UNHCR Operational Guidance on the Use of Special Nutritional Products to Reduce Micronutrient Deficiencies and Malnutrition in Refugee Populations

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EXECUTIVE SUMMARY

BACKGROUND

Micronutrient malnutrition and undernutrition are now widely recognised as priority areas during emergency responses and protracted refugee operations. During 2009, the United Nations High Commissioner for Refugees (UNHCR) commenced implementation of a strategy that aims to achieve a reduction in anaemia and other micronutrient deficiencies / undernutrition, thereby enhancing growth, development and health in refugee populations across their global operations. The approach involves the use, amongst other interventions, of food supplementation products (FSP) including micronutrient powders (MNP) and lipid-based nutrient supplements (LNS).

Project activities were initiated in seven countries during 2009, together with the World Food Programme (WFP) and other partners, and will continue to expand to additional countries during 2011 and beyond. During the initial expansion phase of the project, UNHCR identified the urgent need to improve the assessment of micronutrient, acute, and chronic malnutrition, as well as the design of programmes for their control and reduction in both emergency and protracted situations. As many of the FSPs and home fortification approaches being adopted are still relatively new, there was also a need for additional technical guidance for setting up and maintaining intervention programmes, monitoring and evaluation (M&E) systems, and mainstreaming best practice. This Operational Guidance has been developed to meet this need and to help country staff deal with the challenges involved in designing programmes using new FSPs.

DEVELOPMENT OF THE OPERATIONAL GUIDANCE

This Operational Guidance builds on already existing frameworks (e.g. WFP / Sight and Life 10 minutes to learn about nutrition programming, 2008) as well as standard selective feeding guidelines (UNHCR / WFP Selective Feeding Guidelines, 2009). Whilst these existing frameworks and guidelines provide useful guidance that is widely applicable, the Operational Guidance deals with a new set of FSP that are currently

being used, or considered for use in UNHCR operations. It is aimed at UNHCR health and nutrition field staff and partners and its focus is on children aged 6-59 months but can easily be adapted to other age groups, including women and adolescent girls. The interventions described are not intended for use on their own, but to complement other nutrition and health programmes for this age group.

The Operational Guidance contains six stages covering the key components of planning, implementing, monitoring and evaluating FSP programmes that aim to reduce micronutrient deficiencies and malnutrition in refugee populations. These stages should ideally be conducted in chronological order, although some stages are inter-related and may overlap.

Stage one

Stage one is intended to aid readers in *defining the nutritional needs* of children under five within the population of interest. Three main indicators are suggested for use in the assessment of nutritional problems and what FSPs may be considered as possible options. These are the prevalence of global acute malnutrition (GAM) (weight-for-height <-2 z-scores and / or oedema), anaemia (haemoglobin concentration <11.0 g/dl) and stunting (height-for-age <-2 z-scores). In order to classify the severity of the nutrition situation, prevalence estimates should be gathered for the suggested indicators from the latest cross-sectional surveys conducted in the camp(s). These should be interpreted using any contextual information that may have influenced the survey results as well as any available data on GAM, anaemia, and stunting prevalence trends. Where there is no recent survey data available or indicators are missing, where feasible, priority should be given to carrying out a baseline nutrition survey. A simplified classification table has been provided (based on WHO criteria) which categorises indicators as *low*, *medium* and *high*. High levels of one or more of these indicators suggest that an FSP intervention may be appropriate and readers should proceed to the subsequent stages. Coordination and involvement of any relevant actors (e.g. donors, government, NGO, WFP, UNHCR) should also begin at this point.

Stage two

The purpose of stage two is to aid in the *selection of a potential FSP intervention* for the nutritional problem(s) identified in stage *one*. In addition to fortified blended foods (FBFs), this guidance considers only two types of FSP: micronutrient powders (MNP) and lipid-based nutrient supplements (LNS). LNS are defined here as lipid-based pastes which are used to help prevent malnutrition. A decision tool containing eight scenarios has been developed to guide the identification of potential FSP interventions for children aged 6-59 months. Each scenario depicts a potential camp context with high prevalence estimates of one or more of the nutritional problems previously identified i.e. GAM, anaemia, or stunting. It is recommended to select the scenario which best reflects the camp(s) situation, and to then use the possible intervention options that are listed as a basis for decision making.

Stage three

The objective of stage three is to *identify any risks and precautions* that need to be considered before commencing an FSP intervention. These risks may include, but are not limited to: adverse effects on other programmes; excessive micronutrient consumption; adverse effects on feeding practices and child health; inappropriate duration and frequency of FSP use; delays in importing and obtaining permission for product use; deterioration of stock; and environmental pollution. Suggested solutions are provided for dealing with each of these potential risks that may be highlighted by the risk assessments. Readers are advised to contact UNHCR HQ / Regional Offices for guidance on certain issues requiring senior level advice such as selecting an appropriate micronutrient formulation and iron / folic acid dosage for use in malaria-affected areas.

Stage four

Stage four is designed to *test the acceptability* of the selected FSP to potential beneficiaries and their *adherence to the recommended dosage*. A standard acceptability and adherence test protocol is provided for use. The test includes distribution of the FSP to around 120 participants for a minimum of three weeks. Data on local eating habits, cultural beliefs, health knowledge, acceptability and use of the product are collected using qualitative and quantitative methods, at baseline, midpoint and endline. This is

done through focus group discussions (FGD), key informant (KI) interviews, household interviews and household direct observations. Crosschecking and interpretation of data collected from these activities will help to inform the decision about whether the FSP is acceptable to the community and used correctly, and therefore whether to proceed with the selected intervention. It will also guide the design of appropriate, context specific educational campaigns, distribution mechanisms and packaging.

Stage five

Stage five is intended to aid in identifying the *key components that need to be in place or developed* to ensure that the intervention is implemented effectively. Coordination of all actors needs to be ensured by this stage. Further considerations include: logistical components such as ordering of the product, storage and stock management; training of health workers and staff; development of a context specific communication and education campaign and product distribution channels. Relevant tools are provided to aid with both standardisation of training and effective community mobilisation.

Stage six

Finally, as with any programme, strong *M&E* should accompany any FSP intervention, particularly due to the new nature of the products being used, and this is documented in Stage six. Minimum reporting requirements are provided, that should be adapted depending on individual programming requirements and the products used.

NEXT STEPS

Lessons learnt from the use of this Operational Guidance will be used in future revisions. Future updates to the guidance will be uploaded as and when necessary to ensure that the current version reflects the latest developments in product availability and use in this rapidly changing area of nutrition.

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ONLINE REFERENCE MATERIALS AND TOOLS

A number of reference materials and tools are available to provide assistance when using the Operational Guidance. These can be downloaded from http://www.unhcr.org or http://info.refugee-nutrition.net

While many of the tools and reference materials provided are optional, the standard acceptability / adherence tools will be required for conducting the acceptability and adherence test (Stage 4) and should therefore be downloaded and printed at the appropriate time.

Another useful website referenced in this document is the World Food Programme 'Food Quality Control' website, which provides specifications for the fortified blended foods mentioned in this document: http://foodquality.wfp.org/

In addition, the UNHCR Standardised Nutrition Survey Guidelines can also be downloaded from: http://info.refugee-nutrition.net

Comments, feedback and requests for further guidance should be directed to: HQPHN@unhcr.org

LIST OF ACRONYMS

ANC	Ante-Natal Care
ARI	Acute Respiratory Infection
BBD	Best Before Date
BCC	Behaviour Change Communication
CDC	Centers for Disease Control and Prevention
CSB	Corn-Soy Blend
FBF	Fortified Blended Food
FGD	Focus Group Discussion
FSP	Food Supplementation Product
GAM	Global Acute Malnutrition
GFD	General Food Distribution
GMP	Growth Monitoring and Promotion
HAZ	Height-for-Age z-score
HH	Household
HIS	Health Information System
HR	Human Resources
HQ	Headquarters
IP	Implementing Partner
IPT	Intermittent Preventative Treatment
IYCF	Infant and Young Child Feeding
KAP	Knowledge, Attitude and Practice
KI	Key Informant
LLIN	Long-Lasting Insecticidal Net
LNS	Lipid-based Nutrient Supplements
MAM	Moderate Acute Malnutrition

M&E	Monitoring and Evaluation
MNP	Micronutrient Powder
MoH	Ministry of Health
MoU	Memorandum of Understanding
MUAC	Mid-Upper Arm Circumference
NCHS	National Centre for Health Statistics
NGO	Non-governmental Organisation
PLW	Pregnant and Lactating Women
RDT	Rapid Diagnostic Test
RSB	Rice-Soy Blend
RUSF	Ready-to-Use Supplementary Food
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
UCL CIHD	University College London Centre for International Health and Development
UNHCR	United Nations High Commissioner for Refugees
WASH	Water Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organisation
WHZ	Weight-for-Height z-score
WSB	Wheat-Soy Blend

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In the great majority of areas, the technical content of this guidance reflects the consensus view of the contributors. In the rare instances where technical consensus was not achieved the content reflects the view of UNHCR.

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CONFLICT OF INTEREST STATEMENT

ENN have not received funds from any manufacturer of food supplementation products and no conflicts of interest have been identified.

BACKGROUND

Micronutrient malnutrition and undernutrition are now widely recognised as priority areas during emergency responses and protracted refugee operations. During 2009, the United Nations High Commissioner for Refugees (UNHCR) commenced implementation of a strategy that aims to achieve a reduction in micronutrient deficiencies and acute and chronic malnutrition using, amongst other interventions, food supplementation products (FSP)[a]. FSP include micronutrient powders (MNP) and lipid-based nutrient supplements (LNS). Project activities were initiated in seven countries during 2009 together with the World Food Programme (WFP) and implementing partners (IP), and have now been expanded and scaled up in additional refugee settings, including both emergency and protracted situations.

UNHCR has identified the urgent and continuing need to improve the assessment of micronutrient deficiencies and malnutrition, as well as programmes for their control and reduction. As many of the FSPs and home fortification approaches being adopted are still relatively new (e.g. use of Nutributter®) there was also a need for continued technical support for assessments, setting up and maintaining intervention programmes, monitoring and evaluation (M&E) systems, and mainstreaming best practice. This Operational Guidance has been developed to help meet this need and builds on the already existing frameworks developed by WFP / Sight and Life in 2008 (10 minutes to learn about nutrition programming series) and complements the UNHCR / WFP Selective Feeding Guidelines (2009). Whilst these existing frameworks and guidelines provide useful guidance that is widely applicable, this Operational Guidance deals with a new set of FSPs that are currently being used or considered for use in UNHCR operations. It is aimed at health and nutrition UNHCR field staff and partners.

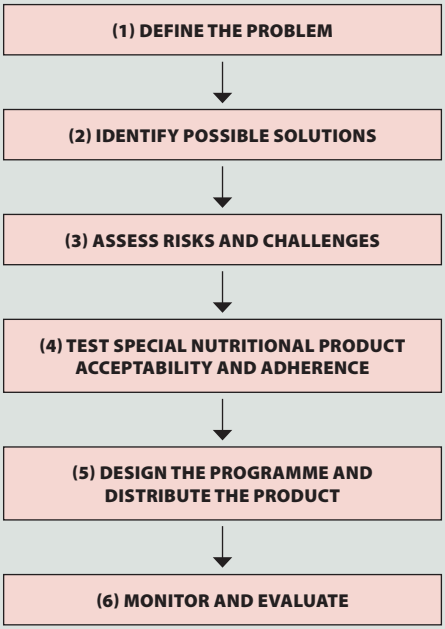
This Operational Guidance focuses on children aged 6-59 months but can easily be adapted to other age groups including women and adolescent girls. It is to be

a UNHCR Strategic Plan for Anaemia Control and Reduction 2008 - 2010: Reducing the global burden of anaemia in refugee populations

used to aid intervention planning, risk assessment, quality assurance, assessment of acceptability and adherence, implementation and setting up of M&E systems in UNHCR camps in project countries. This guidance is available to UNHCR offices and partners online. Updates to the guidance will be uploaded as and when necessary, to ensure that the current version reflects the latest developments in product availability and use in this rapidly changing area of nutrition.

The Operational Guidance covers the key programmatic components in six stages, as shown in the figure below. Ideally, each stage should be conducted in chronological order, although some stages are inter-related and may overlap.

Figure 1. Key Stages of the Operational Guidance



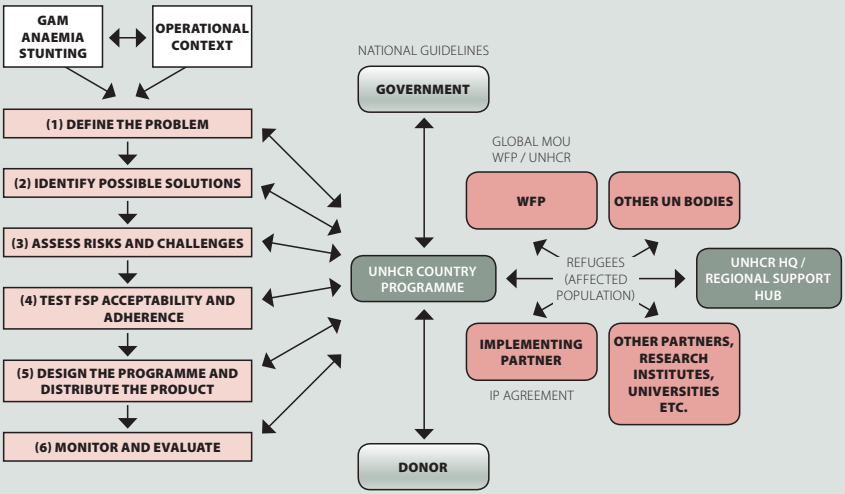
KEY PARTNERS AND COLLABORATION

Refugee nutrition operations involve multiple actors with UNHCR taking the lead in co-ordination of activities (See **Figure 2** below) (see reference material – Anaemia Strategy proposal). As such, implementation of this Operational Guidance on planning, implementing, monitoring and evaluating the use of FSPs at camp level should be inclusive, bringing in all actors linked to the use of the FSP, at all stages.

Identification of key partners is crucial from the beginning and clear roles and responsibilities should be agreed amongst those involved. The roles and responsibilities (including cost sharing arrangements) of UNHCR and WFP will be largely governed by the Memorandum of Understanding (MoU) between the two organisations (last revised January 2011). Agreements with other partners will depend on local arrangements and capacity. Senior management in UNHCR country offices and donors should also be kept involved at crucial stages of the decision making processes.

A carefully planned and adhered to timeline of activities will help with coordination where multiple actors are involved (see reference material – Example Programme Timeline).

Figure 2. Coordination of Actors and Activities in FSP Programmes



STAGE 1 – DEFINE THE PROBLEM

This stage is intended to aid in defining the nutritional problems within the population of interest

A simplified decision making process for defining nutritional problems is presented below. **While this document focuses on the use of special nutritional products such as FSP, targeted at children 6-59 months, it is equally important to ensure adequate nutrition for the whole population and to monitor that the micronutrient adequacy of the general ration meets international standards**[b]**.** Where this is not the case, advocacy should be undertaken with the aim of improving the nutritional adequacy of the ration (according to Sphere Standards). Equally, the importance of good infant and young child feeding (IYCF) and care practices; parasite and disease control; water, sanitation and hygiene (WASH) and health services; and improved food security should be reinforced.

1.1 Classification of the Problem

Malnutrition is caused by numerous interrelated factors including disease, poor caring practices, poor environmental conditions and lack of access to and availability of nutritious food. However, data on all of these factors is not always available or reliable in refugee contexts. This Operational Guidance therefore suggest that three main indicators are used in defining nutritional problems for the assessment of what FSPs may be considered as possible options. These three indicators are the prevalence of **global acute malnutrition (GAM)** (weight-for-height z-score (WHZ) <-2 and / or oedema; note that rapid assessments using Mid-Upper Arm Circumference (MUAC) are not applicable here), **anaemia** (haemoglobin concentration <11.0 g/dl)[c], and **stunting** (height-for-age <-2 z-score). They have been selected as they help describe major nutritional problems, they are widely available, and they can be measured during routine nutrition surveys with reasonable accuracy and precision.

b Monitoring of general ration adequacy can be made easier by using software tools such as NutVal. NutVal can be downloaded from http://www.nutval.net

c If the camp is at high altitude (>1000 meters) a different cut-off for defining anaemia will apply.

To classify nutritional problems, prevalence estimates need to be compiled, with confidence intervals whenever possible, for GAM, anaemia, and stunting in children 6-59 months of age. Data from the *latest* cross-sectional surveys conducted in the camp(s) should be used. If more than one camp was surveyed, use the combined, weighted, prevalence[d]. **Table 1** shows the WHO criteria used to classify the severity of the situation in terms of wasting, anaemia and stunting prevalence in children less than 5 years of age. The simplified classification shown in **Table 2** will be applied in this guidance to help define the nature and magnitude of the problem and identify potential FSP intervention(s). To define the problem in the population of interest use the criteria in **Table 2** as a guide.

Table 1. WHO classification of the public health significance of selected indicators for children under 5 years of age

PREVALENCE %	CRITICAL	SERIOUS	POOR	ACCEPTABLE
Wasting[e]	**≥15**	**10-14**	**5-9**	**<5**
Stunting	**≥40**	**30-39**	**20-29**	**<20**

PREVALENCE %	HIGH	MEDIUM	LOW
Anaemia	**≥40**	**20-40**	**5-20**

Sources: WHO (1995) Physical Status: The Use and Interpretation of Anthropometry available from: http://www.who.int/childgrowth/publications/physical_status/en/index.html; and WHO (2000) The Management of Nutrition in Major Emergencies available from http://www.who.int/topics/nutrition/publications/emergencies/en/

d Refer to UNHCR Standard Nutrition Survey Guidelines for guidance on how to perform and report on a weighted analysis.

e Please note that wasting, as defined in Table 1, is only based on weight-for-height z-score. For the sake of simplicity, the prevalence of global acute malnutrition (GAM) will be used in this guidance rather than the prevalence of wasting.

Table 2. Simplified classification of the severity of GAM, anaemia, and stunting in refugee settings

PREVALENCE %	HIGH		MEDIUM	LOW
GAM	≥15 Critical	10-14 Serious	5-9	<5
Anaemia <5	≥40		20-39	5-19
Stunting	≥30		20-29	<20

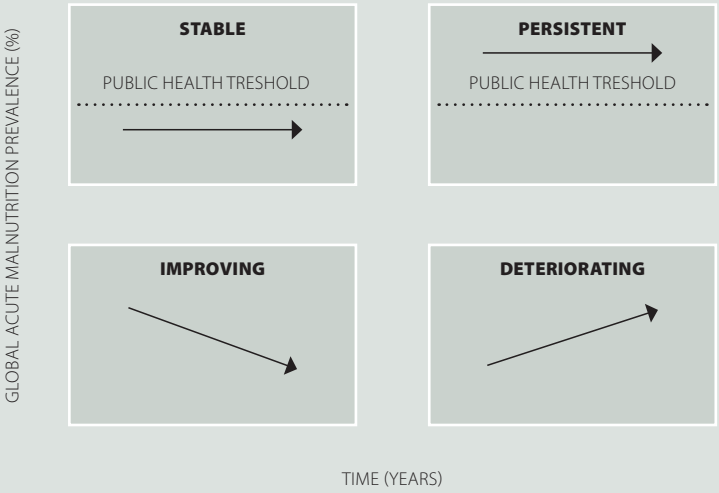
1.2 Interpretation of Prevalence Estimates

When interpreting the prevalence estimates it is important to consider the contextual information that was available at the time of the survey to understand what may have influenced the results. In some cases the prevalence result may fall right on the borderline between two categories and contextual data should be used to help decide on the appropriate classification (see **Example 1** below).

Guidance on selective feeding, issued by UNHCR and WFP in 2009, describes the use of contextual information to guide decisions on when to start supplementary and therapeutic feeding programmes[f]. This type of contextual information is referred to as aggravating factors, and one of these factors is a deteriorating nutritional situation. This Operational Guidance expands on this recommendation and encourages readers to refer to available data on GAM, stunting, and anaemia prevalence trends. To identify a trend, it is advised that prevalence data from at least three time points are obtained from nutrition surveys carried out at similar times of the year. If data is available for the last three or more years, it should allow readers to classify the situation into one of the following categories: Stable; Improving; Persistent; or Deteriorating. These categories are illustrated in **Figure 3** using data for GAM. *If no trend data is available, or no clear trend can be seen, the most recent prevalence estimate should be used to guide decision making in Stage 2.*

f For more information, please refer to page 18 of the UNHCR / WFP (2009) Guidelines for Selective Feeding: The Management of Acute Malnutrition in Emergencies.

Figure 3. Prevalence Trend Classifications



Example 1 – Using Nutrition Survey Data from a Single Time Point to Classify Refugee Camps

The first table shows data from nutrition surveys conducted in seven camps in 2009. In the second table, the same data have been used to classify the nutritional situation, according to the criteria in **Table 2** and the available contextual information. In this example, the GAM prevalence in camp A lay on the borderline, implying that GAM could have been classified as *medium* or *high*. Contextual information therefore had to be used to decide which classification was most appropriate.

Camp	GAM	Anaemia <5	Stunting
A	10.1% (7.3-12.8)	42.3%	12.2% (9.9 - 14.5)
B	7.9%	21.5%	14.9%
C	12.6% (11.1-14.2)	21.1%	32.5% (27.7 - 37.3)
D	4.3%	n.a.	22.9%
E	11.4 % (10.4 - 12.4)	38.2%	27.7% (22.9 - 32.5)
F	7.7% (exhaustive)	38.0%	24.4% (19.0 - 29.8)
G	10.2 % (8.0 - 12.5)	32.1%	24.6% (21.4 - 27.8)

Camp	Ranking		
	GAM	Anaemia <5	Stunting
A	Medium	High	Low
B	Medium	Medium	Low
C	High	Medium	High
D	Low	n.a.	Medium
E	High	Medium	Medium
F	Medium	Medium	Medium
G	High	Medium	Medium

n.a. - not available

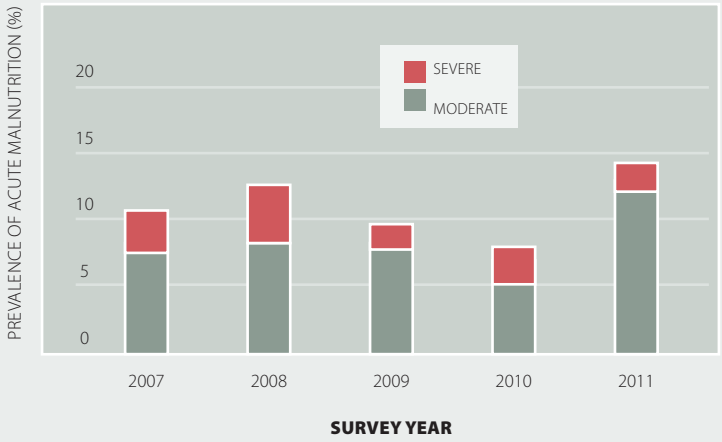
Contextual data may be gathered from several different sources. For example, data on the diagnosis of cases at health facilities or admission to feeding programmes should be examined, or in many camps, data can be accessed via the UNHCR Health Information System (HIS) (http://his.unhcr.org/main.locsis). Other contextual information to consider may include:

- Seasonal trends in malnutrition
- Outbreaks of disease (as this may affect nutritional status)
- Breaks in the food aid pipeline
- Major population movements in and out of the camp / area
- Past prevalence estimates and trends over the last three or more years (see above)
- The quality of nutrition survey data
- The age groups most affected by the various nutritional problems
- General information on food security
- IYCF / care practices
- WASH
- Causes of anaemia
- Causes of malnutrition

Another challenge can occur where the result for one particular year lies outside of what was expected based on existing trend data. This is illustrated in **Example 2** below. In this situation contextual data on health facility admissions indicated that the spike in acute malnutrition in 2011 was almost certainly due to an outbreak of diarrhoea and was short lived. Therefore, the underlying GAM prevalence was considered to be <10% and the severity classified as *medium* rather than *high* when decisions on the use of FSP were made.

Example 2 – Using Acute Malnutrition Trend and Contextual Data to Classify a Refugee Camp

Based on a review of contextual information, it was determined that the high prevalence of GAM in the 2011 survey was due to an unusual outbreak of diarrhoea before the survey. Regular screening of the population had also indicated that the prevalence of acute malnutrition had sharply declined since the outbreak. It was decided that the underlying GAM prevalence was probably <10% (as was found in the nutrition surveys conducted since 2009). Contextual information was critical in deciding which classification was most appropriate.



If there are no recent nutrition survey data available from which to obtain prevalence estimates, or there is a missing indicator (i.e. GAM / anaemia / stunting), one of the following should be done:

- Carry out a baseline nutrition survey
- Use recent nutrition survey data from neighbouring camps or host population in the same region (e.g. where data on anaemia is missing) to estimate the likely prevalence

STAGE 1 CHECKLIST – Define the Problem

- ☐ Obtain results for the prevalence of GAM, anaemia, and stunting from the most recent nutrition survey. Make sure to record the confidence intervals when these are available
- ☐ Obtain contextual information relating to the nutrition survey results as well as data on prevalence trends for the above indicators from the last three or more years (if available)
- ☐ Interpret the nutrition survey results using contextual information and available trend data
- ☐ Classify nutritional problems using the criteria in **Table 2**
- ☐ Organise planning meetings with stakeholders
- ☐ Draft project proposal
- ☐ Define roles and responsibilities
- ☐ **Contact UNHCR HQ / Regional Offices** if senior level advice or guidance is required for any part of Stage 1

STAGE 2 – IDENTIFY POSSIBLE SOLUTIONS

This stage is intended to aid in the selection of an appropriate FSP intervention for the nutritional problems that were identified and classified in Stage 1

This **product selection guidance** is designed as an aid in selecting, if applicable, the most appropriate FSP to be used to address the nutritional problems that have been identified. Please note that only two types of FSP are considered in this guidance: micronutrient powders (MNP) and lipid-based nutrient supplements (LNS). LNS are defined here as lipid-based pastes which are used to help prevent malnutrition. They can be divided into low quantity LNS and medium quantity LNS, depending on the *energy content of the recommended daily dose*. Both low quantity and medium quantity LNS are intended as a supplement to a child's diet and should provide a wide range of vitamins and minerals.

While the focus of this Operational Guidance is on the use of FSP, it also considers the use of improved fortified blended foods (FBF). This guidance does not cover the treatment of acute malnutrition and therefore does not include guidance on Ready-to-Use Therapeutic Food (RUTF) for the treatment of Severe Acute Malnutrition (SAM), e.g. Plumpy'nut® or eeZeePaste™, or Ready-to-Use Supplementary Food (RUSF) for the treatment of Moderate Acute Malnutrition (MAM) e.g. Plumpy'Sup®.

If interested in using other FSPs in programme operations, please **contact UNHCR HQ/ Regional Offices** for further guidance.

2.1 Identifying an Appropriate FSP

Information on the special nutritional products considered in this guidance is provided in **Table 3** (see reference material – Classification of Special Nutritional Products).

This Operational Guidance provides a sequential process for the selection of the most appropriate special nutritional product for a particular context or scenario. However, when selecting an appropriate product, it is important to bear the following issues in mind:

- FSPs may be selected for children in specific age groups (i.e. 6-24, 6-36, 6-59 months). **It is unacceptable to use a combination of two FSPs *simultaneously* in the same age group; use only one FSP at a time in each age group**. If different FSPs are used in different age groups (e.g. Nutributter® in children aged 6-24 months and MNP in children > 24 months) or in the same age groups at different times of the year (e.g. MNP for children 6-36 months for 8 months and Plumpy'doz® for 4 months of the same year), a more complex M&E system will need to be put in place, and to date, there is very limited programme experience with this mixed products approach. The experience so far has illustrated a number of difficulties that may arise with the use of multiple products.

- In order to avoid micronutrient overload, the micronutrient profile of MNPs and LNS may need to be modified and adapted in certain refugee contexts after examination of the general food distribution (GFD) and risk assessments **(refer to Stage 3)**.

- In selecting the most appropriate approach for a particular camp(s), it is important to consider the cultural practices and beliefs, as well as the food items or supplements which are already in use and have been found to be acceptable (e.g. fortified blended foods versus peanut paste; powder versus pills).

- The decision about which product to use with each age group should also be guided by the available distribution systems in each camp as well as whether certain age groups are more affected than others.

- **Note that an FSP may not be the most appropriate option to be chosen if the causes of malnutrition are not food or micronutrient related.**

Table 3. Summary of Newly Developed Fortified Blended Foods[g] and Food Supplementation Products for use in Children aged 6 to 59 Months

(for product fact sheets see http://foodquality.wfp.org/ and online reference material)

	PRODUCT	NUTRITIONAL CONTENTS	TARGET AGE GROUP (CHILDREN)	PRODUCT SHELF-LIFE UNDER IDEAL STORAGE CONDITIONS	PRODUCT DESCRIPTION AND EXAMPLES
FORTIFIED BLENDED FOODS (FBF)	FBF+[1]	Energy (macronutrients) and micronutrients	Children 6-59 months	12 months	FBF+ e.g. Corn-Soy Blend (CSB), Wheat-Soy Blend (WSB) and Rice-Soy Blend (RSB), is a food for young children and other vulnerable groups, as well as the general population. Its content of vitamins and minerals has been modified compared to previous formulations. It is recommended as a partial replacement for nutritionally inadequate local diets.
	FBF++[1]	Energy (macronutrients) and micronutrients	Children 6-24 months	12 months	FBF++ e.g. CSB++ is a newly developed FBF for infants and young children. It contains milk powder and lipids and has a higher energy density than other types of FBF. It is recommended as a partial replacement for nutritionally inadequate local diets in children and to promote weight gain.

1 Improved FBF e.g. CSB, named CSB+ and CSB++ (also named super cereal (+)) have been developed and produced by WFP and others, with new micronutrient formulations and, for CSB++, added milk powder. They are likely to offer advantages over previous formulations in preventing micronutrient deficiencies and malnutrition. Please note that from mid 2011, CSB++ is likely to be more widely available.

g Please note that not all FBF confirm to WFP specifications. Please refer to other guidelines for detailed recommendations on the use of FBF.

	PRODUCT	NUTRITIONAL CONTENTS	TARGET AGE GROUP (CHILDREN)	PRODUCT SHELF-LIFE UNDER IDEAL STORAGE CONDITIONS	PRODUCT DESCRIPTION AND EXAMPLES
FOOD SUPPLEMENTATION PRODUCTS (FSP)	Micronutrient Powder (MNP)	Micronutrients only	Children 6-59 months	24 months	MNPs provide no energy (kcal) in the diet. They are usually packaged in individual sachets to provide a dose of selected vitamins and minerals in powder form, to be added to foods directly after cooking. MNPs have been shown to be efficacious in treating and preventing anaemia. Product brand names include Sprinkles™ and MixMe.
	Low quantity LNS	Energy (macronutrients) and micronutrients	Children 6-24 months manufacturers recommendation[2]	18 months	An example of a low quantity LNS is Nutributter®[2] (product brand name). It is a highly fortified peanut-based paste that contains vitamins and minerals in addition to providing energy. It is usually packaged in individual daily sachets and is to be eaten either directly from the sachet or added to complementary food. It is the only product in this table that has been shown to improve linear growth in young children.
	Medium quantity LNS	Energy (macronutrients) and micronutrients	Children 6-36 months manufacturers recommendation[3]	24 months	An example of a medium quantity LNS is Plumpy'doz®[3] (product brand name). It is a highly fortified peanut-based paste and contains vitamins and minerals in addition to providing energy. It is usually packaged in individual weekly pots. However it will also be available in the form of daily sachets, which is the preferred form for distribution. It has been used to prevent increases in GAM in young children during periods of food insecurity.

2 The published data on Nutributter® describes an improvement in linear growth and iron status after six months of use in infants aged 6-12 months (see below).
Adu-Afarwuah S, Lartey A, Brown KH, Zlotkin S, Briend A, Dewey KG. Randomized comparison of 3 types of micronutrient supplements for home fortification of complementary foods in Ghana: effects on growth and motor development. Am J Clin Nutr 2007;86:412-20.
Adu-Afarwuah S, Lartey A, Brown KH, Zlotkin S, Briend A, Dewey KG. Home fortification of complementary foods with micronutrient supplements is well accepted and has positive effects on infant iron status in Ghana. Am J Clin Nutr 2008;87:929-38.

3 The published data on Plumpy'doz® describes a reduction in the incidence of severe wasting after six months of use in children aged 6-36 months [PLoS One (2009),see below]. WFP indicates that Plumpy'doz® may be used in children between 6-59 months [Sight and Life: Ten Minutes to Learn about Nutrition Programming (2008)]. Defourny I, Minetti A, Harczi G, Doyon S, Sheperd S, Tectonidis M, Bradol JH, Golden M. A large-scale distribution of milk-based fortified spreads: evidence for a new approach in regions with high burden of acute malnutrition. PLoS ONE 4(5):e5455. doi:10.1371/journal.pone.0005455.

The LNS products listed above are those currently accepted for use in UNHCR refugee operations; new products are accepted on a case-by-case basis. Before using any alternative products **contact UNHCR HQ / Regional Offices** for guidance.

2.2. Scenarios for Product Selection

In this section, various scenarios are considered, each depicting one or more of the nutritional problems identified in **Stage 1** (GAM, anaemia or stunting). They illustrate how potential interventions for children aged 6-59 months may be identified, depending on the context. In each box, the prevalence ranges for the scenario are shown in colour. It is recommended to select the scenario that best reflects the camp(s) situation and then use the possible intervention options that are listed as a basis for decision-making. Refer to **Table 3** for guidance on specific products that can be selected for each scenario. In all situations, ***if there is malaria in the concerned camp(s)*** careful consideration needs to be given to the safety of blanket FSPs distribution **(refer to Stage 3)**.

Before spending resources on introducing an FSP in a food aid dependent refugee context, the following nutrition related interventions and programmes should be in place:

- A GFD that supplies adequate energy, macronutrients and micronutrients for the general population.
- FBF should be included in the GFD to provide suitable food for young children and other vulnerable groups such as pregnant and lactating women (PLW) and the elderly. **If there is no FBF included in the GFD then advocate for its inclusion.**
- Detection and treatment of acute malnutrition needs to be functioning well and achieving high coverage, i.e. there should be effective targeted supplementary feeding programmes (MAM) and therapeutic feeding programmes (SAM).
- Public health and WASH programmes need to be established and functioning effectively.

In circumstances where there is no FBF in the GFD, and advocacy to have it included has failed, **older children under 5 (e.g. 36-59 months) not covered by the selected FSP (or FBF) may need to be targeted with a blanket FBF (e.g. CSB).**

In addition to the above, when identifying a potential FSP intervention, it is essential to also give consideration to other factors that will affect the success of the programme. These are considered in detail in subsequent stages of this guidance and include:

- Assessment of **any possible risks** associated with the FSP use **(refer to Stage 3)**
- **Acceptability** of the chosen product to the target group, caregivers and the camp community at large **(refer to Stage 4)**
- The need for careful design of the programme and distribution of the product **(refer to Stage 5)**
- **M&E requirements** need to be considered and be put in place **(refer to Stage 6).**

Scenario 1: High GAM Only

	Prevalence %		
GAM	**≥15 or 10-14**	5-9	<5
Anaemia	≥40	**20-39**	**5-19**
Stunting	≥30	**20-29**	**<20**

This scenario reflects a camp context with high GAM, and medium to low levels of anaemia and stunting.

Purpose: To decrease the prevalence of acute malnutrition in young children.

A) GAM critical or serious and deteriorating
Options to consider*:
- Blanket CSB+ / oil / sugar to children aged 6-59 months OR
- Blanket medium quantity LNS in children aged 6-36 months for 4-6 months per child OR
- Blanket CSB++ in children aged 6-24 months of age

B) GAM serious and persistent
Option to consider*:
- Blanket low quantity LNS in children aged 6-24 months for 6-12 months per child (depending on frequency of use)**

* When selecting intervention options it is important to consider the prevalence of GAM in the different age groups.

** Although the evidence for Nutributter® (low quantity LNS) preventing GAM is lacking, in protracted situations where GAM levels are persistently high throughout the year but fluctuations in food security rare (i.e. more of a food *quality*, than *quantity* issue), it may be acceptable to use Nutributter® as a longer term option.

Scenario 2: High Anaemia Only

	Prevalence %		
GAM	≥15 or 10-14	**5-9**	**<5**
Anaemia	**≥40**	20-39	5-19
Stunting	≥30	**20-29**	**<20**

This scenario reflects a camp context with high anaemia, and medium to low levels of GAM and stunting.

Purpose: To decrease the prevalence of anaemia in young children.

Options to consider:

- Blanket MNP to children aged 6-59 months for 6-12 months per child (depending on frequency of use) OR
- Blanket low quantity LNS in children aged 6-24 months for 6-12 months per child (depending on frequency of use)

Scenario 3: High Stunting Only

	Prevalence %		
GAM	≥15 or 10-14	**5-9**	**<5**
Anaemia	≥40	**20-39**	**5-19**
Stunting	**≥30**	20-29	<20

This scenario reflects a camp context with high stunting, and medium to low levels of GAM and anaemia.

Purpose: To decrease the prevalence of stunting in young children.

Options to consider:

- Blanket low quantity LNS in children aged 6-24 months for 6-12 months per child (depending on frequency of use) OR
- Blanket CSB++ in children aged 6-24 months of age

Scenario 4: High GAM and High Anaemia

	Prevalence %		
GAM	**≥15 or 10-14**	5-9	<5
Anaemia	**≥40**	20-39	5-19
Stunting	≥30	**20-29**	**<20**

This scenario reflects a camp context with high GAM and high anaemia, and medium to low levels of stunting.

Purpose: To decrease the prevalence of acute malnutrition and anaemia in young children.

A) GAM critical or serious and deteriorating

Options to consider*:

- Blanket CSB+ / oil / sugar to children aged 6-59 months OR
- Blanket medium quantity LNS in children aged 6-36 months for 4-6 months per child OR
- Blanket CSB++ in children aged 6-24 months of age

B) GAM serious and persistent

Option to consider*:

- Blanket low quantity LNS in children aged 6-24 months for 6-12 months per child (depending on frequency of use)**

* When selecting intervention options it is important to consider the prevalence of GAM in the different age groups.

** Although the evidence for Nutributter® (low quantity LNS) preventing GAM is lacking, in protracted situations were GAM levels are consistently high throughout the year but fluctuations in food security rare (i.e. more of a food *quality*, than quantity issue), it may be acceptable to use Nutributter® as longer term option.

Scenario 5: High Anaemia and High Stunting

	Prevalence %		
GAM	≥15 or 10-14	**5-9**	**<5**
Anaemia	**≥40**	20-39	5-19
Stunting	**≥30**	20-29	<20

This scenario reflects a camp context with high anaemia and high stunting, and medium to low levels of GAM.

Purpose: To decrease the prevalence of anaemia and stunting in young children.

Options to consider:

- Blanket MNP to children aged 6-59 months for 6-12 months per child (depending on frequency of use) OR
- Blanket low quantity LNS in children aged 6-24 months for 6-12 months per child (depending on frequency of use) OR
- Blanket CSB++ in children aged 6-24 months of age

Scenario 6: High GAM and High Stunting

	Prevalence %		
GAM	**≥15 or 10-14**	5-9	<5
Anaemia	≥40	**20-39**	**5-19**
Stunting	**≥30**	20-29	<20

This scenario reflects a camp context with high GAM and high stunting, and medium to low levels of anaemia.

Purpose: To decrease the prevalence of acute malnutrition and stunting in young children.

A) GAM critical or serious and deteriorating

Options to consider*:

- Blanket CSB+ / oil / sugar to children aged 6-59 months OR
- Blanket medium quantity LNS in children aged 6-36 months for 4-6 months per child OR
- Blanket CSB++ in children aged 6-24 months of age

B) GAM serious and persistent

Option to consider*:

- Blanket low quantity LNS in children aged 6-24 months for 6-12 months per child (depending on frequency of use)**

* When selecting intervention options it is important to consider the prevalence of GAM in the different age groups.

** Although the evidence for Nutributter® (low quantity LNS) preventing GAM is lacking, in protracted situations were GAM levels are consistently high throughout the year but fluctuations in food security rare (i.e. more of a food *quality*, than quantity issue), it may be acceptable to use Nutributter® as longer term option.

Scenario 7: High GAM, High Anaemia and High Stunting

	Prevalence %		
GAM	**≥15 or 10-14**	5-9	<5
Anaemia	**≥40**	20-39	5-19
Stunting	**≥30**	20-29	<20

This scenario reflects a camp context with high GAM, high anaemia, and high stunting.

Purpose: To decrease the prevalence of acute malnutrition, anaemia, and stunting in young children

A) GAM critical or serious and deteriorating
Options to consider*:
- Blanket CSB+ / oil / sugar to children aged 6-59 months OR
- Blanket medium quantity LNS in children aged 6-36 months for 4-6 months per child OR
- Blanket CSB++ in children aged 6-24 months of age

B) GAM serious and persistent
Option to consider*:
- Blanket low quantity LNS in children aged 6-24 months for 6-12 months per child (depending on frequency of use)**

* When selecting intervention options it is important to consider the prevalence of GAM in the different age groups.

** Although the evidence for Nutributter® (low quantity LNS) preventing GAM is lacking, in protracted situations were GAM levels are consistently high throughout the year but fluctuations in food security rare (i.e. more of a food *quality*, than quantity issue), it may be acceptable to use Nutributter® as longer term option.

Scenario 8: Medium to Low GAM, Anaemia and Stunting

	Prevalence %		
GAM	≥15 or 10-14	**5-9**	**<5**
Anaemia	≥40	**20-39**	**5-19**
Stunting	≥30	**20-29**	**<20**

This scenario reflects a camp scenario with medium to low levels of GAM, anaemia and stunting.

In this scenario, a programme using a FSP (MNP, low quantity LNS or medium quantity LNS) may not be the most appropriate approach. Other approaches should be considered.

STAGE 2 CHECKLIST – Identify Possible Solutions

- ☐ Determine the status of the GFD, the existing distribution of FBF and other relevant nutrition / health programmes, and ensure that they are functioning well before considering an FSP intervention
- ☐ Select the scenario that best reflects the camp(s) situation using the classification from Stage 1
- ☐ In the selected scenario, decide on the most appropriate FSP using the options listed, considering the local context, the children's age group, the available distribution systems and the cultural practices and beliefs, as well as the food items or supplements which are already in use and are acceptable to the camp community
- ☐ Select only one FSP for each age group
- ☐ In the circumstance where there is no FBF in the GFD, consider targeting older children under 5 not covered by the FSP, with a blanket FBF distribution
- ☐ **Contact UNHCR HQ / Regional Offices** if senior level advice or guidance is required for any part of Stage 2

STAGE 3 – ASSESS RISKS AND CHALLENGES

This stage is intended to aid in the identification of any risks and precautions that need to be considered before commencing an FSP intervention

Before commencing any FSP intervention, it is important to conduct a systematic risk assessment, as the identification of any risk and challenge will help to guide decisions on whether the FSP selected in **Stage 2** is actually feasible and appropriate for the refugee context. It will also help in setting up the M&E system, as methods to minimize and monitor risks throughout the programme need to be planned from the start. Any risk and challenge identified needs to be recorded and followed up as part of the M&E process and should be included in monitoring reports **(refer to Stage 6).**

It is important to recognise that although certain risks and challenges may present as permanent barriers to an FSP intervention, others can be managed and the risk of harm to refugees reduced to a level that allows the FSP intervention to proceed. Some potential risks are detailed below, however others may be identified. **Readers are advised to contact UNHCR HQ / Regional Offices for guidance in any area of the risk assessment outlined below requiring senior level advice and follow-up**.

3.1. Risk 1 – Adverse Effects on Other Programmes

3.1.1. Inadequate additional resources allocated to FSP programme

The logistical and administrative implications of distributing the selected FSP, such as associated cost and human resource needs related to distribution and M&E, need to be assessed and planned carefully to ensure that other programmes within the refugee operations will not be negatively affected.

✓ **Human Resource**

- An appropriate number of staff need to be hired and trained, considering the time required to carry out activities at all levels. This should not detract from existing programmes and activities.
- M&E requirements should be considered as extra time and even extra staff

or volunteers may be needed to complete the required data collection and reporting activities at all levels, and this should be taken into account when deciding on the number of field staff to hire. Managers should factor in time taken for completing regular monitoring reports and the larger evaluation reports **(refer to Stage 6)**.

✓ **Cost**

- Budgetary requirements for the selected FSP programme should be included from the start to ensure that plans are feasible and realistic within the given context.

3.2. Risk 2 – Excessive Micronutrient Consumption

3.2.1. Exposure to multiple fortified foods and supplements

Consumption of any nutrient in excessive quantities carries a risk of adverse effects. The *Tolerable Upper Intake Level (UL)* is the highest level of a nutrient that is likely to pose no risk of adverse health effects to 98% of a population and refers to total intake of a nutrient from food, fortified food, and supplements. If FSPs are consumed at the recommended doses they provide no risk of excessive intake. However, if they are consumed in larger amounts than recommended, or in combination with other fortified foods and supplements, a risk of excessive intake exists. This risk needs to be estimated and if excessive intake is considered to be likely, either the FSP should not be used or its micronutrient formulation should be adjusted. As an example, re-formulation may result in a reduction in the vitamin A dosage or completely removing iodine from the formulation, as was recently done for refugee camps in Algeria (see reference materials – FSP reformulation examples from Algeria (Nutributter) and Yemen (MNP)).

It is important to note that FSPs should be withheld from children who are being treated with therapeutic foods for SAM.

If the selected FSP will be given to children being treated for MAM, the FSP micronutrient formulation may need to be adapted in order to avoid micronutrient overload, depending on the treatment protocol in use, or it may need to be withheld completely.

At the current time, readers are *required* to **contact UNHCR HQ / Regional Offices** to make sure that the micronutrient formulation of the selected FSP is safe for long-term use. Before doing so, the information listed below should be compiled from the specific refugee context (see Tool 1 for help in gathering the correct data). The potential need for reformulation will then be identified based on the information provided.

a. Estimated current food intake of the target group:

- Compile a table of the GFD and any other food commodities (e.g. CSB, oil, tuna fish, beans, peanuts) provided to certain target groups through existing blanket or targeted supplementary / complementary feeding programmes, including fortification levels, quantity and planned duration
- Include fortification levels of oil (vitamin A), salt (iodine), and FBF (multiple micronutrients)

Note: refugees may have access to food from several different sources, not only from WFP or standard programmes in the camp setting. Information from various sources may help to guide the estimation of which groups of refugees are consuming more or less of various foods e.g. are there vegetable gardens? If yes, is the produce eaten by all families and family members? Is the FBF in the GFD eaten by all families or family members or reserved for children? Is tea consumed by all families or family members? Is tea consumed by infants or children under five?

b. Selective feeding programmes:

- Summarise the systematic treatment protocols for acute malnutrition.

c. Management of anaemia:

- Summarise the systematic treatment protocols for anaemia.

d. Preventative micronutrient supplementation:

- Summarise the systematic micronutrient supplementation protocols provided to certain target groups for example, frequency and dosage of vitamin A supplementation to children 6-59 months; multiple micronutrient supplements or iron / folic acid pills for pregnant women.

3.2.2. Interaction of iron and malaria

The use of iron supplementation in malaria endemic areas has been a long standing controversy due to concerns that iron therapy may exacerbate infections, in particular malaria, given that many pathogens require iron for growth. The World Health Organization (WHO) issued a Statement[h] (2004) advising that *blanket* iron supplementation not be given to young children in regions of high malaria transmission. Some FSP formulations contain relatively high levels of iron and therefore may exacerbate malaria infection and other infectious diseases. MNP and LNS are currently considered to carry the same risk for malaria as a supplemental dose of iron given as a tablet[i] (note that WHO considers that it is safe to distribute FBFs to young children in malaria endemic regions). Current approaches to reducing this risk include:

- ✓ Decreasing the iron dose in the selected FSP or dividing the dose over the day, thus minimising any potential hazard associated with ingesting at once, single large doses of iron[j] (for further information see reference material – Anaemia Issues Paper).
- ✓ Appropriate malaria control activities should be implemented if not already in place (see below).

In addition to this, evidence indicates that supplemental folic acid may interfere with the efficacy of antifolate antimalarial drug therapy (e.g. sulfadoxine and pyrimethamine (Fansidar®)) causing potential adverse effects. To reduce this risk, the following is currently recommended:

- ✓ Supplemental folic acid should *not* be provided to young children where antifolate antimalarial drugs are used. Where applicable, folic acid should be reduced or removed from the FSP formulation.

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h WHO. Iron supplementation of young children in regions where malaria transmission is intense and infectious disease highly prevalent. WHO Statement, 2006. Accessed July 30th 2009 http://www.who.int/child_adolescent_health/documents/pdfs/who_statement_iron.pdf

i WHO Secretariat on behalf of the participants to the Consultation. Conclusions and recommendations of the WHO Consultation on prevention and control of iron deficiency in infants and young children in malaria-endemic areas. (2007) Food Nutr Bull vol. 28, no. 4 S621-631

j A reduced dose of iron (in the form of NaFeEDTA) has been used in a large-scale MNP distribution programme in Kakuma refugee camp in Kenya. However, as iron from this compound is absorbed more easily it is not known whether this formulation does actually carry a lower risk or not.

If the FSP product is to be distributed in a refugee context where there is malaria, at the current time, readers are *required* to **contact UNHCR HQ / Regional Offices** for the latest technical advice on this issue and for guidance on the iron and folic acid dosages to use in the selected FSP product. Before doing so, information on the following contextual data and existing / planned malaria control activities should be compiled (see reference material – Yemen Case Study, for an example of the information collected on malaria control activities during a risk assessment for an MNP programme):

- ✓ Malaria control activities and contextual information required:
  - Mosquito net coverage and use e.g. Long-lasting Insecticidal Nets (LLIN)
  - Indoor residual insecticide spraying
  - Diagnostic and treatment facilities / protocols in place (e.g. use of Rapid Diagnostic Tests (RDT), Intermittent Preventative Treatment (IPT) and other drugs)
  - HIS information on incidence of malaria and mortality
  - Prevalence of anaemia reported in past nutrition surveys including time (month) of year

3.3. Risk 3 – Adverse Effects on Feeding Practices and Child Health

3.3.1 Breast milk displacement

LNS products should only be given to infants over 6 months of age as below this age infants should be exclusively breastfed or, if absolutely necessary, provided with safe infant formula. The potential risk of breast milk displacement when LNS is used in older infants and young children is a concern due to their attractive taste and relatively high energy content. To date, only two published studies have looked at breast milk displacement specifically and found no difference in infants over 6 months of age[k] and 9-10 months of age[l] who were given LNS or typical infant porridge. Nevertheless,

k Galpin L, Thakwalakwa C, Phuka J, Ashorn P, Maleta K, Wong WW, Manary Mark, Breast milk intake is not reduced more by the introduction of energy dense complementary food than by typical infant porridge. J Nutr 2007;137: 1828-1833.

l Owino VO, Bahwere P, Bisimwa G, Mwangi CM, Collins S. Breast milk intake of 9-10 month old rural infants given a ready-to-use complementary food in South Kivu, Democratic Republic of Congo. Am J Clin Nutr 2011;93:1300-4

support for sustained breastfeeding is critical and should always be included as part of efforts to improve complementary feeding practices. LNS should be given *in addition* to breast milk and complementary foods, and breastfeeding continued and not decreased or stopped because of LNS intake. The following key factors are important for reducing breast milk displacement:

- ✓ Never provide LNS to infants less than 6 months of age.
- ✓ Strategies to reduce the potential risk of breast milk displacement in older infants and young children should be part of all Behaviour Change Communication (BCC) activities, for example through encouraging breastfeeding prior to feeding with LNS **(refer to Stage 5)**.
- ✓ When using LNS products, caregivers should be counselled that these products are intended to complement existing food intake, and not replace it.
- ✓ Questions on breastmilk displacement should also be included in programme monitoring as well as knowledge, attitude and practice (KAP) questionnaires and other relevant monitoring tools **(refer to Stage 6)**.

3.3.2. Adverse effects on food habits

It is important that FSPs do not adversely affect existing positive feeding habits, as appropriate complementary feeding is essential for children's health, growth and development potential. FSPs are intended as a supplement to children's diets, and provision of other complementary foods of appropriate quantity and quality along with breastfeeding should be continued. To reduce the risk of adverse effects on food habits from introduction of FSPs, the following should be considered as part of the intervention:

- ✓ Caregivers should receive nutrition education to understand that proper complementary feeding practices and breastfeeding should be continued despite introduction of the new product. Health staff should counsel caregivers who receive FSPs (particularly LNS), and explain clearly and simply that their child also needs additional complementary foods to improve their growth and micronutrient status.
- ✓ Health staff should be aware of the implications of telling caregivers that these

products are the best way to feed their children, but should teach caregivers about locally available food and normal complementary feeding practices.

- ✓ Where they are available and accessible, the importance of dietary diversification with fresh fruits, vegetables and animal products should be stressed.
- ✓ The risk of over-consumption of nutrient dense products in populations where there is co-existent over nutrition should be borne in mind. In the rare camp contexts where a double-burden of malnutrition (obesity and undernutrition) exists, for example in Algeria, decisions on the appropriate FSP for blanket distribution need to consider this risk, so as not to exacerbate the problem through the provision of products with inappropriately high energy content.

Refer to Stage 5 for relevant communication materials and tools.

3.3.3 Peanut allergies

Most LNS products are peanut-based and therefore can cause an anaphylactic reaction (i.e. a rapidly progressing, life-threatening allergic reaction) in a person who is allergic to peanuts. Although this condition is rare outside of the Western world, programme implementers need to be aware of methods of reducing this risk and the action to take should an anaphylactic reaction occur, as outlined below:

- ✓ Where feasible, the first time any peanut-based LNS product is used, caregivers and recipient children should be gathered together at a central place for supervised tasting. Although allergies usually occur during the second tasting of the product, this provides a first opportunity for education on this and related topics, as well as an opportunity for any cases of severe allergy occurring immediately, to be detected in the presence of appropriately qualified health professionals.
- ✓ Health workers should be aware of the *causes* of anaphylactic shock as well as be able to recognise early symptoms of an allergic reaction. They should be properly educated on, and armed with appropriate treatment measures or the necessary testing and evaluation to confirm the allergy.
- ✓ The appearance of symptoms after eating peanut-based LNS may be a sign of a peanut allergy, and may require that these foods be avoided. Symptoms may be mild or severe and usually appear within a few minutes to two hours after a person

has eaten the food to which they are allergic. Symptoms commonly include one or more of the following[mn]; hives (itchy red bumps on the skin's surface), swelling in the tongue and throat, difficulty breathing, abdominal cramps, vomiting and diarrhoea, rash, coughing / wheezing, dizziness.

3.3.4 Adverse effects on dental health

LNS products contain a relatively high concentration of sugar. It is currently not known if there are any long-term consequences of the regular use of these products on dental health in young children. New formulations with lower sugar content are currently under development and will be considered for use when available.

3.4. Risk 4 – Safe and Acceptable Duration and Frequency of Use

A safe and acceptable schedule of use needs to be developed for the FSP, which answers to the needs of the target group and accommodates the beliefs of the refugee community. There is limited evidence to date on the frequency, and especially duration, of use of LNS and MNPs in refugee settings, and the programmatic experience that is available has focused more on use of MNPs rather than LNS. However, considering the information available, decisions on appropriate frequency and duration of product use should bear the following in mind:

- ✓ Overall risk assessment results (and later, if applicable, the results of the acceptability test described in Stage 4)
- ✓ Programme objectives
- ✓ Context (e.g. disease burden: acute / chronic, seasonal / long-term; current micronutrient intake and exposure to other fortified foods; formulation of selected FSP)
- ✓ Age-group being targeted
- ✓ Incidence of malaria

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m http://www.cdc.gov/healthyyouth/foodallergies/

n http://www.fda.gov/Food/ResourcesForYou/Consumers/ucm079311.htm

Depending on the context and duration, the following MNP schedules (based on programmatic evidence using MNP) may be used:

a) Daily use (30 daily doses / month)
b) Every other day use (15 daily doses / month)
c) Bi-weekly use (twice a week for a total of 8 daily doses / month)
d) Flexible use whereby caregivers are told to use a given amount of FSP over a specified period of time without exceeding one daily dose per day (e.g. 15 daily doses to be taken at any time during the month but no more than one per day)

Although less information is available on the advised schedule of use for LNS, recommendations for specific products are available. As an example, the manufacturer's recommendation for Nutributter® (low quantity LNS) is to provide 1 sachet / day (20g), or in malaria endemic areas, to divide the dose over the day (10g in the morning, 10g in the evening). For Plumpy'doz® (medium quantity LNS), where pots are used, the manufacturer recommends providing 3 teaspoons 3 times / day, or 1 tablespoon / day i.e. around 46g / day and 1 pot per week.

The maximum amount of time that Nutributter® and Plumpy'doz® have been used on a daily basis is six months (see footnotes in **Table 3** for study references). However, these products may also be used flexibly, for example, for a longer period of time of up to around 12 months (which may be helpful for project funding). As an example, if the aim of the FSP programme is to reduce seasonal GAM or anaemia / malnutrition during the initial stages of an emergency, a more frequent but shorter term schedule might be required, than if it is aimed at improving the general quality of the diet over a longer term but less frequent schedule. Additionally, flexible schedules are more commonly used with MNPs as evidence indicates that flexibility in taking MNPs lends to greater adherence than rigid schedules, which have been shown to be difficult for caregivers to follow. A flexible schedule may also be more appropriate when the daily diet contains adequate amounts of other fortified foods, as is common in refugee situations, and when households have the ability to supplement their diet.

3.5. Risk 5 – Delays in Importing and Obtaining Permission for Product Use

3.5.1. In-country permission for product use and importation

Most FSPs are new to refugee hosting countries and specific local registration requirements may need to be followed for importation and use of the products in-country. If these requirements are not properly adhered to, or if clearance is not obtained in a timely manner, this could result in considerable delays to the programme and may negatively impact on the community's perception of the intervention. This risk should be reduced as follows:

- ✓ Gather the necessary information on the registration process and approval for the product use in a timely manner.

3.6. Risk 6 – Deterioration of Stock

3.6.1. Damage to product during storage

The suitability of the FSP storage location needs to be considered with reference to temperature, humidity and pest control. The following options should be considered for optimising product quality during storage:

- ✓ Where storage conditions in-country are sub-optimal, delivery of the FSP in batches from the manufacturer may be appropriate. Although this may increase shipping costs, the benefits of increased product quality and reduced losses may outweigh this.
- ✓ In order to ensure and monitor product quality, periodic stability testing of the FSP should be considered.

3.6.2. Shelf life

It is important that the shelf-life of the selected FSP(s) be adhered to. As with any product, the quality and palatability may deteriorate after the best before date (BBD) has expired. When stored and packaged under optimal conditions, the shelf life of the FSPs considered in this guidance are currently as follows: 24 months for MNPs, and

according to manufacturers guidance, 24 months for Plumpy'doz® (medium quantity LNS) and 18 months for Nutributter® (low quantity LNS) (see also **Table 3**) (note that the BBD may vary depending on the manufacturer used). Risks can be minimised by considering the following:

- ✓ The FSP should be stored in as cool and dry conditions as possible (but not allowed to freeze) in order to maintain expected shelf-life durations, as shelf-life may vary depending on storage conditions.
- ✓ Before ordering products, shelf life should be checked (based on date of manufacture), to ensure that once received, the product will be used before the shelf-life has passed.

3.7. Risk 7 – Environmental Pollution

3.7.1. Disposal system of sachets or pots

It is essential to consider how the hundreds of thousands of empty sachets or pots will be disposed of in each specific refugee context to limit the environmental challenge associated with the accumulation of this waste. It is important therefore to ensure that there is a mechanism in place to deal with empty sachets / pots **(refer to stage 5)**. It is also essential to have a plan for pest control.

STAGE 3 CHECKLIST – Assess Risks and Challenges

- ☐ Assess adequacy of available logistical and administrative resources (e.g. HR, cost)
- ☐ Compile information needed to assess the risk of excessive micronutrient consumption and send to UNHCR HQ / Regional Office
- ☐ Assess risk of adverse effects on appropriate feeding practices and child health, and identify strategies to minimise this
- ☐ Obtain permission for product importation and use in-country
- ☐ Assess suitability of planned product storage location and consider carefully the shelf life of the product when ordering
- ☐ Identify environmentally sound disposal systems for FSP sachets / pots
- ☐ **Contact UNHCR HQ / Regional Offices** if senior level advice or guidance is required for any part of Stage 3

STAGE 4 – TEST SPECIAL NUTRITIONAL PRODUCT ACCEPTABILITY AND ADHERENCE

This stage is designed to assess the acceptability of the selected FSP[o] to the potential beneficiaries and their adherence to the recommended dosage. *An FSP distribution should only be carried out if the test shows that the product is acceptable and adherence is adequate.*

Before any FSP intervention can be carried out, an acceptability and adherence test is required to assess the beneficiary's perception and acceptance of the product and adherence to the recommended dosage. The test uses both quantitative and qualitative methods to gain a better understanding of the nutrition related behaviours and beliefs within the population, as well as key factors for encouraging acceptance and correct use of the product. Through the participation of refugees, which is key to the success of the FSP distribution programme, the acceptability test can also be used to identify a locally acceptable name for the FSP and ideal packaging and distribution mechanisms. It can also guide the development of key educational messages and activities for BCC **(refer to Stage 5)**, tailored to the specific needs, knowledge and beliefs of the local population. Findings from the test will help with identification of potential barriers and enablers for the FSP intervention among caregivers, health staff and the camp community. The results of a properly conducted acceptability and adherence test will indicate whether the FSP is acceptable to the refugee community, and therefore whether it is appropriate to go ahead with the intervention programme or not. To date, acceptability tests on FSPs have been conducted in refugee contexts in Algeria, Djibouti and Yemen using the guides and tools presented here.

To avoid confusion, it is important to recognise that the acceptability test described in this guidance differs from more formal acceptability trials. Such trials usually involve testing the acceptability of various products in comparison to one another with a target group of potential consumers or patients. They frequently follow the format of a randomised, controlled, cross-over trial design where food intake, flavour / appearance / colour / aroma preference, overall degree of liking and side effects are studied. The acceptability test described here is not for a comparison of different products. It

o An acceptability and adherence test may also be required for other products apart from FSPs e.g. FBF

examines the acceptability of a product that has already been selected as potentially suitable during the earlier stages of this Operational Guidance. If the objective is to *compare* different FSPs in the same age group, then advice on designing a comparative trial will be required, which is beyond the scope of this guidance.

4.1. Conducting an FSP Acceptability and Adherence Test

Before commencing an acceptability and adherence test, country programmes need to be aware of the specific protocol for ethical approval from the Ministry of Health (MoH) or other governmental bodies in their respective countries. Any appropriate clearances should be obtained before going ahead with the study.

The acceptability and adherence test includes the following key components:

- ✓ Distribution of the product to selected participants for a minimum of **3 weeks**
- ✓ Qualitative data collection: focus group discussions (FGD), key informant (KI) interviews and household (HH) direct observations
- ✓ Quantitative data collection: HH interviews and HH direct observations
- ✓ Analysis and interpretation of the data collected

The following standard documents and tools have been developed to aid with conducting the FSP acceptability and adherence test, and should be accessed from the websites referenced at the beginning of this Operational Guidance. They will need to be adapted to the local context, and therefore serve only as a guide:

- ✓ Standard Protocol: provided to guide the planning and implementation of the test
- ✓ Standard Tools: provided to help with data collection:
  - A. Child Enrolment Questionnaire
  - B. Key Informant semi-structured interview guide
  - C. Focus Group Discussion guide
  - D. Household interview questionnaire
  - E. Household direct observation form
  - F. Food Supplementation Product information sheets
- ✓ Standard Report Template: provides a template for reporting on the test

4.2. Summary of Standard Protocol

The 'Standard Protocol for Testing FSP Acceptability and Adherence' describes in detail the main components that need to be considered for planning and implementation of an FSP acceptability and adherence test in refugee camps. The key points are covered briefly below.

4.2.1 Preparatory work

The following preparatory activities and background information are required:

- ✓ **Gather background and contextual information:** Relevant contextual background information should be gathered and documented including: details of the study area, population numbers and groups present, geography of the area, livelihoods information and any important political / security information. Contextual **nutrition information** should also be collected and presented in the protocol including food aid provided e.g. GFD and the reliability of existing distribution mechanisms, as well as recent nutrition survey results (compiled during **Stage 1**).

- ✓ **Obtain FSP samples:** Try to obtain FSP samples from the product manufacturer for the duration of the acceptability test ensuring sufficient notice has been given.

4.2.2. Methodology

The test methodology requires consideration / implementation of the following key components:

- ✓ **Sample size:** In camps where there is a diverse refugee population, a sample size of **120** children is recommended. Participants should be recruited to ensure that the different populations groups within the camp are represented. However, in camps where the population is more homogenous or resources are limited, a smaller sample size may be used. **The minimum sample size to use is 40. Contact UNHCR HQ / Regional Offices** if proposing to use <100 participants.

- ✓ **Target age group and participant selection:** The acceptability test should be conducted among the target group identified in **Stage 2** of this guidance. Eligible children can be selected through methods such as random or active finding or using registers from health centres if available. Verbal informed consent must be obtained from the child's caregiver and it is important that caregivers are made aware that their child can discontinue at any point during the test. When selecting participants, the following should be ensured:
  - All age ranges within the target group are represented
  - All geographic areas of the camp are covered
  - All ethnic groups (where applicable) are represented

  The following inclusion and exclusion criteria also apply:

  - **Inclusion criteria:**
    - Included children should belong to the specific target age group selected;
    - They should be eating at least one complementary food a day in addition to breastmilk (if they are still breastfeeding);
    - They should be available for the duration of the test.

  - **Exclusion criteria:**
    - Children of the chosen target age group with acute malnutrition, i.e. WHZ < -2.0 using WHO Growth Standards 2006 (or < 80% median NCHS Reference 1977) or the presence of bilateral pitting oedema;
    - Children with severe systemic illness warranting hospital referral;
    - Children with illnesses such as acute respiratory infections (ARI), fever, diarrhoea etc., or who are handicapped or with any illness likely to interfere with food intake;
    - Children who are currently participating in any other test / trial; and
    - Children receiving therapeutic care for anaemia.

- ✓ **Duration of Test:** It is recommended that the product be distributed for a minimum of *3 weeks* in order that participants have sufficient time to become familiar with it.

- ✓ **Dose & Schedule:** The recommended dose and schedule (e.g. whether it is 1 sachet / pot per day / every other day / week) will depend on the product identified in **Stage 2**, the results from the risk assessment (**Stage 3**) and the local context.

- ✓ **Inform the community about the product and the planned acceptability test:** Before commencing the acceptability test, it is important to inform the local community about the possible planned intervention, the test's purpose and duration, and to seek their consent and full cooperation and participation. To do this, meetings should be held with various key partners, participants and stakeholders, e.g. parents, camp / community leaders, clan elders, women's groups, health staff etc.

- ✓ **Staff Recruitment & Training:** It is recommended to include around 5-10 staff depending on the size of the camp. The product information sheets (Tool F) can be used to help train the staff. It is important to note that one of the most important determinants of adherence is the subject's belief in the good intentions of the staff / health provider and this should be emphasised during the training. It is suggested that the duration for staff training be around 2-4 days.

- ✓ **Nutrition Education Sessions:** At the start of the test, nutrition education sessions should be held with caregivers to provide information on the purpose of the FSP and how it should be used as well as potential side effects that may be encountered and how to manage them. Education on appropriate complementary feeding practices and continued breastfeeding should also be provided. Caregivers should be asked to use the product for the entire test duration according to the recommended regimen.

- ✓ **Distribution of the Product:** The necessary FSP sachets / pots for the duration of the test should be distributed to the caregiver of each child at the beginning of the test. Ideally, the distribution should be undertaken using the same distribution mechanism identified for the large-scale programme, if this is feasible and it has already been identified.

4.2.3. Data collection and Analysis

The main methods for data collection and suggested schedule of use for each are provided in **Table 4** below:

Table 4. *Example* acceptability test data collection schedule

	Preliminary Data Collection	Product testing		
		Baseline (Day 1)	Midpoint (Day 11)	Endline (Day 21)
Key Informant Interview	■			■
Focus Group Discussion	■			■
Enrolment Questionnaire		■		
HH Direct Observation			■	
HH Questionnaire				■

More detailed information is provided in the Standard Protocol on how to conduct FGDs, KI interviews, HH questionnaires and HH direct observations, as well as suggestions for the number of each that should be conducted. Example question guides / themes are also provided for each method (see Tools B-E within the Standard Tools). As mentioned, each tool should be adapted to the local context and the product being tested. Depending on resources, it may be necessary to stagger recruitment of participants so that baseline, midpoint and endline data collection can be spread over time.

Preliminary Data Collection

It may be necessary (where feasible) to use KI interviews and FGDs to gather baseline information before commencing the acceptability and adherence test, to help guide staff training and implementation of the test. These activities should be carried out with different target groups as appropriate. These can be used to develop a baseline understanding of feeding habits, beliefs etc. as well as to help in designing preliminary

key messages for the test. The information collated can also be used for the caregiver nutrition education sessions described above. Completion of this preliminary data collection will be particularly useful where little is known about the context. The level of existing knowledge should therefore influence the number of activities carried out.

Product Testing

As indicated in **Table 4** above, an enrolment questionnaire should be completed at baseline (Day 1). This is to ensure that only eligible children are included in the test, that caregivers understand and have given their full consent for their child to participate in the test, and that required additional baseline information is collected (e.g. recent illnesses experienced).

Where feasible, an iterative process should be used for data collection, whereby topics for KI interviews / FGDs etc. are sketched out in a checklist and evolve as the test develops. However, this will require experienced staff with an understanding of all aspects of the test. Questions asked in FGDs and KI interviews should be tailored to the participant's background and / or area of expertise, so that they are answering questions on which they are most knowledgeable. This will help to improve the reliability of information obtained. In many cases, the focus of the questions asked and topics discussed will be different between the beginning (baseline) and the end of the test.

Examples are provided below of some of the key participants to be included in the acceptability and adherence test and the type of topics that they should be questioned on, with the ideal timing shown in brackets for certain topics:

Key Informant Interviews	
Caregivers	• Feeding practices, controversial areas (baseline) • Beliefs regarding food (baseline) • Child caring practices – common practices (baseline) • Causes of malnutrition / anaemia and local terminology (baseline / endline) • Experience of using the FSP – personal views (endline) • Packaging and potential names for FSP (baseline / endline) • Follow-up visit to caregivers who have not used up all of the FSP to discuss why (endline) • Health benefits and knowledge / understanding of the FSP (baseline / endline)
Female Elders	• Common feeding practices (baseline) • Causes of malnutrition / anaemia (baseline / endline)
Shopkeepers	• Sale of FSP on the market (this may be better monitored during programme implementation; during a 3-week test, it is highly unlikely that the product would be sold however it may happen and where applicable it is important to find out why the product is being sold) (endline).
Camp leader / UNHCR staff	• Ethnic make-up of camp (baseline) • Cultural differences among refugee groups (baseline)
Health Professionals	• Local views on malnutrition / anaemia (baseline / endline) • Arrivals at clinic presenting with malnutrition / anaemia (baseline) • Distribution systems for the FSP (baseline)

Focus Group Discussions	
Caregivers	• Knowledge of malnutrition / anaemia / micronutrients / healthcare (baseline / endline) • Child caring practices and feeding practices: controversial areas to complement what is already known (this is best done in a FGD after an initial KI interview has been conducted to gather contentious topic areas) (baseline) • Community perception of the FSP intervention e.g. what do other people say in the family and in the community as a whole (baseline and endline) • FSP usage / proposed name / packaging / distribution system / side effects / understanding of the product (endline) • Barriers to FSP acceptance / adherence, superstitions related to product, sharing of FSP, perceived benefits of FSP (baseline / endline) • Health benefits and knowledge / understanding of the FSP (baseline / endline) • Appropriate health messages / FSP communication materials (baseline / endline)
Fathers	• Community perception of FSP intervention e.g. to find out what other people say (endline)
Elder women / men	• Feeding practices, controversial areas (baseline)

HH Direct Observation	
Caregivers	• Child caring practices (baseline / mid-point) • Feeding practices (baseline / mid-point) • Use / storage of the FSP (mid-point) • Adherence to the FSP (through counting the number of full / empty sachets, missing sachets, observing sharing etc.) (mid-point)
Children	• Likeability of the FSP (mid-point / endline)

HH Interview (endpoint)	
Every Participant	• Use of the FSP (where applicable: with which foods, effect on food etc.) • Acceptability of the FSP (ease of use, likeability, impact on appetite / level of activity / playfulness, major difficulties) • Adherence to the FSP • Side effects attributed to the FSP (presence of loose stools, stool color change etc) and perceived benefits of the FSP

Data Analysis

- ✓ **Analysis of Qualitative Data:**
  - Qualitative data should be analysed manually and organised according to themes, by looking at participant responses to identify any consistencies, differences and relationships around FSP acceptability and adherence
- ✓ **Analysis of Quantitative Data:**
  - HH forms should be collected and assessed for accuracy and completeness
  - Statistical analysis can be conducted using software such as Excel or Epi Info

4.2.4. Results

Acceptability

Acceptability can be defined as **the extent to which participants or caregivers of selected children liked the use, appearance and taste of the product.** Acceptability is assessed through exploration of the following topics / areas:

FGD, KI interviews and direct observations (qualitative):

- ✓ Product likeability (if disliked, reasons why);
- ✓ Whether the product is easy to use (if not, why not);
- ✓ The effect of the product on foods and / or food habits;
- ✓ Worries associated with its use;

- ✓ Perceived side effects and benefits and how / if these influenced FSP use;
- ✓ Recommendations on long term use of the product; and
- ✓ Health benefits and knowledge / understanding of the FSP.

HH interviews and HH direct observations (quantitative):

- ✓ Proportion of HHs who liked using the FSP and liked its taste.

Adherence

Adherence can be defined as **the extent to which product consumption conforms to the recommendations provided to the caregivers[p].**

Adherence is calculated using the following formula and classifications when the FSP is in sachet form (refer to the Standard Protocol and Pot Monitoring Guide in **Appendix 4** for guidance on how to assess this from a pot).

Individual Adherence (%) = $\frac{\text{number of empty sachets counted} \times 100}{\text{number that should have been consumed}}$

The acceptable adherence level for an individual participant is ≥ 50% and less than 110%

Classification of levels of adherence:
The examples shown in brackets are for a 3-week test during which the recommended dose was one sachet per day.

- ≤25% - Very low adherence (from the 21 sachets distributed, 0 to 5 empty sachets are counted at the end of the test)
- 26-49% - Low adherence (from the 21 sachets distributed, 6 to 10 empty sachets are counted at the end of the test)
- 50-74% - Adequate adherence (from the 21 sachets distributed, 11 to 15 empty sachets are counted at the end of the test)
- ≥75% - High adherence (from the 21 sachets distributed, 16 to 21 empty sachets are counted at the end of the test)
- >110% - Over consumption (calculated at mid-point only - more than 12 empty sachets are counted)

p Note that 'adherence' is sometimes referred to as 'compliance'. In this guidance, the term adherence will be used throughout

Population Adherence (%) = number of participants with acceptable adherence x 100
total number of participants

Population adherence of >70% is considered acceptable

Naming of FSP and Packaging Design

A popular, culturally acceptable name for the FSP needs to be identified, for example, one that the community associate with health and well-being. Results from the FGDs and KI interviews should also have explored and helped identify whether the generic packaging of the FSP is appropriate or not. If not, these discussions should help with the identification of an appropriate packaging (design) for the FSP, assuming it is feasible for it to be changed. If the packaging design needs to be changed, it can be quite time consuming and may need to be contracted out as a separate project.

Distribution System

A feasible and trusted distribution system for the product should be explored and identified from the data collected.

BCC Messages and Activities

Appropriate formative research is a pre-requisite for a successful communication and education campaign. The information gained from the acceptability and adherence test should therefore also be used for the purpose of crafting appropriate key BCC messages, materials and activities for the target audience, as well as to guide health worker training messages. This will help to ensure that the messages and activities developed during planning and implementation of the intervention in **Stage 5** are tailored to existing health beliefs and knowledge gaps in the population and will be easily understood (**see Stage 5 – 'Develop a Communication Plan'**).

4.2.5. Interpretation of Results

Results from all methods of data collection during the acceptability and adherence test should be triangulated, in order to identify the predominantly held opinions and perceptions of the FSP and its potential for integration into local practices and cultural eating habits. Qualitative data from the FGDs, KI interviews and HH direct observations should be used to cross-check the quantitative data from the HH questionnaires and vice versa.

It is important to follow up on any negative opinions expressed towards the FSP programme, or indications that the product is being used incorrectly or not adequately adhered to, in order to identify potential reasons for this. If any barriers to implementation are found, this will help identify whether these are permanent or can be overcome, and therefore whether it is appropriate to proceed with the FSP intervention or not.

STAGE 4 CHECKLIST – Test Special Nutritional Product Acceptability and Adherence

- ☐ Refer to the Standard Acceptability Tools provided at http://info.refugee-nutrition.net or http://www.unhcr.org:
  1) Standard Protocol for Testing FSP Acceptability and Adherence
  2) Standard Tools for Testing FSP Acceptability and Adherence
  3) Standard Report Template for FSP Acceptability and Adherence Test
- ☐ Complete the standard protocol as a planning tool to conduct the acceptability and adherence test, and design a timeline of activities according to the context
- ☐ Obtain sufficient samples of the FSP being tested
- ☐ Adapt the standard tools for data collection
- ☐ Identify the target group according to the inclusion and exclusion criteria
- ☐ Hold key baseline meetings including FGDs and KI interviews to aid with implementation and understand the context
- ☐ Distribute the FSP for a minimum of 3 weeks to approximately 120 participants (depending on camp population groups and resources)
- ☐ Collect data on acceptability and adherence using quantitative and qualitative methods
- ☐ Analyse and provide interpretation of the data collected and complete the standard report
- ☐ Decide whether it is appropriate to continue with the full-scale FSP intervention
- ☐ **Contact UNHCR HQ / Regional Offices** if senior level advice or guidance is required for any part of Stage 4

STAGE 5 – DESIGN THE PROGRAMME AND DISTRIBUTE THE PRODUCT

This stage is intended to aid in identifying the key components that need to be in place or developed to ensure that the intervention is implemented effectively

The introduction of any FSP intervention requires careful and systematic planning, taking into consideration the outcomes of the previous stages, local context and any potential barriers and enablers. The characteristics of a well-designed FSP programme may differ between refugee settings because of different beliefs, culture, and the available infrastructure. The participation of the refugee population is therefore key to the success of any FSP programme and distribution. It is important that the results of the acceptability and adherence test be considered during this stage of programme planning, in order to increase the likelihood that the product will be accepted and used properly within the community and the target population, and to encourage effective programme implementation.

Some of the following key components have been highlighted at previous stages of this guidance, however it is important for them also to be considered at this stage of the planning / implementation process, now that the decision to proceed with the FSP intervention has been made.

5.1. Coordinating programme implementation

The following key components should be considered for effective coordination of programme implementation:

- ✓ **Coordination with involved actors:** Any roles and responsibilities in planning, implementing, managing, monitoring and evaluating the FSP programme among the different actors involved, need to be refined and agreed upon. Regular coordination meetings should be held in order to maintain communication between all actors involved and allow timely resolution of any arising issues or challenges. The programme timeline should be updated where necessary (see reference material – Example Programme Timeline).

- ✓ **M&E requirements and staff capacity**: **Stage 6** describes the recommendations for setting up an M&E system for an FSP programme. Before programme implementation, it is essential to adapt the standard M&E guidelines to the context, assess staff and HR requirements, and prepare a corresponding budget.
- ✓ **Resource mobilisation**: Programme inputs in the form of FSP, equipment, materials and staff etc. need to be planned and the resources to cover the additional costs need to be sought (any challenge and risk associated with this should have been identified in the risk assessment). Cost sharing arrangements between UNHCR and WFP are set out in the revised MoU (January 2011) and traditional and non-traditional donors may also be approached for contribution.

5.2. Logistics

5.2.1. Select an appropriate storage facility

At both the central level and at distribution sites, the selected FSP should be stored in hygienic areas that are free of pests and contamination from chemicals and other residues. Ideally, storage temperatures should not rise to unreasonably high temperatures. To prevent unnecessary damage and to safeguard the product the following considerations are important:

- ✓ At the household level, the FSP should be stored in a cool, dry and clean place.
- ✓ To facilitate distribution and to safeguard the product, the FSP should preferably be given in a secondary package (preferably reusable) (e.g. small cardboard box or plastic box).

5.2.2. Plan the stock management and disposal system

A system needs to be set-up for stock management and disposal of used products (including empty sachets and pots) or expired supplies. The following mechanisms are suggested for efficient disposal / destruction of FSP sachets / pots:

- ✓ Used / empty sachets / pots could be collected from households and brought

to a central place, or returned at each distribution, and then be incinerated or buried.

- ✓ Information from the field indicates that specific incinerators are frequently used to eliminate sachets (this can also be done for the polypropylene pots). It is important that staff wear appropriate personal protection when using incinerators due to the release of certain organic compounds during burning.

5.2.3. Ordering the product

All nutritional products licensed for use in UNHCR-run camps will conform to certain standards of manufacture and will be safe if used according to recommendations. It is very important to receive clearance for the product (produced by an approved manufacturer) and permission for the programme from UNHCR HQ or Regional Offices (see reference material – FSP Approved Suppliers). Before ordering any FSP, the following also need to be considered:

- ✓ **Lead time:** It is important to give sufficient lead time when ordering any FSP product and a minimum of three months is advised, although longer may be needed.
- ✓ **Extra procurement requirements:** If the product comes in a pot, it may be necessary to procure appropriately sized spoons that comply with the manufacturer's recommendations for dosing, or to estimate dosage based on spoons already available.
- ✓ **Quantity / Supply:** The quantity of FSP needed for the target group (based on the most current census data, birth rates, new arrivals, in and out-migration etc.) needs to be estimated at the start of the programme. It is usually recommended to procure the estimated stock needed plus approximately 20% surplus or back-up source to ensure continuity of supplies (see tools – FSP Quantity Calculator Tool).

5.3. Train health workers and staff

Hiring appropriate staff, training them well and supervising them is crucial for effective programme implementation. The number of trainings and number of people requiring training should be planned ahead to ensure that capacity exists. Health workers and staff who will educate and counsel caregivers about the FSP (intervention) and the reasons for using it need to be trained. They should be familiar with the recommendations and reasons for using the FSP as well as the benefits and potential associated side effects (see guidance provided below on adverse effects). It is important to consider the following:

- ✓ **Training materials:** It is essential to create proper training materials for reference purposes and to ensure standardisation of training (see reference material – Model Training Material, Pushtika Manual). These should also be based on the findings from the acceptability test. In some cases, health workers and staff involved in the FSP programme may need to be educated almost as much as the refugee community members.
- ✓ **Staff skills and knowledge**: It is critical that health workers and staff have good interpersonal skills to convey effective messages to caregivers. As previously mentioned, staff's attitude towards the caregiver is an important consideration as one of the most important determinants of adherence is the subject's belief in the good intentions of the health provider. Rude staff may also result in high defaulting. It is recommended that even health workers not working with the FSP be familiar with the programme in order to support it in their work and motivate community participation, and that staff be supervised appropriately.
- ✓ **Follow-up evaluation and refresher training**: Plans for follow-up and refresher training should be made for after the intervention has commenced. As the FSPs under consideration are new to most refugee settings, it is recommended to follow-up and monitor health workers' knowledge and understanding to ensure that they adhere to the protocol and key messages (see guidance below on key messages). Refresher training should also be provided after at least six months of programme implementation (**refer to Stage 6** for further guidance on monitoring of training).

5.4. Develop a communication plan

In order to introduce the FSP effectively to the refugee population, a carefully considered communication plan needs to be developed including a significant public education campaign and strategy for effective BCC. It should aim to raise awareness of the FSP among caregivers and the refugee community, promote behaviour change and ensure that the population has access to the FSP, accepts it and uses it appropriately. This will be largely based on the formative research / acceptability test results **(Stage 4)** as well as careful analysis of the local context, including the community's existing knowledge and cultural beliefs. Engaging the target group as well as the local community and religious leaders from the start is also key to a successful communication campaign. After implementation of the FSP programme, the communication plan may need to be adjusted in response to how the population reacts; M&E of BCC activities is therefore important to allow on-going modifications and improvements to be made as necessary **(refer to Stage 6)**. The following key components should be incorporated into planning the communication campaign.

5.4.1. BCC messages

Without appropriate, well-communicated information, the FSP may be misused or not utilised at all. In order to be successful, suitable messages and communication materials should be designed for the target audience, and for use in training of health workers (see reference materials – BCC examples for MNP, Plumpy'doz® and Nutributter®). They should be developed within the context of the community's current beliefs, attitudes and health knowledge, by using the formative research described in **Stage 4** of this guidance (also see below guidance on designing key messages[q] and / or refer to HTP module 19 at the following link:
http://www.unscn.org/en/gnc_htp/modul.php?modID=24 for further information).

q Adapted from 1) Hyde J, Agble R, Nestel P. The role of communication in comprehensive anaemia control: a framework for planning and implementing a strategic communication plan. June 2003 INACG/ILSI and 2) Micronutrient Supplementation Throughout the Life Cycle: Report of a workshop held by the Ministry of Health, Brazil and UNICEF. Rio de Janeiro 1999, edited by Rainer Gross.

The key messages and materials should have the following attributes:

- ✓ Be culturally sensitive and grounded in local knowledge and practices about nutrition
- ✓ Show clear benefits to using the FSP
- ✓ Aim to empower caregivers with information on how to protect their children against malnutrition, anaemia and other micronutrient deficiencies
- ✓ Help caregivers to understand what to expect and what not to expect from the use of the FSP
- ✓ Provide consistent messages on:
  - How and when to take the FSP (will depend on product and context)
  - Whom the FSP is intended for
  - Why the FSP should be used
  - How the potential side effects should be managed.
- ✓ Around 3-5 key messages should be provided.

It is crucial to consider caregivers' concerns about side effects and educate them on how to manage them if they occur e.g. dark stools when using MNP (due to the ingestion of iron) or different stool consistency when using LNS. These side effects may be more common at the start of taking the product when the body is not used to it. The following advice should be provided:

- ✓ Caregivers should be told that these side effects are not serious and should most likely subside in a few days to a few weeks of product use. This will ensure that they do not discontinue the use of the product should minor side effects occur.
- ✓ If side effects persist or are serious, they should be told to consult the health staff.

5.4.2. Pre-test of BCC activities / messages

Once appropriate BCC materials have been developed they should be pre-tested with a group of community members representing different groups of people. This allows feedback to be obtained on whether key messages have been understood correctly and have the desired effect, so that approaches can be refined if necessary. It also checks that different activities are consistent with one-another. Participatory methods can be used such as FGDs and community meetings.

5.4.3. Communication Channels

BCC activities and messages should be communicated via a range of locally understood communication channels, to convey the key messages on the selected FSP intervention. Communication channels should be selected prior to producing and printing the materials, as different materials will be required for different channels. Selected communication channels will vary depending on the available resources and infrastructure as well as the objective of the BCC activity:

- Educational material can be developed in the form of posters, pictures and flyers or can be communicated through the broadcast media such as radio, television and newspapers, via face-to-face contact, group and community activities or **preferably by a combination of channels**.
- Memory aids for home use should also be developed, either as a card or on the packaging, and provided to caregivers to help remind them to give the FSP to their child. It is important that the different methods of communication used provide consistent and clear messages.

DESIGNING MESSAGES

Primary Audience - caregivers of children receiving the FSP

1. Choose a simple attractive name for the FSP. Usually this name would have been explored during the acceptability test.

2. Identify and use simple messages that emphasize benefit and action:

   - Messages must be developed within the context of the audience's current beliefs, attitudes, and emotions. For example, **"every Ghanaian mother wants to have a strong and healthy child."**
   - The message should convey some information or an explanation about why the listener should care. For example, **"Your child will be healthy and strong if he or she has enough blood."**
   - The message being sent is very likely competing with many other messages that the audience is receiving. Consequently, the message must be designed to break through that clutter or 'noise'.
   - Remaining focused on the behaviour change sought is essential when crafting the message. For example, **"Giving your child a supplement or complementary food supplement will make him or her strong and healthy."**
   - The tone of the message must be appropriately matched to the behavioural objective. For example, a humorous tone would not be fitting for a campaign about the importance of using insecticide-treated bed nets to prevent death from malaria.

3. Identify and use the channels of communication that are most effective and adequate for the groups to be targeted.

4. Use consistent messages across the target audiences.

5. Messages should be delivered frequently and not only once at the beginning of the programme:

    - The messages must be sustained over time. Few communication campaigns have succeeded by delivering a single message one time. It is through repetition and hence reinforcement that people begin to internalize the message.

6. Various message strategies and stages of communication should be used.

Secondary Audience - those who influence the primary audience

1. Create social acceptance by those who are more likely to influence the primary audience. For example, ensure that fathers or grand-mothers and refugee leaders accept the FSP intervention and understand its benefits. Usually this would be informed by the results of the acceptability test.
2. Train those involved in distributing and educating on the FSP in communication skills and delivery of correct messages and actions (refer to section above on training the health workers and staff). As part of the monitoring process, reassess their knowledge and practices and re-train as necessary, reinforcing basic messages and delivery skills (**refer to Stage 6** for further guidance).

Tertiary Audience - those who help to make the programme a success

1. Provide relevant information on cost-effectiveness, safety assurance, proofs of efficacy and effectiveness, and guidelines for advocacy and programme management, to decision makers, donors, implementing partners, government institutions and civil groups etc.
2. Endorse and advocate for FSP interventions being implemented by international organizations, as this is likely to positively influence decision makers.
3. Provide consistent and clear information to the tertiary audience groups.

5.5. Distribution of product

A well-organized distribution system with a regular supply of products, and adequate population coverage are all key to a successful distribution model. The following key components should be considered.

5.5.1. Distribution channel

It is best to integrate the FSP distribution into already existing health programmes or distribution systems that have the capacity to manage the distribution and educational campaign associated with it, and have a high attendance rate of the target population. This is the most efficient way of distributing the FSP in a refugee setting and will help keep costs low, as facilities and staff can be shared between different programmes or distribution systems. When choosing the most efficient distribution system, it is essential to consider that waiting time for caregivers collecting the FSP needs to be kept as short as possible. Depending on the refugee context, viable distribution systems can include:

- Growth monitoring and promotion (GMP) programmes
- Ante-natal care (ANC) programmes
- Complementary feeding programmes
- General food distribution
- In certain settings, a distribution system may need to be custom designed (least preferred)

5.5.2. Frequency of distribution

As the FSPs under consideration are new to most refugee settings, it is recommended to provide the products on a monthly basis. There are several advantages to caregivers having a limited supply of the product in their household: sharing with individuals other than the target recipient and selling of the product are likely to be minimised if a product is not available in excess quantity; risk of overdosing by eating a lot of product in one go is reduced; monitoring of adherence is more easily conducted; and a high frequency of contact between implementing staff and recipients is maintained, allowing caregivers to be reminded of the key messages on a regular basis and at each distribution (this is especially important during the first six months of a programme).

STAGE 5 CHECKLIST – Design the Programme and Distribute the Product

- ☐ Continue to coordinate with and involve relevant actors and stakeholders
- ☐ Select an appropriate FSP storage facility
- ☐ Plan a stock management and disposal system
- ☐ Order FSP with sufficient lead-time
- ☐ Train health workers and staff
- ☐ Develop and pre-test a communication plan including education on potential side effects
- ☐ Identify an appropriate distribution channel and distribute the FSP
- ☐ **Contact UNHCR HQ / Regional Offices** if senior level advice or guidance is required for any part of Stage 5

STAGE 6 – MONITOR AND EVALUATE

This stage is intended to aid in developing and implementing an appropriate M&E system for the FSP programme

The primary purpose of M&E systems is to facilitate project improvement and allow those involved in programming to track what is being done; to check this against what should be done according to the project plan or protocol; to improve or remedy anything that is not working as it should; and to see if the programme is making a difference. M&E is therefore an important tool to aid programme implementation and decision making at various levels and allows UNHCR and partners to learn from the process of programme implementation in order to improve operations now and in the future.

M&E should be tailored to fit the specific needs of the FSP programme and the available budget. The M&E strategy described below relates only to interventions involving the distribution of MNP and LNS. M&E of other elements of anaemia control or nutrition programmes (e.g. malaria control, distribution of iron-folic acid tablets to pregnant women, helminth control) are not covered in this guidance (see **Appendix 1** for FAQs on monitoring and evaluation systems in general and in the context of UNHCR anaemia programmes).

6.1. Overview of Setting up M&E Systems

M&E systems are often based on the Logical Framework (LogFrame). The recommended LogFrame included in this guidance (see below) gives an overview of the M&E plan for the FSP element of UNHCR micronutrient / malnutrition reduction interventions.

In the case of UNHCR programmes using FSP, the ultimate **goal** will be to reduce, control and prevent micronutrient deficiencies and malnutrition in vulnerable refugee population groups. In order to achieve this goal, **inputs** such as budget and staffing are used in **activities** to produce **outputs** such as supply of FSP. If these outputs are well designed and reach the populations for whom they were intended, the programme is likely to achieve its **objectives** and have positive **outcomes**, for example increased

micronutrient consumption, which can then be measured. These outcomes help to achieve the goal (along with other elements of the overall programme, such as disease control), and should contribute to positive **impact**, measured as lower prevalence of micronutrient deficiencies / malnutrition in the target populations. For further guidance on the different components of M&E and relevant terminology, refer to **Appendix 1**.

6.1.1. Adapting the M&E system

While this guidance provides minimum reporting requirements for M&E purposes, it is likely that individual programmes will differ, and the M&E system will need to be adapted accordingly. For example, where the LogFrame below says 'FSP', the actual product(s) in use in the camp(s) should be named. It is also likely that the 'means of verification' and 'remedial actions' will need to be adapted to the context (refer to **Appendix 2** for further details on the LogFrame format). Key considerations are as follows:

- ✓ Adapting the LogFrame provided below to the specific context and intervention should be the first stage of setting up the M&E plan.
- ✓ Indicators and their respective targets should not be altered, as these are standard for monitoring performance throughout UNHCR programmes using FSP.

6.1.2. Costs and budget

The additional budget required for M&E will vary according to existing data collection, reporting structures and the evaluation type selected, but should always be factored in during programme design and a separate budget line allocated. A general rule is to add 10% to the programme budget for M&E activities, including extra staff / staff time, materials, and evaluation consultants where appropriate.

UNHCR LOGICAL FRAMEWORK, FSP PROGRAMME MONITORING AND EVALUATION

	Narrative Summary	Indicator
1. Goal	1.1 To control and prevent micronutrient deficiencies and malnutrition among vulnerable refugee population group(s)[b]	1.1.1 Anaemia prevalence reduced by at least 20% of the baseline figure
2. Objective	2.1 Increased intake of micronutrients and nutritious foods in vulnerable refugee population group(s)	2.1.1 Adequate population adherence >70%
3. Output	3.1 Supply FSP to target group(s)	3.1.1 Coverage >70% (in each target group)
4. Activities	4.1 Procure and appropriately transport and store FSP	4.1.1 Sufficient stock at 100% of distribution site(s)
		4.1.2 Product wastage <5%
	4.2 Train staff on FSP and programme systems (including nutrition/anaemia; FSP; distribution system; M&E system)	4.2.1 >90% of necessary staff trained and available
		4.2.2 >90% of trained staff pass post-training test and interim test[e]
	4.3 Implement BCC activities for target group(s)	4.3.1 >90% of required FSP BCC sessions held [f]
		4.3.2 Availability and adequacy of posters/pictures/flyers/radio/TV messages checked, as appropriate.
	4.4 Distribute FSP to target individuals	4.4.1 >90% of distributions undertaken
	4.5 Follow up recipients to ensure proper understanding and usage	4.5.1 >75% of recipients able to recall ≥50% of key FSP programme messages
		4.5.2 <15% of recipients reporting offering LNS before breastmilk to children 6-12 m
		4.5.3 <25% of recipients reporting sharing of FSP
		4.5.4 No selling of FSP on market
		4.5.5 FGD/KIs and/or mini-KAP assessment (via HH visits or at distribution) completed during first two months of implementation, and AS NEEDED [g]
5. M&E	5.1 Implement nutrition surveys	5.1.1 Annual nutrition survey completed according to UNHCR Standardised Nutrition Survey Guidelines [h]
	5.2 Monitor programme and alter as necessary to maintain proper function	5.2.1 Monitoring report produced regularly [i]
		5.2.2 >90% of remedial action points in the previous monitoring report followed up
	5.3 Extra evaluation activities as appropriate [m]	5.3.1 Extra evaluation(s) completed [j]

	Core / Desired	Means of Verification	Remedial actions	Tool[a]
	Core	▪ Haemoglobin measurements in annual nutrition surveys	–	–
	Core	▪ Pot/sachet counts via HH visits (adherence, usage and knowledge monitoring form)[c]	▪ Assess barriers to adherence using FGD/KIs and/or mini-KAP, and target with BCC as appropriate	2, 4
	Core	▪ Distribution lists ▪ ProGres database ▪ Coverage survey[d]	▪ Assess barriers to uptake using FGD/KIs and/or mini-KAP, and target defaulters[d] with BCC as appropriate	4
	Core	▪ Order records ▪ Delivery slips	▪ Address issues with appropriate contractor / staff member	4
	Core	▪ Regular logistic checks	▪ Review transportation, storage and handling procedures	4
	Core	▪ Training attendance ▪ HR	▪ Implement more trainings ▪ Recruit more staff	4
	Desired	▪ Test	▪ Review and improve training in problem areas ▪ Provide refresher training	1, 4
	Core	▪ Education session attendance/implementation lists	▪ Increase availability of staff for BCC	4
	Core	▪ BCC strategy	▪ Modify/improve BCC strategy as appropriate	2, 4
	Core	▪ Distribution lists and dates	▪ Assess & address issues ▪ Distribute FSP to missed recipients by other means	4
	Desired	▪ Usage & knowledge monitoring form via HH visits or at distribution	▪ Assess problem areas using FGD/KIs and/or mini-KAP, and target with BCC as appropriate ▪ Ensure key messages about usage are given at home visits and distributions	2, 4
	Desired	▪ Usage & knowledge monitoring form via HH visits or at distribution		2, 4
	Desired	▪ Usage & knowledge monitoring form via HH visits or at distribution		2, 4
	Desired	▪ Market visits		4
	Desired	▪ Assessment and/or KAP report		4
	Core	▪ Survey reports	–	
	Core	▪ Monitoring report	▪ Encourage staff to produce and use reports	4
	Core	▪ Monitoring report		3, 4
	Desired	▪ Evaluation reports	–	

a Tools (see **M&E tools and overview** section for an overview of these tools):
Tool 1: Nutrition worker post-training test (see **Appendix 3**)
Tool 2: Adherence, usage and knowledge monitoring form (see **Appendix 4**)
Tool 3: Mini-KAP questionnaire (see **Appendix 5**)
Tool 4: Monitoring data reporting form (see **Appendix 6**)

b Target groups as defined in UNHCR Strategic Plan for Anaemia Prevention, Control and Reduction 2008-2010:
- Children under 5
- Women – especially pregnant and lactating women (PLW) (not covered in the current version of this guidance)
- Adolescent girls (not covered in the current version of this guidance)

c Regular assessments of FSP used/remaining can be used to calculate adherence, using pot/sachet counts in the home. See **Appendix 4** for guidance.

d A coverage survey can be done in contexts where population numbers are difficult to obtain. A defaulter is defined as a registered individual missing 2 distributions, with the exception of those having left the camp or legitimately exited the programme for another reason.

e Staff tests should be administered immediately after training and again during the programme, to ensure adequate staff knowledge (e.g. every 6 months).

f Includes behaviour change communication (BCC) sessions with target groups on nutrition, proper complementary feeding, breastfeeding, anaemia, micronutrient deficiencies and FSP usage prior to the intervention starting; regular community BCC meetings in all sections/blocks of the camp(s); and individual/group BCC for new arrivals to the camp that are eligible for the FSP programme.

g Focus group discussions (FGD) and key informant interviews (KI) can be conducted to gather the information using the tools provided in Stage 4 or using the mini-KAP questionnaire as a guide If feasible, the mini-KAP survey provided in **Appendix 5** should be undertaken during the first two months of the programme, and again as required (for example if coverage or adherence fall below target) in order to assess acceptance of the programme after implementation, and identify any problem areas that the programme needs to address. This can be undertaken as a house-to-house survey, or as exit interviews at distribution sites.

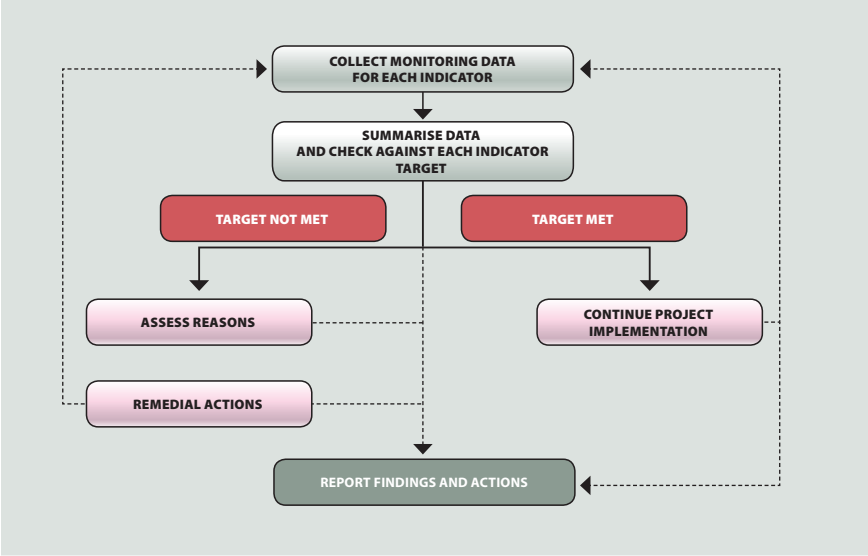
h Annual nutrition surveys, including the Anaemia Module from the UNHCR Standardised Nutrition Survey Guidelines, to be undertaken at the same time each year to ensure comparability and minimise seasonal fluctuations.

i Desired frequency: suggestions are provided in **Appendix 6**.

j See Evaluation section below for advice on further evaluations to undertake according to context..

6.2. Monitoring

The monitoring system summarised in the LogFrame is detailed in the diagram and sections below.



Collecting data for monitoring indicators

All programmes should regularly collect, summarise and report outcome and process monitoring data (to calculate the indicators in the LogFrame), and use this to adjust programmes as necessary during implementation. Indicators in the LogFrame are divided into 'core' and 'desired' indicators. Data for each *'core'* indicator should be collected and used from the start of the programme. Data for the '*desired*' indicators should also be collected where possible; if this is not possible from the start of a programme, these indicators should be phased in as a programme becomes more established. The suggested frequency for the collection of data and the production of monitoring reports is shown in **Appendix 6**.

The outcome monitoring and process monitoring indicators used to monitor FSP quality, and its availability to the programme and recipients include:

- Staff training and information
- BCC activities for FSP recipients and the community at large
- Caregiver's understanding of the intervention and their adherence to messages on the recommended dosage, given during programme implementation
- Implementation of FGD / KI interviews and / or the Knowledge, Attitude and Practice (KAP) questionnaire to assess acceptance of the intervention.

6.2.1. Indicator Descriptions

Descriptions are provided below for each indicator specified in the LogFrame.

The formulas required for calculating each of the indicators are given in Appendix 6 in addition to suggested frequencies of use.

Any problems identified through monitoring of the following indicators should be further investigated using a KAP questionnaire (see **Appendix 5**). The suggested sample size for this is 105, however if the problem(s) are isolated (e.g. to a specific target group) then a minimum sample size of 50 can be used. Alternatively, problems can be investigated using FGDs or KI interviews.

OUTCOME MONITORING INDICATORS

Indicator 2.1.1 - Adequate population adherence >70% (proportion of target population eating ≥50% of the FSP)

This ***adherence indicator*** assesses whether the FSP is being consumed at the correct rate, and therefore whether instructions on consumption are likely to have been followed. **Acceptable individual adherence has been defined as adherence of ≥50% (and < 110%), and the target for the proportion of the target population with acceptable**

adherence (i.e. population adherence [r]) defined as >70%. If this target is reached, it means that at least half of the FSP that was supposed to be consumed, appears to have been consumed by at least 70% of the target population. The 'adherence, usage and knowledge monitoring form' (provided in **Appendix 4**) is used to collect data for this calculation through the physical counting of *full* FSP pots / sachets during household visits by trained field staff or volunteers. The correction of any misconceptions regarding product usage is also done during the household visit. Adherence should be assessed as follows:

- ✓ Randomly select a sample of recipients (suggested total sample size is 210[s]) from a full list of recipients in the refugee operation. If no list is available and random selection is not possible, the recipients should be selected purposefully in each camp section / block / division, making sure that children whose ages fall within the range of the target group from different refugee groups are represented.
- ✓ Complete the 'adherence, usage and knowledge monitoring form' for each participant.
- ✓ Calculate individual adherence according to the number of pots / sachets actually consumed over the number that should have been consumed (target consumption) since the last distribution. Note that the calculation of individual adherence during programme implementation differs from the calculation used in the acceptability test as it is calculated from the number of full sachets. The main reason for this difference is that it cannot be expected for the caregivers to keep empty sachets in their HH for the duration of a long-term programme.
- ✓ **Note:** The individual adherence calculation can show both under-consumption (adherence <100%) and over-consumption (adherence >110%) of FSP in an individual recipient. Over-consumption could indicate sharing, selling, or over-eating by an individual recipient, and these should be addressed with the recipient and investigated.
- ✓ If the proportion of recipients with acceptable adherence falls below 70%, participatory methods should be used to gain information from the community

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r Note that when calculating population adherence, figures from *all* recipients should be included even, for example, if the potential recipient missed the last product distribution (i.e. defaulting does not apply).

s This sample size gives 10% precision using the formula $\mathbf{n = DEFF\ z^2(pq)/d^2}$
n= sample size z= statistical certainty chosen (normally 95% = 1.96) p= estimated level/coverage to be investigated (default 50% gives largest possible sample size= 0.5) q= 1-p d= precision (0.1) DEFF=design effect (2)

and assess possible reasons for this, in order that any issues can be addressed (see indicator 4.5.5). This may include use of FGDs and KI interviews and / or by conducting a mini-KAP survey during HH visits or at product distribution, using the questionnaire in **Appendix 5** (suggested minimal KAP sample size is 105).

- ✓ In case reported adherence is unsatisfactory, a 'positive deviant' approach could be used by collecting in-depth information from a participant who demonstrated a high adherence, about their perception of the FSP and their behaviour etc. FGDs and KI interviews could also be held with caregivers of both children with acceptable adherence, and children with poor adherence, to try and establish why there is a difference.

Normally, adherence will be better in communities that have been consulted and well-informed about all aspects of the FSP before and during the intervention. However there is a risk of beneficiaries reporting 'desirable answers' rather than their true FSP consumption. This risk needs to be avoided / minimised to the extent possible. Possible methods of doing so are to make sure that the field workers distributing the products are not the ones collecting adherence data. If household visits are not being conducted to assess adherence (**Appendix 6** shows the suggested frequency), reasons for this should be assessed (e.g. not enough staff members / volunteers for the amount of recipients; environmental issues such as flooding), and issues addressed.

PROCESS MONITORING INDICATORS

Indicator 3.1.1 - Coverage >70% (in each target group)

This ***coverage indicator*** assesses whether intended recipients are attending distributions and collecting the FSP. In many UNHCR-administered camps, lists detailing registered individuals in population groups eligible for FSP are available from the ProGres database. **These lists of eligible recipients can be compared to actual recipients attending each distribution, and programme coverage estimated.** Where ProGres is not available, or is not updated for any reason, UNHCR or IPs should conduct a coverage survey. The following key points should also be considered:

- ✓ Where coverage falls below 70%, barriers to programme uptake should be assessed by using participatory methods deemed appropriate including FGDs

and KIs and / or by conducting a mini-KAP survey using the questionnaire in **Appendix 5** (suggested minimal KAP sample size is 105) and BCC campaigns conducted to address the barriers identified.

- ✓ Defaulters may also be targeted individually, to address properly any concerns they may have.

Indicator 4.1.1 - Sufficient stock at 100% of distribution site(s)

This is a ***logistics indicator***, and information on FSP quantities available in stock at the distribution site(s) should be readily available from storekeepers or logistics managers in the form of delivery notes, waybills, or similar. **This indicator should be checked at each distribution site; the quantity of FSP available in stock before the distribution should be equal to or greater than the quantity of FSP distributed.** The following key point should also be considered:

- ✓ If sufficient stock at distribution site(s) falls below 100%, the reasons for this should be assessed, and issues addressed at the appropriate stage of the supply chain, for example, by checking with the manufacturer; transport / haulage contractor; local partners; logistics departments or from the orders placed by the distribution sites.

Indicator 4.1.2 - Product wastage <5%

Another ***logistics indicator***, product wastage can provide information on whether the FSP is being appropriately transported, stored and handled. The following key points should be considered:

- ✓ **FSP should be checked for quality (undamaged, unopened, clean packaging; unspoiled product; no heat, water, animal, insect or other damage) at the time of delivery, and then regularly throughout the programme.** This should normally be part of standard store checks, and data should be available through normal reporting.
- ✓ In some cases it may include initiating new checks, and storekeepers should be trained to check for problems and record the amount of product checked and

the amount found to be unfit for distribution, and therefore wasted. If >5% of FSP is found to be unfit for distribution, the reasons for this should be assessed, and issues addressed with the appropriate people (e.g. manufacturer; transport contractor; UNHCR / IP logistics departments).

Indicator 4.2.1 - >90% of necessary staff trained and available

This ***training indicator*** relates to the implementation section of the guidance **(refer to Stage 5)**, including staff recruitment and training. The following key points should be considered:

- ✓ Staff and community volunteers should be trained on relevant nutrition, proper complementary feeding, breastfeeding, anaemia, micronutrient deficiencies and the FSP in use in the refugee operation(s), according to their level of responsibility.
- ✓ **A calculation of the number of staff / volunteers required in each role should be made, and this compared to actual levels of fully-trained individuals available to the programme in each reporting period**.
- ✓ If <90% of required, fully-trained staff / volunteers are available to run the programme properly, reasons for this should be assessed (e.g. suitable staff / volunteers unavailable in camp area; staff available but untrained so far), and issues addressed in order to make the required fully-trained staff available.

Indicator 4.2.2 - >90% of trained staff pass post-training test and interim test

Another ***training indicator***, this assesses whether knowledge gained in training sessions is understood and retained. A basic test of knowledge related to the training curriculum at various levels of responsibility is provided in **Appendix 3.** The following key points should be considered:

- ✓ **This test should be administered immediately after the training session and again after the intervention has been running for some time (refer to Appendix 6 for suggested frequency)**. The test can be administered orally for community volunteers who may be illiterate.
- ✓ If a staff member / volunteer does not pass the test **(pass mark 75%),** any weak

areas should be addressed until understanding is achieved. If many individuals are not passing the test, the training curriculum should be reviewed and improved based on weak areas identified.

Indicator 4.3.1 - >90% of required FSP BCC sessions held

This ***BCC indicator*** covers BCC sessions with target groups on appropriate nutrition, proper complementary feeding, breastfeeding, anaemia, micronutrient deficiencies and FSP usage prior to the intervention starting; regular community BCC meetings in all sections of the camp(s); and individual / group BCC for new arrivals at the camp eligible for the FSP programme. The following key points should be considered:

- ✓ **A calculation of the number of sessions required in each reporting period should be compared to the number actually run.**
- ✓ If less than 90% of required sessions are being held, reasons for this should be assessed (e.g. lack of trained staff to run sessions; lack of venue; lack of community participation), and issues addressed. Appropriate topics for BCC are discussed in **Stage 5** of this guidance.

Indicator 4.3.2 - Availability and adequacy of posters / pictures / flyers / radio / TV messages checked, as appropriate

This ***BCC indicator*** will provide information on whether the BCC strategy is being implemented as planned and whether there are any problems that need to be addressed. This indicator along with indicators *4.5.1 - 4.5.5* shown below will indicate **the appropriateness of the different BCC tools and strategy as a whole, to ensure proper understanding of the key messages among the refugee community**.

Indicator 4.4.1 - >90% of distributions undertaken

This is a ***distribution indicator*** assessing whether a programme is functioning. If distributions are not being undertaken then the FSP is not reaching its intended recipients, and the programme is not functioning. The following key points should be considered:

- ✓ **Information on dates and locations of FSP distributions can be compared with planning documents to ensure that all planned distributions are going ahead.**
- ✓ If the proportion of intended distributions falls below 90%, the reasons for this should be assessed and issues addressed (e.g. lack of FSP availability; lack of staff available to cover distributions; unforeseen events in the camp). FSP from missed distributions should be distributed to intended recipients by other means whenever possible.

Indicator 4.5.1 - >75% of recipients able to recall ≥50% of key programme messages

This ***usage and knowledge indicator*** assesses recipients' ability to recall key messages and is therefore an indicator of recipients' understanding of the programme. Each FSP programme should have certain 'key messages' regarding the product's nutrition and health benefits and directions for correct usage **(refer to Stage 5)**. These key messages should be learned and understood by health staff and volunteers, and taught to caregivers and community members at BCC sessions and via posters, pictures, flyers, radio or TV as appropriate. The following key points should also be considered:

- ✓ This indicator should be monitored regularly in a sample of recipients using the 'usage and knowledge monitoring form' provided in **Appendix 4** either in recipients' homes or at distributions (suggested total sample size is 210).
- ✓ To facilitate the process of interview, recipients can be shown a poster or pictures about the FSP and can be questioned about the key messages that come to their mind, for example.
- ✓ **The number of recipients able to recall greater than or equal to 50% of these messages should be compared to the number of recipients**

interviewed in each reporting period; if less than 75% of recipients can recall 50% or more of the key messages', BCC should be strengthened.

Indicator 4.5.2 - <15% of recipients reporting offering LNS before breastmilk to children aged 6-12 months

This ***usage and knowledge indicator*** assesses whether LNS may be displacing breastmilk in the diets of breast-fed children aged 6-12 months (children <6 months should not be included in the FSP programme and should not receive FSPs). Please note the following:

- ✓ Data for this indicator are collected using the 'adherence, usage and knowledge monitoring form' provided in **Appendix 4** either in recipients' homes or at distributions (suggested total sample size is 210).
- ✓ **The number of recipients reporting the provision of LNS before breastmilk, to a child 6-12 months should be compared to the number of recipients with children aged 6-12 months interviewed;** if any individual reports the provision of LNS before breastmilk to children 6-12 months, action should be taken to explain the risks of this practice to the individual and if necessary to the community. If breastmilk displacement seems to be a problem, it may be necessary to also observe / investigate whether LNS is being provided to younger children i.e. <6 months, in order that the appropriate action can be taken if necessary, such as described above.

Indicator 4.5.3 - <25% of recipients reporting sharing of FSP

This ***usage and knowledge indicator*** assesses whether the FSP is being shared (either one pot / sachet shared among more than one person, or a person receiving full pots / sachets when they are not the intended recipient). Please note the following:

- ✓ Data for this indicator are collected using the 'adherence, usage and knowledge monitoring form' provided in **Appendix 4** either in recipients' homes or at distributions (suggested total sample size is 210).
- ✓ **The number of recipients reporting any sharing should be compared to**

the number of recipients interviewed. If more than 25% of recipients are found to be sharing, reasons for sharing, age categories, and amounts shared should be investigated (using FGD / KI interviews etc.), and BCC messages emphasising reasons for not sharing should be strengthened.

Indicator 4.5.4 - No selling of FSP on market

This ***usage and knowledge indicator*** assesses selling of the FSP by the recipient, potentially leading to lack of adherence and reduced FSP intake in intended recipients. Please note the following:

- ✓ Data for this indicator are collected using the 'reporting form for monitoring data' provided in **Appendix 6**.
- ✓ Market visits should be regularly conducted to assess whether the products are being sold on the market and at what value.
- ✓ If it seems that a significant amount of FSP is being sold on the market, KI interviews with the camp community should be conducted to investigate reasons why the product is being sold. This may reflect an acceptability issue, which will require a change in the strategy.

Indicator 4.5.5 - FGD / KIs and / or mini-KAP survey completed as appropriate

This ***usage and knowledge indicator*** shows whether an assessment of the problems encountered is being conducted. FGDs, KI interviews and / or a mini-KAP assessment should be conducted to aid in the evaluation of problems encountered with programme implementation, specifically programme coverage and adherence. The assessment will provide information on problems in the programme including barriers to implementation, so that these can be addressed. FGD / KIs can be conducted using the tools provided in **Stage 4** or using the mini-KAP questionnaire as a guide. Alternatively, if conducting a KAP assessment (using the questionnaire provided in **Appendix 5** as a tool), it should preferably be administered to a sample of FSP recipients early on in the programme (**suggested minimum sample size is 105**), and then again, if core indicator targets such as coverage and adherence are missed, in order to assess and

address issues. The questionnaire should be utilised as follows:

- ✓ Randomly select a sample of recipients from a full list of recipients in the refugee operation. If no list is available and random selection is not possible, the recipients should be selected purposefully in each camp section, making sure that children whose ages fall within the range of the target group from different refugee groups are represented.
- ✓ If the KAP is being used to assess a particular problem (with coverage or adherence) that is only present in a certain camp or a certain target group, the sample should only be drawn from this camp or group to allow for assessment of the problem (**suggested minimum sample size is 50**).
- ✓ Administer the questionnaire in the homes of the recipients or at distributions (e.g. exit interview).

Indicator 5.2.1 - Monitoring report produced regularly

Monitoring data should be collected throughout the programme and needs to be summarised and incorporated into monitoring reports. Tools to aid in data collection and reporting are provided in the appendices and summarised in **M&E tools and overview** section below. The suggested frequency for the production of monitoring reports for stable programmes is shown in **Appendix 6.** Please note the following:

- ✓ The frequency of reporting should be decided upon before implementation, and monitored throughout the programme. Reporting of monitoring data 'upwards' will follow usual reporting structures.
- ✓ IPs should report summarised programme data to the in-country UNHCR health / nutrition division.
- ✓ Reports including summarised data on each indicator and a brief analysis should then be forwarded to the Branch Office health / nutrition co-ordinator and the regional / main head office in the standard format (see reporting form in **Appendix 6**).
- ✓ Feedback of monitoring findings must also flow 'downwards', back to the field: one-page summaries of monitoring information (page one of the monitoring report in **Appendix 6**), including action points to address missed targets, must be regularly given to staff in the field (both UNHCR and IP, as appropriate) to increase

ownership of the project and ensure that improvements to the programme are made where necessary.

Indicator 5.2.2 - >90% of action points in the previous monitoring report followed up

Action points are generated on the monitoring report when any targets are missed. **Action points must state what is to be done to ensure that the target is achieved in the next reporting period; who is to carry out the action; and by when the action should be completed.** Action points should be followed up at the next reporting period, and the number of actions completed compared to the number of actions generated in the report.

6.3. Evaluation

Evaluations should be undertaken either at the end of a programme or annually and should be completed internally by country offices.

6.3.1. Impact evaluation

Anaemia

The minimum required impact evaluation of the FSP interventions will be the assessment of anaemia prevalence in the target group through annual cross-sectional surveys, taken in conjunction with monitoring data such as coverage, adherence, usage, and other indicators (see websites detailed at the beginning of this guidance (page 11) to access UNHCR Standardised Nutrition Survey Guidelines). With this type of evaluation, it will not be possible to conclude that the observed impact (if any) in the target population is *directly* related to the FSP intervention, as other programmes in the camps will also influence anaemia status (see below information on more rigorous designs to directly measure change related to the FSP). This type of evaluation will provide information on whether the FSP along with the other public health activities in the camps have a positive impact on anaemia. Although it is not the most rigorous design for evaluating the impact of an FSP intervention, it will be the most feasible option in most settings and will provide invaluable information on the

overall impact of public health activities as a whole in the camp. The following targets are recommended:

✓ When measuring impact on anaemia, a reduction in the prevalence of anaemia by at least 20% of the baseline would be expected. An example of this is provided below.

Example 3 – Calculating a 20% reduction in anaemia prevalence

Current prevalence	Target prevalence (≥20% reduction)[1]
90%	<72%
85%	<68%
80%	<64%
75%	<60%
70%	<56%
65%	<52%
60%	<48%
55%	<44%
50%	<40%
45%	<36%
40%	<32%
35%	<28%

1 An example of the calculation used to work out a 20% decrease in anaemia is as follows:
If baseline prevalence is 60%: 20/100 x 60 = 12%, 60-12=48%

✓ Anaemia prevalence should be below 40% (WHO cut off for anaemia of high public health significance). Note that although a 20% reduction in the baseline prevalence of anaemia might be achieved, this will not always mean that anaemia prevalence is reduced to below 40%. This does not mean that the project has failed, but further work may be required to achieve this target.

Malnutrition

GAM and stunting prevalence should be determined in all cross-sectional nutrition surveys conducted in refugee settings, along with anaemia prevalence. It is important to note that stunting data need to be interpreted with caution in contexts where age data is not reliable (i.e. where the coverage of age documentation is low).

For GAM and stunting, a reduction in the prevalence of these indicators in the target group would be hoped for when using an FSP aimed at these problems. For example, if scenario 1 (high GAM) applies **(refer to Stage 2)**, a decrease in the prevalence of GAM would be expected in the target group receiving the FSP. However there is currently limited evidence available as to the extent of the change that would be expected when using these relatively new products. Furthermore, target groups for FSPs aimed at decreasing GAM and / or stunting will be children aged 6-24 months or 6-36 months. This complicates the impact evaluation through a simple cross-sectional survey due to limited sample size, compared to children aged 6-59 months. It is hoped that in the future, as a greater evidence base is accumulated, more guidance will be provided. Nevertheless, the following targets are recommended for situations where high GAM / high stunting has been identified as the major nutritional problem (where anaemia is the focus, it is unlikely that the following targets will need to be considered):

- ✓ GAM prevalence should be reduced to below 10% (WHO cut off for GAM of serious public health significance). As a longer-term target, the UNHCR target is to reduce GAM to below 5%.
- ✓ Stunting prevalence should be below 30% (WHO cut off for stunting of serious public health significance). As a longer-term target, the UNHCR target is to reduce stunting to below 20% (for children 6-23 months of age).

It is important to bear in mind that there are many factors that can affect the GAM and stunting levels and the FSP project is only one contributing factor. If the reductions presented above are not achieved, this does not mean that the project has failed, but further work may be required to achieve these targets in the longer term.

Additional Evaluation Designs

Further to the above, in those contexts where it is felt that this can be ethically and logistically undertaken (i.e. where the situation is stable and resources exist to carry out operational research), rigorous evaluation designs (e.g. cohort study) are preferred to evaluate programmes and demonstrate impact. Briefly, this would require the following:

- ✓ Obtaining baseline values from a sub-sample cohort of the target beneficiaries and following them over time.
- ✓ Ideally an appropriate comparison group would be included, however this is unlikely to be feasible 'within' camp settings, although it may be possible to include nearby camps as control camps.
- ✓ This would also require further resources in addition to ethical approval and logistical requirements.

Interpretation

To interpret the evaluation results, a detailed context assessment along with a description of other public health / anaemia reduction / nutrition activities undertaken in the camp(s) in parallel to the FSP distribution will be necessary. This will help to understand what other factors may have affected anaemia, GAM and / or stunting prevalence over the duration of the programme, as detailed below.

6.3.2. Process and outcome evaluation

The programme monitoring reports should contain information on each core indicator, as well as desired indicators in some instances, at different time points throughout the programme. **Every monitoring report produced since the introduction of the programme should be collected, and the information on each indicator compiled into separate tables, one per indicator. These tables (and any graphs and charts that are created from this data) should show whether targets were regularly achieved or missed**. A summary of this information will form the basis of the evaluation, and will indicate whether any changes in GAM, anaemia or stunting prevalence can be attributed to the FSP intervention. Please note the following:

- ✓ The programme monitoring reports also contain details on the context surrounding the FSP intervention, and an explanation of why specific targets may have been missed (if any). This context analysis can help to explain any observed changes in GAM, anaemia or stunting prevalence for the evaluation.
- ✓ As well as understanding and discussing the overall context, an evaluation should also note the contribution of other anaemia / micronutrient deficiency / malnutrition prevention, control and reduction activities undertaken in the camp(s), in order to put into context any possible contribution of the FSP intervention to any change in prevalence of these nutritional problems. Routine cross-sectional surveys can also be used to measure outcome evaluations.

6.3.3. Reporting evaluations

Routine evaluation reports will be produced internally either at the end of the intervention, or for long-term interventions, at the end of each programme year, and should be submitted at the Branch Office, Regional Office and HQ level.

While routine evaluations will be completed internally by country offices, following standard M&E guidelines and using the same core indicators will facilitate external 'meta-evaluations' of interventions, combining data from different camps. Such evaluations may be commissioned periodically by head offices, and will require that monitoring and survey data should be made available to evaluators. They are not however mandatory in the evaluation of UNHCR nutrition interventions involving FSP, and will normally be undertaken / initiated by an external consultant. See **Appendix 1** for further reading on evaluation study design.

6.4. M&E Tools Overview

Various M&E tools are provided in the appendices. A brief description of each is given below.

Appendix 3: Tool 1 - Nutrition worker post-training test

This tool details an example test for field staff involved in FSP programmes. The test should be administered directly after training on the FSP and the intervention, and throughout the programme, to ensure that staff members are adequately trained and are retaining the necessary knowledge. The pass mark for the test is 75%; those failing the test should receive refresher training. If many staff members are failing, the training itself should be assessed and problem areas improved.

Appendix 4: Tool 2 - Adherence, usage and knowledge monitoring form

This tool is a simple form for collecting data to be used in the calculation of adherence, and the assessment of product usage and understanding. Adherence, usage and knowledge information should be assessed regularly by field staff or trained volunteers during household visits (suggested total sample size is **210**). Usage and knowledge information can also be gathered during interviews at FSP distributions (e.g. exit interviews). If problems with beneficiary's adherence, usage and knowledge are identified, these should be further investigated using a KAP questionnaire (see below), FGDs or KI interviews.

Appendix 5: Tool 3 - KAP questionnaire

This tool is a questionnaire to facilitate the interview of FSP recipients or their caregivers. It aims to gather data on knowledge of and attitudes to nutrition, anaemia, malnutrition and the FSP being provided; actual usage of the FSP; adherence to the intended usage protocol, as well as reasons why FSP may or may not be accepted and used appropriately so that these can be addressed. The interview can be administered in the home or at FSP distributions (e.g. exit interview), on a sample of recipients (suggested minimum sample size is **105**). Where feasible, it should preferably be undertaken during the first month of intervention to pinpoint any problems with programme acceptance, and

then later on as appropriate (for example if coverage or adherence targets are being missed), to provide information on why programmes might be faltering. FGDs and KIs can also be conducted to gather information, particularly where it is not feasible to conduct a mini-KAP questionnaire. Where a particular problem is thought to be more isolated (e.g. within a certain target group), the suggested minimum sample size is 50.

Appendix 6: Tool 4 - Monitoring data reporting form

This tool is provided for use in creating regular monitoring reports. A form is provided on which to enter summarised data and notes for each indicator as well as for creating action points to follow up for programme improvement. Notes can also be made on the current local context.

STAGE 6 CHECKLIST – Monitor and Evaluate

- ☐ Complete logical framework and adapt to specific context and FSP
- ☐ Adapt M&E tools and questionnaires to specific context and FSP
- ☐ Conduct process and outcome *monitoring* requirements and reports in a timely manner throughout programme life-cycle
- ☐ Complete impact *evaluation* requirements and reports in a timely manner throughout programme life-cycle
- ☐ Conduct process and outcome *evaluation* requirements and reports in a timely manner throughout programme life-cycle
- ☐ Adjust and improve programme implementation where necessary as directed by M&E results
- ☐ **Contact UNHCR HQ / Regional Offices** if senior level advice or guidance is required for any part of Stage 6

APPENDIX 1: FAQS - AN OVERVIEW OF M&E

Commonly used terms in M&E:	
Activity	Actions or tasks that must be undertaken in order to achieve the programme outputs
Adherence	Correct following of instructions as given in the programme (for example, correct frequency and dosing of FSP)
Cost-effectiveness	A measure of whether the programme was economical in terms of services provided / health impact achieved, for the money spent
Coverage	The proportion of eligible beneficiaries who are actually receiving the intervention
Effectiveness	A measure of the extent to which a programme or intervention achieves its objectives in programme (rather than controlled) settings
Efficacy	A measure of the extent to which a programme or intervention achieves its objectives in scientifically controlled settings
Goal	Wider impact the programme is designed to achieve
Impact	Wider change or benefit the programme has achieved
Indicator	Measurable variable that can indicate whether an activity, output, objective or goal has been achieved (also known as a performance indicator)
Input	Any resources (physical, monetary or human) required to run the programme
LogFrame	Comprehensive tool for organising project details, including project goals and objectives, inputs and outputs and their conceptual linkages to desired outcomes and impacts
Objective	Immediate outcome in the programme area or target group hoped to be achieved by the programme
Outcome	Immediate change or benefit in the programme area or target group that the programme has achieved
Output	Results or effects expected from actions, tasks or activities, that are necessary to achieve the programme objectives
Proxy indicator	An alternative indicator used when measurement of the actual characteristic is not practical or feasible (for example, assessing clinical signs of vitamin A deficiency when it is not possible to test retinol levels in the blood)
Usage	Actual use of a product, including uses not given in instructions (for example, sharing, selling, or over-consumption of FSP)

What is the difference between surveillance, monitoring, and evaluation?

SURVEILLANCE: Surveillance is the regular tracking of nutritional status (nutritional surveillance), using the same methods over time, to track trends and act as an early warning system. **Surveillance is not covered further in this guidance.** Please refer to camp Health Information Systems (HIS) guidelines to read about surveillance at camp level.

MONITORING: Monitoring is the routine collection and use of priority information about a programme and its intended outcomes in order to keep the programme on track. There are two broad levels of monitoring:

Process monitoring: The routine collection of information about programme inputs, activities and outputs in order to check that the programme is functioning correctly, and to make adjustments if it is not.

Outcome monitoring: The tracking of programme outcomes after implementation to make sure the programme is on track to achieving the desired impact.

EVALUATION: UNHCR defines evaluation as "the analysis and assessment, as systematic and objective as possible, of the organization's policies, programmes, practices, partnerships and procedures, focusing on their planning, design, implementation and impact".[t] Well-designed evaluations should be able to link outputs, outcomes and impacts directly to a specific intervention by ruling out other explanations for change, and so determine the significance of a particular programme to achieving objectives and goals. The main components of evaluation are as follows:

t UNHCR Evaluation and Policy Analysis Unit, 2002, ***UNHCR's Evaluation Policy,*** EPAU, Geneva

Process evaluation: The assessment of a programme's content, scope and coverage, together with the quality of implementation. While process monitoring provides checks and balances in real-time in order to make changes to keep the programme on track, the process evaluation looks at the programme as a whole, after the event, to decide whether it was appropriate and adequately run, including relevance to the context; programme coverage; coherence with other UNHCR and national policies; and connectedness to long-term goals.

Outcome evaluation: The evaluation of programme outcomes to produce causal evidence about the effectiveness of a specific programme. An outcome evaluation should look at issues relating to adherence and product usage and also, when feasible, at cost-effectiveness.

Impact evaluation: The evaluation of broader impacts, such as anaemia / GAM / stunting prevalence. The evaluation design should be able to show effectiveness, demonstrating that changes are not the result of non-programme factors. Impact evaluation should look at unintended as well as intended consequences, as well as cross-cutting themes such as protection; gender; HIV; the participation of stakeholders and the environment.

Where can I go for more information on M&E?

For further information about M&E in general, refer to publications listed below.

UNHCR plans, policy and statements

UNHCR, *Strategic plan for anaemia prevention, control and reduction 2008-2010*

UNHCR, *Strategic plan for nutrition and food security 2008-2012*

United Nations Evaluations Group (UNEG), 2005, *Norms for evaluation in the UN system,* available from: http://www.uneval.org/normsandstandards/index.jsp?doc_cat_source_id=4

United Nations Evaluations Group (UNEG), 2005, *Standards for evaluation in the UN system,* available from: http://www.uneval.org/normsandstandards/index.jsp?doc_cat_source_id=4

General humanitarian monitoring and evaluation documents

Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP), *Annual Review 2003, Humanitarian Action: Improving Monitoring to Enhance Accountability and Learning,* available from: http://www.alnap.org/pool/files/ar2003_ch2.pdf

Beck, T, 2008, *Evaluating humanitarian action using the OECD/DAC criteria: An ALNAP guide for humanitarian agencies,* available from: http://www.alnap.org/resources/guides/evaluation/ehadac.aspx

UNHCR, 1998, *Planning and organising useful evaluations*

Monitoring and evaluation of nutrition interventions

Humanitarian Development Network / World Bank, 1999, *Monitoring and evaluation: A guidebook for nutrition project managers in developing countries,* available from:
http://www.scribd.com/doc/3577697/Monitoring-and-Evaluation-A-Guidebook-for-Nutrition-Project-Managers-in-Developing-Countries

Study design for extra evaluations

TREND group, 2004, Improving the Reporting Quality of Nonrandomized Evaluations of Behavioral and Public Health Interventions: The TREND Statement, *Am J Public Health*; 94:361–366

Brown, C, and Lilford, R, 2006, The stepped wedge trial design: a systematic review, *BMC Medical Research Methodology*, 6:54

Pakistan / IDPs in school / IDP children found refuge in a school near Mardan. As of May 19, UNHCR teams had assessed that 457 schools in Mardan district were accomodating IDPs from the Swat, Lower Dir and Buner districts. Schools were requested to finish classes earlier than usual fo rthe summer in order to provide accomodation for the IDPs. 1.4 million people have been displaced from those areas following fighting between governmental troops and Talibans. UNHCR / H. Caux / Mardan, May 17, 2009

APPENDIX 2: THE LOGFRAME AND FORMAT

It is important to develop a LogFrame for organising project details, including project goals and objectives, inputs and outputs and their linkages to desired outcomes and impacts. Consider the following key points when developing the LogFrame:

- ✓ Each stage of the *narrative* (column 2) has one or two corresponding *indicators* (column 3), with an indication of whether these are *core or desired* (column 4) and a plan of how information for the indicators will be collected (*means of verification*, column 5) **(see Table 5 below).**
- ✓ These indicators are designed to be a guide for programme managers to monitor their programmes and ensure performance targets are being met, and ultimately to assess programme impact.
- ✓ *If targets are not being met this does not mean the programme is failing, only that there is an indication that improvements may be needed.*
- ✓ '*Remedial actions*' (column 6) describes actions to be taken if monitoring of the performance indicators falls below any one of the targets.
- ✓ '*Tools*' (column 7) indicates which of the tools supplied should be used to collect, assemble and report the monitoring data.

Table 5. LogFrame Format

	COLUMN 2	COLUMN 3	
	NARRATIVE	**INDICATOR**	
Goal	Wider problem the project will help to resolve	**Impact indicators:** quantitative and/or qualitative ways of measuring, when feasible	
Objective	Immediate impact to project area/ target group, i.e. change or benefit to be achieved by the project	**Outcome indicators:** quantitative and/or qualitative ways of measuring	
Outputs	Expected results	**Output indicators:** quantitative and/or qualitative ways of measuring **per output/expected results**	
Activities	Tasks that must be delivered to achieve outputs/target results	**Activity indicators:** quantitative and/or qualitative ways of measuring per activity	

	COLUMN 4	COLUMN 5	COLUMN 6	COLUMN 7
	CORE/ DESIRED	MEANS OF VERIFICATION	REMEDIAL ACTIONS	TOOLS

APPENDIX 3: TOOL 1 – NUTRITION WORKER POST-TRAINING TEST

Below is the format for a basic test of knowledge related to staff and volunteer training on nutrition and the food supplementation product (FSP). This test should be administered immediately after the training session and again after the intervention has been running for some time (the test can be administered orally for community volunteers who may be illiterate). If a staff member / volunteer does not pass the test (pass mark 75%), any weak areas should be addressed until understanding is achieved. If many individuals are not passing the test, weak areas in the training curriculum should be assessed and improved.

This is a generic test, to be adapted and translated for each individual refugee / country context. The following should be done before using the test with staff / volunteers:

- **Ensure that the correct FSP name is inserted into questions**. (For example, if the intervention in the refugee context is using Plumpy'doz®, this name (or the locally adopted name) should be added wherever the term 'FSP' appears. If an electronic version of this guidance is available, this can be done very quickly in Word, using the 'find and replace text' function - see Microsoft Word Help for assistance.)

- **Ensure that all questions are relevant to the context**. Although this test has been designed with differing contexts in mind, some questions may be less relevant in some places and should be altered to avoid confusion. (For example, if the key messages relate to dose and frequency of FSP consumption, there is no need to include question 3, as this is covered in question 2).

- **Translate and back-translate the test**. Have the entire test translated into the local language, and then have a different person translate it back into English. If some terms or meanings have changed, find words or phrases in the local language that better reflect the original meaning of the text.

Note: This test is provided as a guide. Extra questions can be added according to the context, to reflect other important elements of staff and volunteer training.

Answers and marking scheme (for examiner only):

#	Question			Points
1	Which of the following statements are true (T), and which are false (F)?	Babies should be fed only breast milk, nothing else, for the first 6 months of life	T	1
		Anaemia is a problem with the blood that can result from poor diet	T	1
		Vitamins and minerals are elements found in food which help to keep people healthy	T	1
		Hand-washing will cause diarrhoea	F	1
2	What are the key messages about FSP to give to the community?	*One answer space should be provided for each of the key messages for the FSP programme. One point should be given for each key message accurately remembered.*		
3	How often should FSP be taken by children? How much should be taken each time by children?	*One point should be given for accurately remembering how much FSP should be taken each time, and one more point for remembering how often it should be taken.*		1 + 1

Staff Test (Core) UNHCR Anaemia Prevention, Control and Reduction Project

Name	Country	Camp name(s)	Date

Information:

This is a test to make sure that you have understood and remembered information given to you during training. The result of the test will not affect your employment or your pay. If you do not pass this test, more help will be given to you so that you understand and remember the information. It is important that you understand and remember this information, so that you can do your work well.

Instructions:

1. Fill in the boxes at the top of the form, including your name, country, camp name and the date.
2. There are 3 questions in this test.
3. For question 1, choose the correct answer ('T' for True or 'F' for False) for each statement. Circle the correct answer.
4. For all other questions, write your answers in the spaces provided.
5. Complete all questions in the amount of time given to you, and then submit this form.
6. Grey areas are for examiner's use only

	Question			Points
1	Which of the following statements are true (T), and which are false (F)?	Babies should be fed only breast milk, nothing else, for the first 6 months of life	T / F	
		Anaemia is a problem with the blood that can result from poor diet	T / F	
		Vitamins and minerals are elements found in food which help to keep people healthy	T / F	
		Hand-washing will cause diarrhoea	T / F	
2	What are the key messages about FSP to give to the community?			
3	How often should FSP be taken by children? How much should be taken each time?			

A. Total points achieved	
B. Total points possible	
C. % mark = (A / B) *100	
D. Pass mark (%)	75
E. C ≥ D = Pass; C< D = Fail	Pass / Fail

APPENDIX 4: TOOL 2 – ADHERENCE, USAGE AND KNOWLEDGE MONITORING FORM

The one-page monitoring form below (Form 1) can be used to assess knowledge, usage and adherence to selected special nutritional products through HH visits. The form is designed to be used by community workers or volunteers with adequate training on data collection and proper use of the special nutritional product in the camp(s). Questions should be asked to recipients directly, or to their caregivers if the recipients are children. Community workers should only fill in the white sections of the form; the grey sections (calculations such as 'days since last distribution' (C), 'Amount of product used' (F), 'expected consumption, and ' individual adherence' should be completed by supervisors or managers.

The second monitoring form (Form 2) is a simplified version to be used to assess the proper usage and understanding of these products, without an assessment of adherence. This can be done through HH visits or at distributions (e.g. exit interview).

These are generic data collection forms, to be adapted, translated and tested for each individual refugee / country context. Specifically, the following should be done before using the form in target populations:

- **Ensure that the correct product name is inserted**. (For example, if the intervention in the camp is using Plumpy'doz®, this name (or the locally adopted name) should be added wherever the term 'Product' appears. If an electronic version of this guidance is available, this can be done very quickly in Word, using the 'find and replace text' function - see Microsoft Word Help for assistance.)

- **Remove columns for indicators that will not be measured**. For example, the column 'feeding infants 6-12 months' is relevant only in programmes using LNS, which may displace breastfeeding if not used correctly.

- **Translate and back-translate the form**. Have the entire form translated into the local language, and then have a different person translate it back into English. If some terms or meanings have changed, find words or phrases in the local language that better reflect the original meaning of the text.

Instructions for collecting and summarising data and calculating adherence (Form 1):

1) Each interviewer should fill in the camp name, their name, the date of the last distribution, the planned distribution amount, and the frequency of distribution at the top of the form.
2) For each recipient visited, fill in the recipient's identifying (ID) number, their address and the date of the interview (B).
3) The number of days between the date of the last distribution (A) and the date of the interview (B) gives the days elapsed since the last distribution (C). It is recommended that a calendar be provided for help in calculating this.
4) For each recipient, fill in the amount of product collected at the last distribution (D) and the amount of product remaining (E). The amount of product used (F) can be calculated from the amount of product collected by the recipient (pots / sachets; recorded or recall) (D), minus the amount of product remaining (including fractions of pots, if necessary) (E).
5) **Expected consumption** can be calculated by following the instructions shown at the bottom of form 1.
6) **Individual adherence** can be calculated by dividing the amount of product actually used (F) by the amount expected to be used i.e. the expected consumption. Multiplying the result by 100 gives a percentage. Individual adherence ≥50% is deemed to be acceptable in most programmes. Recipient's individual adherence can then to be used to calculate **population adherence** for indicator 2.1.1.
7) Reported giving of LNS before breastmilk to children 6-12 months of age at any time provides data for indicator 4.5.2.
8) Reported sharing provides information for indicator 4.5.3.
9) The number of key messages about the product recalled by recipients or their caregivers provides information for indicator 4.3.2 and 4.5.1 (key messages are

given regularly in BCC sessions and should be defined in the programme planning stage).

10) After all of the questions have been asked and data recorded, take the opportunity to correct any misconceptions and provide accurate information.

Note: While counting individual full sachets of FSP for adherence calculations is relatively straightforward, estimating fractions of a pot of LNS is more difficult, especially for those with little mathematical training. A 'pot monitoring guide' has been provided to act as a guide for data collectors in situations where LNS is provided in pots. In addition to this, markings should be made on an empty LNS pot indicating what a ¼ (0.25), ½ (0.5), ¾ (0.75) etc. of left over LNS is, to act as a further guide. These guides should only be used after thorough training on estimating fractions, including practical sessions estimating amounts remaining in actual LNS pots.

Ethiopia / Eritrean refugees / Shimelba refugee camp / UNHCR / F. Courbet / December 2008

Form 1. Adherence, Usage, and Knowledge Monitoring Form (Core)

Camp name(s)	Interviewer name	Date of last distribution (A) (dd/mm/yy)

Instructions for interviewer:

1. At the top of the form, fill in the camp name, your name, date of the last distribution, the planned distribution amount and the frequency of distribution.
2. For each recipient / caregiver visited, fill in one line of the form, including the recipient ID, address and date of interview.
3. Fill in the amount of product that was collected at the last planned distribution.
4. Ask to see where the recipient keeps the product, and record how much product is remaining.

		Adherence				
ID	**Address**	**Date of interview (B)**	**Days since last distribution (C)**	**Amount of product collected at last distribution (D)**	**Amount of Product remaining (E)**	
		dd/mm/yy	(B-A)	Number	Number (including fractions)	

* If F is a negative number (e.g. because the recipient did not attend the last distribution), use zero instead

** **Expected consumption = (C / number of days between distributions) x planned distribution amount**

*** **Individual Adherence = (Amount of product used (F) / Expected consumption) x 100**

NOTE: When calculating population adherence, include figures from all recipients (defaulting does not apply)

Planned distribution amount (E.g. number of pots / sachets)	**Frequency of distributions** (I.e. number of days between planned distributions)

5. Ask the recipients / caregivers (from HH's with children 6-12m) if they ever give the product before breastmilk to children 6-12 months of age.
6. Ask the recipient if they ever give the product to anyone other than the target child (i.e. if it is shared).
7. Ask the recipient to recall all the key messages from the programme and record the number that they are able to recall.

				Usage & Knowledge		
	Amount of Product used (F)*	**Expected Consumption**	**Individual Adherence (%)**	***Only for children 6 – 12 months:***	***For all carers:***	
				Is the product ever given before breastmilk?	**Is the product shared?**	**How many key messages are remembered?**
	(D-E)	See footnote***	See footnote***	Y / N	Y / N	Number

Correct any misconceptions at the end of each interview

Form 2. Usage and Knowledge Monitoring Form (Desired)
UNHCR Anaemia Prevention, Control and Reduction Project

Camp name(s)	**Date** (DD/MM/YY)	**Interviewer name**

Instructions for interviewer:

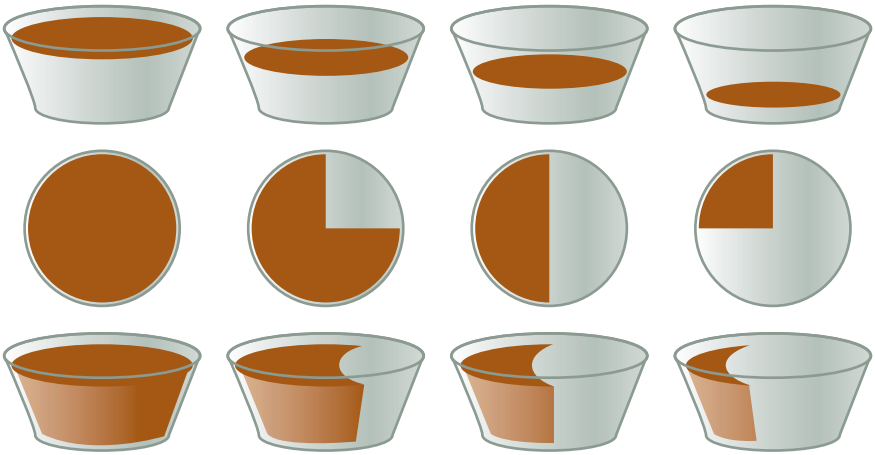
1. Fill in the camp name, date of interview, and your name at the top of the form.
2. For each recipient visited, fill in one line of the form, including the recipient ID number and the address.
3. Ask the recipient if they ever give LNS before breastmilk to children 6-12 months of age (only ask recipients from households with children 6-12 months of age), and if they ever give it to anyone other than the target child (i.e. if it is shared).
4. Ask the recipient to recall all the key messages from the programme. Record the number they are able to recall.

		Usage & Knowledge		
ID	**Address**	***Only for children 6 – 12 months:***	***For all carers:***	
		Is the product ever given before breastmilk?	**Is the product shared?**	**How many key messages are remembered?**
		Y / N	Y / N	Number

Correct any misconceptions at the end of each interview!

Pot Monitoring Guide

If pots of LNS are being distributed a pot monitoring guide can be used to estimate the fraction of left over product in each pot. An example is given below. The actual pots used in the distribution should be used during training sessions and fraction markings written on the pots to help data collectors accurately estimate the amount of product.



1	**3/4** (0.75)	**1/2** (0.50)	**1/4** (0.25)

APPENDIX 5: TOOL 3 – KAP QUESTIONNAIRE

Below is the questionnaire for the Knowledge, Attitudes and Practice (KAP) interview. The questionnaire aims to provide detailed information on knowledge, attitudes and practices related to nutrition, anaemia (if applicable), and the food supplementation products (FSP). It will provide information on any problems in the programme or barriers to implementation, so that these can be addressed. The questionnaire takes about 30 minutes to complete, once the interviewer is practiced, and should preferably be administered to a sample of FSP recipients early on in the programme, and again if core indicator targets such as coverage and adherence are missed in order to assess and address issues.

The questionnaire should be used in a sample of recipients (suggested minimal sample size is 105) selected randomly from a full list of recipients in the camp(s) and administered in the homes or at distributions (e.g exit interview). If no list is available and random selection is not possible, the recipients should be selected purposefully in each camp section, making sure that children whose ages fall within the range of the target group from different refugee groups are represented. If the KAP is being used to assess a particular problem (e.g. with coverage or adherence) that is only present in a certain camp or a certain target group, the sample should only be drawn from this camp or group to allow for assessment of the problem (suggested minimal sample size is 50).

This is a generic questionnaire, to be adapted, translated and tested for each individual camp / country context. The following should be done before using the questionnaire in target populations:

- **Ensure that the correct FSP name is inserted into questions and instructions at every stage of the questionnaire**. For example, if the intervention in the camp is using Plumpy'doz®, this name (or the locally adopted name) should be added wherever the term 'FSP' appears. If an electronic version of this guidance is available, this can be done very quickly in Word, using the 'find and replace text' function - see Microsoft Word Help for assistance.

- **Ensure that all questions and information fields are relevant to the context**. Although this questionnaire has been designed with differing contexts in mind, some questions may be less relevant in certain locations and should be removed to avoid confusion. (For example, questions in section E should be altered according to whether children or adults are receiving the FSP; and questions in section F should be formulated depending on whether the FSP is provided in pots or sachets).

- **Translate and back-translate the questionnaire**. Have the entire questionnaire translated into the local language, and then have a different person translate it back into English. If some terms or meanings have changed, find words or phrases in the local language that better reflect the original meaning of the text.

- **Test the questionnaire and get feedback**. Gather a focus group of local people representative of those with whom the questionnaire will be used. Ask the following questions and incorporate suggestions into the final questionnaire where appropriate:
    1. What questions did they not understand?
    2. What questions seemed awkward or foolish?
    3. What are their suggestions to improve the wording of questions?
    4. Have they any suggestions for improving the questionnaire?

The questionnaire can then be used to monitor the knowledge, attitudes and practices of FSP recipients / recipients caregivers. Supervisors or field workers administering the questionnaire should have adequate training and practice before using the questionnaire in the population. Interpretation of the questionnaire data should be basic and should identify recurrent themes in answers. The questionnaire data should normally be interpreted by a programme manager, who should then use the information to alter programming as necessary.

Mini-KAP Questionnaire (Desired)

UNHCR Anaemia Prevention, Control and Reduction

A: Identification details			
A1 Interviewer name	A2 Interview date (DD/MM/YY)	A3 Camp name	A4 Interview #

B: Introduction
INTERVIEW OBJECTIVES

To assess the recipients' understanding of the FSP intervention, including reasons for the intervention, programme duration and objectives, and their usage of the FSP, to allow for programme modification if necessary.

INSTRUCTIONS TO INTERVIEWER

Note: This interview is for recipients of FSP, or their usual caregiver, not another family member.

If the recipient or usual caregiver is not available, select another household.

1. Fill in information on location, date and interviewer name at the top of the page (Section A).
2. Read the information in the section below to the respondent, and ensure they understand.
3. Read each question in turn to the respondent, but do not read out the responses unless the question requests this.
4. Circle the selected answer(s) in the 'code' column.
5. Remember to thank the respondent for their time and cooperation at the end of the interview.

READ TO RESPONDENT

We wish to learn about your knowledge, attitudes and practices regarding nutrition, anaemia, and *'FSP' (adapt as appropriate)*. We hope to understand your needs, and the best way to bring information and assistance to you, as well as how you use the products we supply. Your participation is voluntary and you may stop the interview at any time. If you stop being in this survey, it will not have any negative effects on how you or your household is treated within the camp. Your answers will not be released to anyone and will remain anonymous. Your name will not be written on the questionnaire or be kept in our records. Thank you for your assistance.

Q#	Questions	Response categories	Code	Skip to
C: General information				
C1	Age of recipient [*alter as appropriate*]	6-11 months	1	
		12-23 months	2	
		24-35 months	3	
		36-59 months	4	
C2	Gender of recipient	Male	1	
		Female	2	
D: FSP knowledge				
D1	Have you ever attended an education session for the FSP?	No	0	
		Yes	1	

D2	According to you, please tell me what is FSP? **Note: Do not probe; circle only the answers given by the respondent. Circle <u>ALL</u> responses given**	Vitamins / minerals / nutrients for the family	1	
		Vitamins / minerals / nutrients for children	2	
		Vitamins / minerals / nutrients for adults	3	
		Food supplement	4	
		Food	5	
		Medicine	6	
		Other (specify)	88	
D3	Why should FSP be consumed? **Note: Do not probe; circle only the answers given by the respondent. Circle <u>ALL</u> responses given**	FSP can make people healthier	1	
		My neighbours will respect me more	2	
		FSP can make people strong	3	
		FSP can help protect from illness	4	
		FSP can help to prevent anaemia	5	
		Other, (specify)	88	
		Don't know	99	
D4	Do you know how often the FSP *should* be consumed? Please specify. ***Record whether this is the correct frequency, as specified by the programme or if the respondent does not know.***	No	0	
		Yes	1	
		Don't know	99	
D5	Do you know what quantity of FSP should be consumed each time? Please specify. ***Record whether this is the correct amount, as specified by the programme or if the respondent does not know.***	No	0	
		Yes	1	
		Don't know	99	

E: FSP attitudes and use [*alter as appropriate*]				
E1	Have you / your child ever consumed FSP?	No	0	E3
		Yes	1	
E2	Are you / your child still consuming FSP?	No	0	E3
		Yes	1	E4
E3	Why don't you / your child consume FSP? Next question is E9 **Note: Do not probe; circle only the answers given by the respondent. Circle <u>ALL</u> responses given**	Not available	1	
		Do not like it	2	
		Taboo	3	
		FSP is bad for health	4	
		The FSP has negative side effects	5	
		It doesn't have any positive effects	6	
		Don't know enough about it	7	
		It is hard to remember to take it / give it to my child	8	
		Would rather trade the FSP for other things	9	
		Dislike the logo / packaging	10	
		Was told not to use it by community / religious leader	11	
		Other, specify	88	

E4	Why do you / your child consume FSP? **Note: Do not probe; circle only the answers given by the respondent. Circle <u>ALL</u> responses given**	It has health benefits	1	
		Like it	2	
		Recommended by friend / neighbour / family member	3	
		Recommended by doctor / NGO staff	4	
		Recommended by community / religious leader	5	
		Other, specify	88	
E5	How was FSP eaten the last time it was consumed? **Note: One answer only**	Added to family pot during cooking	1	
		Added to family bowl after cooking	2	
		Added to individual cup / bowl of one person only	3	
		Single dose added to cups / bowls of many people	4	
		Not added to food - eaten on its own	5	
		Other, specify	88	
		Don't know	99	
E6	Do you / your child drink tea within one hour of consuming the FSP (before or after)?	No	0	
		Yes	1	
		Don't know	99	
E7	How often do you consume the FSP? **Question for interviewer:** *Is this the correct frequency, as specified in the programme?*	No	0	
		Yes	1	

E8	*How much* FSP do you consume each time? **Question for interviewer:** *Is this the correct amount, as specified in the programme?*	No	0	
		Yes	1	
E9	Are you / your child consuming any other complementary / supplementary products provided by nutrition workers, for example… (*list products in use in the camp*)?	No	0	
		Yes	1	
		If yes, which?		
E10	Have you noticed any changes in yourself / your child as a result of taking FSP? **Note: Do not probe; circle only the answers given by the respondent. Circle <u>ALL</u> responses given**	No changes	0	
		More appetite	1	
		More energy / playfulness	2	
		Less sick	3	
		Weight gain	4	
		Other, specify	88	
E11	In the past 2 weeks, have you / your child had any physical illness?	No	0	E15
		Yes	1	
E12	What physical symptoms did you / your child experience? **Note: Do not probe; circle only the answers given by the respondent. Circle ALL responses given**	Constipation	1	
		Diarrhoea	2	
		Changed faeces colour	3	
		Nausea / vomiting	4	
		Fever	5	
		Abdominal pain	6	
		Other, specify	88	
E13	Did any of these physical symptoms cause you / your child to stop using FSP?	No	0	E15
		Yes	1	

E14	If yes, why did you stop using it / giving it to your child?	FSP caused illness	1	
		No appetite to eat FSP	2	
		Other	88	
E15	Is the FSP given to anyone other than the intended recipient?	No	0	
		Yes (who?)	1	
E16	Is the FSP used for anything else, other than being eaten by the intended recipient?	No	0	
		Yes (specify)	1	
E17	What does your family think about the FSP? **Note: Do not probe; circle only the answer that is mentioned. One answer only.**	Like FSP - encourages use	1	
		Does not like FSP - discourages use	2	
		Does not talk about FSP	3	
		Does not know about FSP	4	
		Other, specify	88	
E18	What does your community think about the FSP? **Note: Do not probe; circle only the answer that is mentioned. One answer only.**	Likes FSP - encourages use	1	
		Does not like FSP - discourages use	2	
		Does not talk about FSP	3	
		Does not know about FSP	4	
		Other, specify	88	
E19	Do you know how long the distribution will continue? (Specify amount of time) ***Record whether the answer stated is correct or if the respondent does not know***	No	0	
		Yes	1	
		Don't know	99	

F: FSP collection, storage and adherence				
F1	Did you collect FSP at the last distribution? Date of last distribution: _____	No	0	F3
		Yes	1	
F2	How many pots / sachets did you collect at the last distribution? *Record whether this is the number that was supposed to be collected.*	Record response		
		No	0	
		Yes	1	
F3	Where do you store full sachets / pots? **Note: Observe storage situation at end of interview**	With food	1	
		In pot / box / container, protected	2	
		On table / surface inside home, unprotected	3	
		On floor , unprotected	4	
		Other, specify	88	
F4	Where are empty sachets / pots kept until next distribution / disposed of? **Note: Observe storage situation at end of interview**	Littering the floor / compound	1	
		Thrown away outside	2	
		Disposed of at rubbish point	3	
		Kept safely until return at next distribution	4	
F5	Count full pots / sachets remaining (adherence)	Number (including fractions)		

F6	Do you feel you have received enough information and support in using the FSP?	No	0	
		Yes	1	
		Reason:		
G: Nutrition and anaemia knowledge [*alter as appropriate*]				
G1	Have you ever heard of anaemia? *(Include local names for anaemia)*	No	0	G5
		Yes	1	
G2	What do you think are the causes of anaemia? **Note: Do not probe; circle only the answers given by the respondent. Circle <u>ALL</u> responses given**	Poor food	1	
		Illness (malaria, fever, infection)	2	
		Parasites (worms)	3	
		Poor hygiene and sanitation conditions	4	
		Poor breastfeeding practices	5	
		Don't know any	99	
G3	What do you think are the signs and symptoms of anaemia? **Note: Do not probe; circle only the answers given by the respondent. Circle <u>ALL</u> responses given**	Fatigue / tiredness	1	
		Pale skin	2	
		Weakness	3	
		Dizziness / fainting	4	
		Short of breath	5	
		Heart palpitations	6	
		Headaches	7	
		Sore mouth	8	
		Don't know any	99	

G4	What ways do you know to prevent or treat anaemia? **Note: Do not probe; circle only the answers given by the respondent. Circle <u>ALL</u> responses given**	Good food / nutrition	1	
		FSP	2	
		Iron tablets / supplements	3	
		Good breast feeding practices	4	
		Bed nets	5	
		De-worming / parasite treatment	6	
		Don't know any	99	
G5	Have you heard of iron in food?	No	0	G7
		Yes	1	
G6	What foods do you know that contain iron? [*alter as appropriate*] **Note: Do not probe; circle only the answers given by the respondent. Circle <u>ALL</u> responses given**	Red meat	1	
		Green leaves	2	
		FSP	3	
		Add other local foods containing iron	88	
Include the following questions only if a child is receiving LNS:				
G7	Is the child currently being breastfed?	No	0	G9
		Yes	1	
		Don't know	99	
G8	Has the child changed the amount of breast milk he or she takes since starting to eat the FSP?	No change	0	
		Takes more	1	
		Takes less	2	
		Don't know	99	
G9	Is the child receiving complementary foods, semi-solid foods or solid foods, other than the FSP?	No	0	
		Yes	1	
		Don't know	99	

G10	Has the child changed the amount of food he or she eats since starting to eat the FSP?	No change	0	
		Eats more	1	
		Eats less	2	
		Don't know	99	

Interviewer's observations

READ TO RESPONDENT

If you have any questions about the FSP or the programme, I can try to help you now, or you can see a nutrition worker at the next distribution. Thank you for your help!

INSTRUCTIONS TO INTERVIEWER

If any incorrect knowledge has been displayed, correct it now. Then go and observe the storage situation of the FSP containers.

End of interview

APPENDIX 6: TOOL 4 – EXAMPLE MONITORING DATA REPORTING FORM

Below is the reporting form for the monitoring of FSP interventions. Monitoring data should be summarised regularly according to the suggested frequency, and the full report submitted to the Country Office / HQ. The first page of the report, detailing indicators, targets and remedial actions should also be shared with staff and implementing partners in the field. Action points should detail what needs to be done to improve the programme and meet the indicator target next time; who needs to implement the action; and by when the action needs to be completed.

Page two of the report has space for additional explanatory notes on a brief context analysis, so that any changes in context can be documented to help explain the performance indicators achieved. Information should also be provided on target groups and coverage; adherence, usage & knowledge; training and BCC; and major challenges, risk assessment follow-up and the way forward. The boxes can be expanded and pages added if more space is required.

This is a generic report, to be adapted for each individual camp context. The name of the specific FSP in use in the camp(s) should be inserted in place of the generic term 'FSP', and indicators not in use (for example 'desired' indicators that have not yet been phased in) should be removed from the form.

Reporting Form for Monitoring Data (Core)

UNHCR Anaemia Prevention, Control and Reduction

Country	Camp(s)	Date	Author

The following indicators should be calculated and reported regularly. See M&E Guidelines for further information.

Indicator		Calculation (*100)	Target	Actual	Suggested Frequency of monitoring
2.1.1	Recipients with adequate adherence i.e. population adherence	Number of recipients with individual adherence of ≥50% and <110% Number of actual recipients interviewed	>70%		- At least after 2 months of implementation and at 6 and 12 months of implementation. - To be repeated, as needed
3.1.1	Programme coverage (for each target group)	Number of actual recipients at each distribution Number of eligible persons registered in the camp(s)	>70%		- Monthly throughout programme implementation.
4.1.1	Sufficient stock at distribution site(s) for full distribution	Number of distribution site(s) with sufficient stock for full distribution Number of distribution site(s)	100%		- Monthly throughout programme implementation.
4.1.2	Product wastage	Quantity of FSP found to be unfit for distribution Quantity of FSP checked	<5%		- Monthly throughout programme implementation.

4.2.1	Staff training and availability	Number of staff fully trained and available Number of staff required	>90%		- Before programme implementation. - To be repeated, as needed.
4.2.2	Staff knowledge test	Number of staff passing test Number of staff taking test	>90%		- Before programme implementation. - One refresher training to be done after 6 months of implementation. - To be repeated, as needed.
4.3.1	BCC for recipients and community	Number of BCC / education sessions held Number of BCC / education sessions needed	>90%		- Before programme implementation and during programme roll-out. - To be repeated, as needed. - As the programme rolls-out and the refugee community gets used to the FSP, less BCC sessions can be held.
4.3.2	BCC strategy adequacy and availability checked	Yes / No	Yes		- Before programme implementation and during programme roll-out. - To be repeated, as needed.
4.4.1	Distributions undertaken	Number of distributions undertaken Number of distributions planned	>90%		- Monthly throughout programme implementation.

4.5.1	Recipients understanding of programme	Number of recipients able to recall ≥50% of key messages Number of recipients interviewed	>75%		- At least after 2 months of implementation and at 6 and 12 months of implementation. - To be repeated, as needed.
4.5.2	Breast milk displacement	Number of recipients reporting offering LNS before breastmilk to children 6-12 m Number of recipients interviewed with children 6-12 m in HH	< 15%		- At least after 2 months of implementation and at 6 and 12 months of implementation. - To be repeated, as needed.
4.5.3	Sharing of FSP	Number of recipients reporting sharing of FSP Number of recipients interviewed	<25%		- At least after 2 months of implementation and at 6 and 12 months of implementation. - To be repeated, as needed.
4.5.4	Selling of FSP	Yes / No	No		- At least after 2 months of implementation and at 6 and 12 months of implementation. - To be repeated, as needed.
4.5.5	FGD / KIs and / or mini-KAP survey conducted	Yes / No / Not needed	-		- At least after 2 months of implementation and at 6 and 12 months of implementation. - To be repeated, as needed.

5.2.1	Monitoring report produced last reporting period	Yes / No	Yes		- If the programme is stable, monthly during first 6 months of implementation and quarterly thereafter.
5.2.2	Action points followed up	Number of action points followed up from last report / Number of action points in previous monitoring report	>90%		- When the monitoring report is produced and action points are set.

For each indicator where the target was not achieved, create an action point below to improve the programme for next time. Refer to the programme Logical Framework in the M&E section for suggested remedial actions.

Action points (Who, What, When):

Changes in context since last report:

Target groups, distributions and coverage:

Adherence, usage and knowledge:

Training, BCC, and house visits:

Major challenges, risk assessment follow-up and way forward:


UNHCR
The UN Refugee Agency


UCL


ENN