROGRAM GOAL?

WHAT ARE YOUR FINAL STRATEGIC OBJECTIVES?

WHAT ARE YOUR INTERMEDIATE RESULTS?

WHAT ARE THE MAIN APPROACHES YOU ARE CONSIDERING TO ACHIEVE YOUR OBJECTIVES?

HOW WILL YOU COMBINE THESE APPROACHES TO ACHIEVE YOUR OBJECTIVES AND INTERMEDIATE RESULTS? WHY DID YOU SELECT THIS COMBINATION?

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

SUMMARIZE THE PROPOSED PROGRAM'S GENERAL RESOURCE REQUIREMENTS? (SEE INFORMATION ON COSTING IN THE REFERENCE GUIDE ON PAGES 72-73)

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 IS YOUR TARGET GROUP? WHY?

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 contact@coregroup.org.

Annex 1. Nutrition Program Approaches: Prevention

The following table provides a side-by-side comparison of the approaches listed in Step 4 of the Reference Guide for easy reference while filling out Step 4 in the Workbook.

	Community Mobilization[26]	Counseling at Key Contact Points	Home Visits (e.g., auxiliary nurses, CHWs, care groups)
Brief Summary Description	A capacity-building process through which community members, groups, or organizations plan, carry out 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.	Counseling is provided by a health care provider to a caregiver during the delivery of health services. Counseling messages can be personalized to the needs of the mother/caregiver or child. Within this approach, consider opportunities to improve the quality and timeliness of the counseling, in addition to reinforcing the same message across various contact points. Contact points include: •IMCI or sick-child visits •Well-child visits •Immunizations •PMTCT clinics •Antenatal or prenatal care visits •Baby delivery (potentially via traditional birth attendants) •Post-partum care •GMP sessions •Child health days •Recuperative feeding sessions •Schools or community meetings for mother and father involvement •Rally points •Mobile clinics •Local shops, wells and marketplaces	Home visits, conducted by CHWs, auxiliary nurses, or specialized community CNVs, 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.
Objectives	• Build greater community participation, commitment and capacity for improving child nutrition • Strengthen civil society	• Improve care and feeding practices for pregnant and lactating women and children under 5 years of age	• Ensure child's health or growth is improving • Improve care and feeding practices • Support family

[26] Adapted from Demystifying Community Mobilization: An Effective Strategy to Improve Maternal and Newborn Health

	Community Mobilization[26]	Counseling at Key Contact Points	Home Visits (e.g., auxiliary nurses, CHWs, care groups)
Target Groups	• Everyone in the community	• Pregnant and lactating women • Mothers/caregivers of children 0-23 months or up through 59 months • Influencers of caregivers of children under 5	• Pregnant and lactating women, mothers/caregivers of children 0-23 or up to 59 months
Criteria	• Community members most affected by and interested in child nutrition are involved from the very beginning and throughout the process	• Time available for counseling • Adequate coverage: community where women access services at the health facility	• Willing and available volunteers • Community where homes are located a short distance of each other
Defining Characteristics	• 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	• Messages targeted to the child's developmental stage when the mother/caregiver seeks the service • Individually tailored guidance	• 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	• 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	• 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	• Counseling materials developed through formative research, appropriate for a low-literate population, if necessary • Training on counseling and negotiation skills • Continuous supportive supervision

	Community Mobilization[26]	Counseling at Key Contact Points	Home Visits (e.g., auxiliary nurses, CHWs, care groups)
Resources	*Demystifying Community Mobilization -- An Effective Strategy to Improve Maternal and Newborn Health* http://www.savethechildren.org/publications/technical-resources/saving-newborn-lives/publications/ACCESS_DemystCM.pdf *How to Mobilize Communities for Health and Social Change* http://www.hcpartnership.org/Publications/Field_Guides/Mobilize/pdf/index.php	Diene, Serigne, Kinday Samba and Ismael Thiam, *Training Manual for Health and Social Workers in sub-Saharan Africa: Implementation of Essential Nutrition Actions* http://www.basics.org/publications/Training_Manual_Implementation_of_ENA.pdf#search="counseling"	

	Support Groups (Mothers/ Grandmothers, Other Community Affinity Groups)	Mass Media	Care 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, a health care provider or other community member.	Mass media includes options such as radio, billboards, bus advertising and posters in addition to community gatherings such as health fairs or market days. Mass media can transmit messages to a wide audience and educate and entertain them, but will generally not change behavior by itself. Since it is generally an expensive strategy, a program may want to consider collaborating with others conducting mass media efforts to align messages for greater repetition and support.	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 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	• Promote optimal child care and feeding behaviors	• To create awareness of specific behaviors or draw attention to ongoing activities or health issues	• Improve coverage of health programs • Sustainable behavior change
Target Groups	• Mothers of young children (<2, <3 or < 5 years of age) • Pregnant women • First-time mothers • Adolescent mothers	• Communities in area -- can target all members with broad messages	• Mothers of children 0-59 months of age
Criteria	• Group members willing and able to meet and share with each other • Community mobilized	• People need access to the media being used	• Community with houses close enough together so that volunteers can walk between them and to meetings • Need a sufficient volunteer pool

	Support Groups (Mothers/ Grandmothers, Other Community Affinity Groups)	Mass Media	Care Groups
Defining Characteristics	• 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 strong[27] • Requires minimal outside resources	• Simple messages -- can generate discussion • High inputs at beginning and then message carried by advertising channel • Can reach many people in little time	• 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	• Group leader must have strong facilitation skills • Training may be necessary • Variation in methodology from very interactive to lecture driven • Can link into the non-health sector	• Careful selection of appropriate messages • Good understanding and pilot testing of the message • Creativity	• Time available – leader mothers must have 5 hours per week to volunteer • Comprehensive and ongoing training of leader mothers • Long start-up time (due to training) – program should be of 4-5 year duration • Supervisor-to-promoter ratio should be 1:5
Resources	Linkages. *Training of Trainers for Mother to Mother Support Groups* http://www.linkagesproject.org/media/publications/Training%20Modules/MTMSG.pdf 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. For more information visit: http://ffhtechnical.org/ La Leche League. Mother-to-Mother Support Handbook www.lalecheleague.org La Leche League International Peer Counseling Program http://www.llli.org/ed/PeerAbout.html#pc		*A Guide to Mobilizing Community-Based Volunteer Health Educators: The Care Group Difference* http://www.coregroup.org/diffusion/Care_Manual.pdf www.CareGroupInfo.org

[27] Linkages and World Health Organization. 2003. Community-based Strategies for Breastfeeding Promotion and Support in Developing Countries.

	Community-Based Growth Monitoring and Promotion (CBGMP)	Food Supplementation/Food Assistance: Prevention	Conditional Cash Transfers (CCT)[28]
Brief Summary Description	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, CBGMP 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.	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 program, 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.	CCT programs provide cash payments to poor households that fulfill program-mandated requirements, such as participation in certain nutrition programs (e.g., BCC, GMP, supplementation, attending health services). CCTs 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 CCT programs have improved nutritional status in children (stunting) and school enrollment, and have reduced illness. CCT programs tend to be large-scale, government-run programs. Results are very dependent on the quality of program implementation and targeting. Administering and monitoring CCT can be costly.
Objectives	• Improve child growth • Prevent undernutrition • Early detection of growth faltering and undernutrition	Reduce prevalence of chronic malnutrition	• Break the intergenerational cycle of poverty • Provide incentive to participate in essential health and nutrition services • Promote behavior change
Target Groups	• Children 0-23 months	• 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	• Poor households with children under age two • Women are generally the recipients of the cash because they are more likely to invest it in the well-being of their family
Criteria	• Best used in communities with high prevalence of mild or moderate underweight or stunting	• 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	• Nutrition and health services/programs that beneficiaries must participate in are in place, accessible and of good quality • Government/community support the program

[28] Information on Conditional Cash Transfers drawn from: Bassett, Lucy. 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.

	Community-Based Growth Monitoring and Promotion (CBGMP)	Food Supplementation/Food Assistance: Prevention	Conditional Cash Transfers (CCT)[28]
		production. (Bellmon Estimation for Title II is a resource for this) • 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)	• 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	• 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 • Home visits • Active community involvement in problem solving and planning • Potential contact for MUAC and edema screening and SAM referral • Addresses many causes of poor growth, not just the symptoms, and is closely tied to promoting evidence-based interventions	• 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, when the food needs are the greatest	• Resource transfer is cash • Conditions for receiving the cash • Comprehensive program addressing resource constraints, poverty, health-seeking behaviors and behavior change
Needed Elements for Quality Programming by implementers	For the individual child: • Routine monthly assessment of growth status • Feedback on growth and on 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 Across the whole program: • Quality counseling • Analysis of causes of inadequate growth with guidelines for taking actions • A large network of community-based workers or	• 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	• 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 CCT

	Community-Based Growth Monitoring and Promotion (CBGMP)	Food Supplementation/Food Assistance: Prevention	Conditional Cash Transfers (CCT)[28]
	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	Griffiths, Marcia, Kate Dickin and Michael Favin. 1996. *Promoting the Growth of Children: What Works*. Rationale and Guidance for Programs. Tool #4, The World Bank Nutrition Toolkit. Washington, DC: The World Bank. http://www.worldbank.org (Search for "Nutrition Toolkit") Fiedler. 2003. *A cost analysis of the Honduras Community-based Integrated Child Care Program*. Washington, DC: World Bank HNP Discussion Paper. http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/Fiedler-ACostAnalysis-whole.pdf Ashworth, et al. 2008. Growth Monitoring and Promotion: A Review of the Evidence. *Maternal and Child Nutrition (*February 2008). http://www3.interscience.wiley.com/journal/119424907/abstract?CRETRY=1&SRETRY=0	• USAID Office of Food for Peace: http://www.usaid.gov/our_work/humanitarian_assistance/ffp/ • FANTA-2: www.fanta-2.org • World Food Programme: www.wfp.org	Bassett, Lucy. 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. October 2008. http://siteresources.worldbank.org/SOCIALPROTECTION/Resources/SP-Discussion-papers/Safety-Nets-DP/0835.pdf Son, Hyun H. 2008. *Conditional Cash Transfer Programs: An Effective Tool for Poverty Alleviation?* Asian Development Bank, Economics and Research Department Policy Brief Series No 51. July 2008. http://www.adb.org/Documents/EDRC/Policy_Briefs/PB051.pdf Lindert, Kathy et al. 2007. *The Nuts and Bolts of the Bolsa Familia Program: Implementing CCTs in a Decentralized Context.* SP Discussion Paper No. 0709. Washington, DC: The World Bank. May 2007. http://siteresources.worldbank.org/INTLACREGTOPLABSOCPRO/Resources/BRBolsaFamiliaDiscussionPaper.pdf

	Child Health Weeks/Days	Community Integrated Management of Childhood Illness (C-IMCI)	Community Case Management (CCM)
Brief Summary Description	They should occur every six 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 IFA to pregnant women, deworming, iodized salt testing, distribution of LLINs and promotion of infant and young child nutrition.	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 of16 key family practices; and coordination with other sectors.	CCM is 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 (ORT); antimalarials; zinc; and vitamin A.
Objectives	• Increase coverage of vitamin A supplementation • Increase coverage of other nutrition approaches • Provide deworming	• Reduce morbidity and mortality of children under 5 years of age • Address diarrhea, malaria, undernutrition, measles and pneumonia • Improve access to curative services	• 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	• Children 0-59 months of age	• Children 0-59 months of age	• Children 0-59 months of age
Criteria	• Vitamin A program in-country	• National IMCI policies and protocols • Collaborating health facility implementing IMCI for patient referral • Cadre of available community health workers or volunteers • High prevalence of common childhood illnesses: undernutrition, diarrhea, malaria, pneumonia and/or measles	• High mortality from illnesses treated by CCM • Lack of continual access to curative interventions • Low use of health facilities • Policy environment supports CCM (e.g., CHWs able to administer medications) • Treatment protocols available
Defining Characteristics	• High coverage rates • Feasible in diverse settings • Community census and social mobilization	• 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 IMCI key family practices • Mostly applied to children who present at health facilities or to CHWs with illness •	• 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	• Best suited for areas with high prevalence of vitamin A deficiency • Requires coordination with district health plan	• Involvement and commitment of the health sector needed • Training of health staff • Refresher courses	• Requires sound training and supervision • Strong links with functional health facilities for training, supervision and referral • Requires access to supply of curative products:

	Child Health Weeks/Days	Community Integrated Management of Childhood Illness (C-IMCI)	Community Case Management (CCM)
	• 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	• Supplies • Supervision	medicines, ORT, vitamin A and zinc • Promotion of timely care-seeking and improved feeding during illness
		Household and Community IMCI. Washington, DC: CORE Group Available: http://207.226.255.123/working_groups/imci_c-imci.cfm	*Community Case Management Essentials*. 2010. Washington, DC: CORE Group. Available: http://www.coregroup.org/storage/documents/CCM/ccm%20essen%20final%20dec%2009.pdf

Annex 2. Nutrition Program Approaches: Recuperation

The following table provides a side-by-side comparison of the programs listed in Step 5 of the Reference Guide for easy reference while filling out Step 5 in the Workbook.

	PD/Hearth	Food Supplementation/Food Assistance: Recuperation	Community-based Management of Acute Malnutrition (CMAM)[29]
Brief Summary Description	PD/Hearth is an approach to rehabilitate underweight children. PDIs identify successful practices and strategies of poor local families that have healthy children. In a two-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.	In a recuperative food supplementation program, children (usually 6-59 months of age, but target ages vary) with moderate underweight or MAM receive a supplementary food ration along with health services and BCC for a set period of time or until recovery. Recent research has found that a preventive program that targets all children under 2 and pregnant and lactating women with the same services is more effective at reducing prevalence of undernutrition than a recuperative program that only targets the malnourished. Supplementary feeding programs are also often established in emergencies to fill dietary gaps, protect lives and protect nutritional status of women and children.	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 < 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.
Objectives	• Rehabilitate moderately underweight children[30] • 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	• Manage MAM Manage moderate underweight	• Treat acute malnutrition in the community • Reduce morbidity and mortality of children with acute malnutrition

[29] CMAM originated as an emergency care model known as Community-based Therapeutic Care (CTC).
[30] Recent evidence indicates that PD/Hearth is most effective in rehabilitation where underweight is reflecting wasting rather than stunting.

	PD/Hearth	Food Supplementation/Food Assistance: Recuperation	Community-based Management of Acute Malnutrition (CMAM)[29]
Target Group	• Children 6-36 months of age with moderate underweight (WFA < -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	• Children 6-59 months of age with MAM • Lactating mothers of malnourished children < 6 months of age	• Children 6-59 months of age with SAM (MUAC < 115 mm, WFH < -3 Z-scores and/or bilateral pitting edema) • Children 6-59 months of age with MAM (MUAC < 125 but > 115 mm, WFH < -2 Z-scores) may be included if there is a supplementary feeding program • Children under 6 months of age with SAM (inpatient care)
Criteria	Consider PD/Hearth if you can answer yes to the following questions: • Are at least 30 percent of children 6-36 months moderately or severely underweight (WFA <-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?	• Food-insecure environment • Evidence that food supplementation will not displace local production • Logistical capacity for transport, storage and management of food commodity Very high prevalence of underweight (> 30 percent) or high prevalence of MAM (> 10 percent, >5 percent with aggravating factors)	• 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 percent of population of children 6-59 months • Communities with > 10 percent 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	• 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	• 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 the food needs are the greatest • Food is provided to children 6-59 months of age with MAM	• 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

	PD/Hearth	Food Supplementation/Food Assistance: Recuperation	Community-based Management of Acute Malnutrition (CMAM)[29]
Needed Elements for Quality Programming	• PDI 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 PDI • 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, micronutrients)	• 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	• Active community case-finding using MUAC and assessment of edema • SBC strategies for sustainable prevention • Health services to address common childhood diseases • Skills in anthropometric measurement • Trained community members who can identify cases of severe or complicated acute malnutrition for referral • Technical assistance from someone skilled in the CMAM approach • Resources (financial, in-kind) for a supply of RUTF and medications • Trained clinical staff to conduct medical evaluation, identify medical complications, refer and treat cases • Inpatient services available
Resources	CORE Nutrition Working Group. 2002. *Positive Deviance / Hearth: A Resource Guide for Sustainably Rehabilitating Malnourished Children.* Washington, DC: CORE Group. Available: http://www.coregroup.org/working_groups/pd_hearth.cfm	• USAID Office of Food for Peace: http://www.usaid.gov/our_work/humanitarian_assistance/ffp/ • FANTA-2: www.fanta-2.org • World Food Programme: www.wfp.org	FANTA, Concern Worldwide, UNICEF, and Valid International.2008. *Training Guide for Community-based Management of Acute Malnutrition.* Washington, DC: AED. Available: http://www.fanta-2.org/

The Nutrition Program Design Assistant: A Tool for Designing Nutrition Programs 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.

www.coregroup.org

CORE Group fosters collaborative action and learning to improve and expand community-focused public health practices. Established in 1997 in Washington D.C., 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.

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