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Food Security and Nutrition Standards: Essential Concepts

1. Everyone has the right to adequate food

International legal instruments recognise the right to “available, accessible, and adequate” food, including the right to be free from hunger. It entails having physical and economic access to adequate food at all times. States are obliged to ensure this right directly when individuals or groups are unable – for reasons beyond their control – to access adequate food, including in crises. States may request international assistance if their own resources do not suffice, and they should facilitate safe and unimpeded access for international assistance. The right to food also implies that states should :

- *respect* existing access to adequate food by not taking any measures that result in the prevention of such access;
- *protect* individuals’ access to adequate food by ensuring that enterprises or individuals do not deprive individuals of such access; and
- *actively facilitate* people’s access to – and use of – resources and means to ensure their livelihoods, including food security.

The Geneva Conventions and their additional protocols include the right to access to food in situations of armed conflict and occupation:

- It is prohibited to starve civilians as a method of warfare.
- It is also prohibited to attack, destroy, remove, or render useless foodstuffs; agricultural areas that produce foodstuffs; crops; livestock; drinking water installations and supplies; or irrigation works.
- In the case of occupation, international humanitarian law obliges the occupying power to ensure adequate food for the population and to bring in supplies if those in the occupied territory are inadequate.

States should make every effort to ensure that refugees and internally displaced persons have access to adequate food and nutrition at all times.

The minimum standards on food security and nutrition reflect the core content of the right to adequate food and help to progressively realise the right. The right to adequate food is intricately linked to the realisation of other universal rights, including the right to water and sanitation, the right to health, and the right to shelter.

2. Food security and nutrition in humanitarian response

In disasters, access to food and the maintenance of an adequate nutritional status are critical determinants of people’s survival. People affected are often already chronically undernourished when the disaster hits. Under-nutrition is a serious public health problem and among the leading causes of death – whether directly or indirectly.

Food security and nutrition are intricately linked to the other minimum standards and require complementary responses with all other life-saving sectors. For example, food generally needs safe water for cooking and ensuring hygiene. The treatment and prevention of malnutrition is linked to health. Cooking fuel and energy sources can have a significant impact on shelter, protection, and health. Food security and

nutrition interventions must be designed and planned in coordination and collaboration with other sectors to have effective responses.

The causes of under-nutrition are complex. The conceptual framework shows the interaction between the various factors contributing to under-nutrition (*see diagram*). The immediate causes of under-nutrition are disease and/or inadequate food intake, which result from:

- underlying poverty;
- household food insecurity;
- inadequate care practices at household or community levels;
- poor water, hygiene, and sanitation; and
- insufficient access to healthcare.

Crises directly affect the underlying causes of under-nutrition. The vulnerability of a household or community determines its ability to cope with exposure to the shocks of disasters. The characteristics of a household or community (particularly its assets and coping and livelihoods strategies) largely determine its ability to manage the risks associated with disasters. **Exposure to risk** is determined by the frequency and severity of shocks, as well as their socio-economic and financial scope. **Coping capacity determinants** include: the levels of a household's financial, human, physical, social, natural, and political assets; the levels of its production, income, and consumption; and its ability to diversify its income sources and consumption to mitigate the effects of risks.

Recognising distinct roles in family nutrition is key to improving food security at the household level.

Women often play a greater role in the planning and preparation of food for their households. **Addressing the nutrition of infants and young children must be a priority, given their vulnerability.** Prevention of under-nutrition is just as important as treating acute malnutrition. Food security interventions may determine nutrition and health in the short-term, and survival and well-being in the long-term.

Understanding the unique nutritional needs of pregnant and lactating women, young children, older people, and persons with disabilities is important when developing appropriate food responses.

Responding to urban food security and nutrition in a crisis requires a particular approach. Urban areas generally have higher rates of obesity, dependency on markets, and vulnerability to market price fluctuation. Urban households are often not traditional: a large or small number of people from different families may live in one house. Urban food consumption often includes eating street food, which may provide enough energy, but limited micronutrients. The Food Consumption Score (FCS) may not adequately reflect food insecurity in an urban context so it is crucial to undertake a nutritional causal analysis. Both diet and experiential measures should be used in urban responses to capture different constraints in accessing food.

When using the Food Expenditure Share (and its established thresholds), be aware that it may not be suitable in urban households given that several people may be in charge of the food basket, household members are likely consuming food outside of the house, and a number of people may be contributing to household income. In urban food security assessments it is important to capture information about access to markets, financial capital, livelihoods, and economic vulnerability. These elements are all linked to commodity prices, income earning opportunities, and wage rates, which each impact food security. Analysis of markets, their functionality, structures, and commodity availability is also a key component of urban food security assessments. When assessing the nutrition situation, note that women are more likely to work outside the home in jobs or income generating activities that directly impact on child caring practices (such as breastfeeding and disease management).

3. Food security and nutrition, Key Protection Considerations, and the Core Humanitarian Standard

Food assistance has the potential to lead to serious protection violations if it is misused. It can be used as a tool for sexual abuse and exploitation, so particular care must be taken with regards to distribution and monitoring and ensuring that individuals are not exposed to harm. Feedback mechanisms must be put in place with food security interventions (see *Core Humanitarian Standard commitment 5*). The Core Humanitarian Standard commitments 1 to 6 are essential to ensuring effective food security and nutrition responses.

In some conflicts, the denial of food – despite being a violation of international humanitarian law – can lead to under-nutrition, malnutrition, and even famine. Ensuring adequate protection and access to populations to highlight and help prevent such protection violations can have a positive impact in terms of food security. Military, police, or peacekeeping missions may be involved, or associated, with food distributions, for example, and can provide a protective presence, but there is also the risk of protection violations taking place. Ensure that any such distributions are carefully planned with due consideration given to mitigating protection risks (see Civil-Military Coordination section in What is Sphere?).

It is particularly important to disaggregate data by sex, age, and disability to be able to understand who needs what kind of food and who may be missing important nutritional elements. Post-distribution monitoring must equally be done through sex, age, and disability disaggregation to ensure that the food security and nutrition interventions are progressively achieving the right to adequate food.

4. Key Terminology

Key terms related to food security, nutrition, and livelihoods are introduced prior to each (set of) standard(s). Other important terms to consider across all the food security and nutrition standards include the following:

The first 1,000 days: The age from conception until two years is particularly important in nutrition terms. It is increasingly recognised that emphasis must be placed on ensuring appropriate nutritional support to pregnant women and children under two, given the long-term impact that nutrition can have on health, development, and physical growth. Malnutrition in early life can have serious negative effects on individuals throughout their lifetimes, given reduced capacities to learn, increased risk of diseases, and irreversible damage to brain and physical development.

Infant and child feeding in disaster response: Proper infant and child feeding practices can have a significant impact on survival, growth, and development. In disaster response, it is essential to ensure and promote proper feeding practices to avoid unnecessary long-term damage to infants and children.

For further reading:

OHCHR and FAO (2010). *The Right to Adequate Food: Fact Sheet No.34.*
<http://www.ohchr.org/Documents/Publications/FactSheet34en.pdf>

Food Security and Nutrition

1. Food Security and Nutrition Assessment

A decrease in food security is one of three underlying causes of undernutrition, along with disease and poor feeding and care practices.

Food security is influenced by macroeconomic and socio-political factors. National and international policies, processes or institutions can impact affected people's access to nutritionally adequate food, as can the degradation of the local environment and the increasingly variable and extreme weather caused by climate change.

Timely nutrition assessments are useful in establishing the magnitude of a nutrition crisis and the underlying factors. The process helps in identifying most affected and at-risk populations, sub-groups or individuals in a given area. Rapid Nutrition Assessments (RNA) provide a rough estimate of the needs among the affected population and identifies priority nutrition actions to be implemented. More detailed nutrition assessments follow initial RNA through collection and analysis of representative data to generate prevalence rates of acute malnutrition and Infant and Young Child Feeding (IYCF) and other care practices. These are useful in planning, implementing and monitoring nutrition programs.

With a greater variety of food available and accessible, urban contexts may require more nuanced food security and nutrition assessment than rural settings. Food security in urban areas is closely linked to commodity prices, income opportunities and wage rates. Assessments in urban contexts should therefore address:

- access to markets and cash;
- livelihoods; and
- underlying and crisis-affected economic vulnerability.

Urban areas generally have higher rates of obesity, for instance, and the most commonly used measures of food security do not consider this. Frequent consumption of prepared/street foods may provide enough energy, but limited micro-nutrients. Food Consumption Score - Nutritional Quality Analysis (FCS-N) can be more relevant in urban contexts, to gain a better understanding of the adequacy of consumption of micro-nutrient rich foods.

All assessments should include an analysis of market functionality which meets the Minimum Standard for Market Analysis (*Reference to Annex on 'Delivering through Markets'*).

A joint food security and nutrition assessment is recommended to increase cost-effectiveness and link nutrition to food security programming. Civil-military coordination or co-operation should be considered specifically in conflict environments where civilians may be vulnerable to risks. Focus on identifying the barriers to adequate, equitable, and safe access to nutrition and the interventions needed to improve the availability, access and optimal utilisation of food intake. The following two food security and nutrition assessment standards build on CHS Commitment 1 to design appropriate food security and nutrition interventions for the affected population. For assessment checklists see Appendices 1, 2 and 3.

Food security and nutrition assessment Standard 1.1:

Food security Assessment

Food security assessments aim to understand the degree and extent of food security, to identify those most affected and to define the most appropriate response.

Key Action 1: Collect and analyse information on food security at the initial stage of the crisis.

- Use different sources of information, such as crop assessments, satellite images and household assessments.
- Use tools such as the Coping Strategies Index for rapid measurement of household food security.
- Use local and regional food security information systems, including famine early warning systems, and the Integrated Food Security Phase Classification (IPC) to analyse information.
- Include assessment questions that will highlight any critical environmental issues linked to food security and nutrition.

Key Action 2: Analyse the impact of food security on the nutritional status of the affected population.

- Consider other relevant underlying causes of undernutrition, including broader economic and socio-political factors.
- Collect data more frequently in urban contexts as the situation can change more rapidly and be more difficult to observe than in rural contexts.
- Pay specific attention to age, sex, gender norms and practices, and diversity.

Key Action 3: Analyse available cooking methods, including the type of stove and fuel used.

- Analyse how the affected population acquired food, cooking fuel and income before the crisis with particular attention to the rights and protection needs of women and girls, who are most commonly responsible for fuel collection (for example, firewood) and food preparation, and how they cope now.
- Consider the food and cooking fuel security of the host population into account where people have been displaced.
- Consider that cooking fuel may be sold as a coping strategy, and identify any related protection risks, particularly for women and girls.

Key action 4: Conduct a market assessment to contribute to response analysis

- Define the analytical and geographical scope of the assessment
- Consider overall market functionality and food-specific market systems
- Build a competent and knowledgeable team for data collection and analysis
- Use data collection methods and information sources of sufficient quality

Key indicators

Number of systematic and objective food security needs assessments conducted within the first week of an emergency response (CHS 1.1).

- At least one comprehensive assessment conducted

Number of assessment findings that include clear recommendations and actions for targeting the most vulnerable individuals and groups.

- All findings have clear recommendations

Percentage of targeted households that report that the food assistance provided corresponds to their requirements (CHS 1.2).

- Establish baseline and move towards improvement

What else do I need to know?

Data sources

Pre-crisis data combined with GIS data can provide a first snapshot of the potential impact. Secondary data about the pre-crisis situation in urban areas is unlikely to be disaggregated to the level required to show a clear picture of the pre-crisis situation of the urban poor.

Environment and food security

Environmental degradation can cause food insecurity. Responses to food insecurity can lead to environmental degradation. Assessments should include environmental issues to ensure that response activities do not further impact these negatively

At-risk groups

Women and men may have different, complementary roles in securing household nutritional well-being. Consult with both women and men, separately if necessary, about practices of the affected population related to food security, food preparation and household resources. Encourage gender equality, such as greater engagement of women in decision-making about household resources, and of men in food preparation, young infant child-feeding and care practices. Take specific measures to include girls and boys, especially child-headed households, separated or unaccompanied children, and children living in alternative care. Be mindful of children in different humanitarian contexts. For example, during infectious disease outbreaks, include children in observation, interim care and treatment centres; in conflict settings, include children in demobilization centres.

Proxy measures

Food consumption reflects the energy and nutrient intake of individuals in households. It is not practical to measure actual energy content and nutrient details during initial assessments. Changes in the number of meals consumed before and after a crisis can be a revealing indicator of changes in food security. The number of food groups consumed by an individual or household, and the frequency of consumption over a given reference period reflect dietary diversity. This is a good proxy measure of food security as well, especially when correlated with a household's socio-economic status, total food energy intake, and diet quality. Tools for measuring food consumption patterns include the Household Dietary Diversity Score, the Household Food Insecurity Access Scale and the Food Consumption Score.

Causes of undernutrition

Assess all underlying causes of decreased food security in parallel to fully understand context-specific causes of undernutrition. Be aware that, due to discriminatory social norms, girls and children with disabilities may be excluded in intra-household distribution of food assistance.

Market analysis and cost of diet

Include a market analysis as part of initial and subsequent context assessments (see Annex X on Delivering through Markets). Market systems can go beyond short-term needs after a crisis to protect livelihoods by supplying productive items (such as seeds and tools). Market analysis should assess whether local markets can support nutritional needs. Establish the minimum cost and affordability of foods that meet the nutrient needs of a typical household.

Most interventions in an urban area are market-based, utilising vendors, market spaces, local food products and transportation services. Conduct a vulnerability analysis to understand market access for certain groups, especially people with special needs. (Ref MISMA)

Response analysis

Focus on how the affected population acquired food, cooking fuel and income before the crisis, and how they cope now. Assessing incomes and expenditures is particularly relevant in urban areas. Urban households may have several people in charge of the food basket, and a number of people may be contributing to household income. Household members are probably consuming food sourced from outside

of the house. It is crucial to do an analysis of nutrition and its causes through urbanised approaches. Both diet and experiential measures should be used in urban responses in order to capture different constraints to food access. The standard Food Consumption Score (FCS) indicator and the Household Dietary Diversity Score (HDDS) may not adequately reflect food security and nutrition in an urban context.

Coping strategies

Consider the different types of coping strategies, who is applying them and when, how well they work, and the nature of negative effect (if any). Some coping strategies, such as the sale of land, migration of whole families, or deforestation, may permanently undermine future food security.

Some coping strategies employed by or forced on women, girls and boys may significantly impact their health, psychological well-being and social integration. These coping strategies include transactional or 'survival' sex, marrying daughters for bride price, women and girls eating last and least, child labour, risky migration, and sale and trafficking of children.

Coping strategies may also affect the environment, such as over-exploitation of commonly-owned natural resources leading to deforestation. Collecting firewood and producing traditional charcoal make it possible not only to cook food but also to generate short-term income in and around displacement camps. Analysis should identify the most appropriate combination of responses that protect and support food security.

Cooking methods

Assessments should examine cooking methods and facilities. Most of the food provided by humanitarian organisations must be cooked before it can be eaten, but stoves and fuel are rarely provided. As a result, displaced people – often women and girls – walk for hours to find firewood and have to carry heavy loads back to camp. This puts them at risk of physical and sexual attack, dehydration, and physical injuries. Many affected people sell or exchange a portion of their food rations in order to procure the firewood needed to cook the remaining food. Such coping mechanisms can have serious consequences including malnutrition.

Food security and nutrition assessment Standard 1.2: Nutrition Assessment

Nutrition assessments use accepted methods to identify the type, degree and extent of undernutrition, those most at risk, and the appropriate response.

Key Action 1: Compile existing information from pre-crisis and initial assessments to establish the nature and severity of the nutrition situation.

- Determine if the situation is stable or declining.
- Gather information on the causes of undernutrition from primary or secondary sources.

Key Action 2: Identify groups with the greatest nutritional support needs and the factors that affect nutritional status.

- Consult the local community and stakeholders on the potential causes of undernutrition.

Key Action 3: Determine if population-wide qualitative or quantitative assessments are needed.

- Use these to measure and understand factors such as anthropometric status, micronutrient status, infant and young child feeding, maternal care practices, and associated potential determinants of undernutrition.
- Examine trends in nutritional status over time, where representative data are available. This is preferable to assessing the prevalence of malnutrition at a specific time.
- Conduct anthropometric surveys to get an estimate of the prevalence of malnutrition (chronic and acute), and non-anthropometric surveys to complement those.
- Determine if there are micro-nutrient deficiencies among the population.
- Determine whether levels of undernutrition need intervention
- Use Rapid MUAC and IYCF-E assessments to quickly assess the nutritional situation to provide data on the impact of a major crisis.

Key Action 4: Evaluate national and local capacity to lead and/or support the response.

Key indicators

Number of assessment and analysis methodologies adopted, including standardised indicators adhering to widely accepted principles for both anthropometric and non-anthropometric assessments

- Single standard methodology for each nutrition response.

Number/percentage of analytical reports presented on assessment findings, including clear recommendations for actions targeting the most vulnerable individuals and groups.

- All reports contain clear recommendations to meet prioritized needs.

What else do I need to know?

Contextual information

This includes existing health and nutrition profiles, research reports, early warning information, health facility records, food security reports. Where information is not available for specific areas of assessment or potential intervention, consult other sources, such as:

- demographic health surveys;
- multi-indicator cluster surveys;
- national nutrition information databases;
- other national health and nutrition surveys national institutions (ministries, local offices for emergency preparedness, drugs and food standards authorities);
- WHO Nutrition Landscape Information System;
- WHO Vitamin and Mineral Nutrition Information System;
- Complex Emergency Database (CE-DAT);
- Nutrition in Crisis Information System (NICS);
- World Breastfeeding Trends Initiative (WBTi) country profiles;
- national nutrition surveillance systems; and
- admission rates and coverage in existing programmes for the management of malnutrition.

Consider nutrition assessments within broader assessments, especially those focusing on public health and food security. Gather information on existing nutrition initiatives, their operational capacity, and local and national response capacity to identify gaps and guide response.

Scope of analysis

Only conduct further in-depth assessments if additional details would inform decision-making, to measure programme outcomes or for advocacy purposes. Sources of in-depth nutrition assessments include anthropometric surveys, infant and young child feeding assessments, micronutrient surveys, causal analyses, and nutrition surveillance and monitoring systems.

Methodology

Nutrition assessments of any type should have clear objectives, use internationally accepted methods and identify nutritionally vulnerable individuals. They should identify factors (including discriminatory social norms and structural barriers), that may contribute to undernutrition. Assessment approaches need to be impartial, representative and well-coordinated between humanitarian organisations and governments. Information must be complementary, consistent and comparable. Multi-agency assessments may be beneficial in assessing large-scale multi-sectoral and wide geographical areas.

Anthropometric surveys

Anthropometric surveys provide an estimate of the prevalence of malnutrition (chronic and acute). They are representative cross-sectional surveys based on random sampling or specific screening. Further details are provided in Appendix XX: Measuring acute malnutrition.

They should report Weight for Height in Z score according to WHO standards (see Appendix XX: Measuring acute malnutrition). Reporting Weight for Height in Z score according to the National Center for Health Statistics (NCHS) reference allows for comparison with past surveys. Include wasting and severe wasting measured by mid upper arm circumference (MUAC) data in anthropometric surveys.

Assess prevalence of nutrition oedema and record it separately. Report confidence intervals for the prevalence of malnutrition and demonstrate survey quality assurance. Use existing tools such as the Standardised Monitoring and Assessment of Relief and Transitions (SMART) methodology manual, ENA (Emergency Nutrition Assessment) software or Epi Info software. The most widely accepted practice is to assess malnutrition levels in children aged 6–59 months as a proxy for the population as a whole. However,

consider assessment of other groups that face a greater nutritional risk (see Appendix X: Measuring acute malnutrition amongst adults).

IYCF-E Assessments: Assess the needs and priorities for IYCF emergency response and monitor impact of interventions, humanitarian action, and inaction. Use pre-crisis background information (secondary data) to inform early decision-making. Explore opportunities to include IYCF questions in other sectoral assessments and draw on relevant multi-sectoral data. Early needs assessment findings requiring further investigation and likely intervention include the following:

- prevalent artificial feeding pre-emergency;
- low exclusive breastfeeding rate pre-emergency;
- mothers reporting difficulties breastfeeding;
- low continued breastfeeding at one year;
- reports of non-breastfed infants under six months of age;
- requests for infant formula;
- infants under six months of age presenting with acute malnutrition;
- pre-existing nutrient gap in complementary foods;
- lack of appropriate complementary foods;
- separated or unaccompanied infants, including those who have been abandoned, whose parents have died, and whose parents' whereabouts are unknown; and
- reports of BMS donations or untargeted distributions of BMS.

Also document capacity for IYCF-E including the number of available counsellors, trained health workers, and other support services and their capacity. Where more in-depth IYCF assessment is required, conduct random sampling, systematic sampling or cluster sampling involving a standalone IYCF survey or an integrated survey. The integrated survey might have sample size limitation.

IYCF-E Monitoring: Monitor activities and interventions using suitable IYCF-E indicators (see FSN appendix Operational Guidance on IYCF-E). Monitor and report on violations of the Code. Use standard indicators where they exist; develop context-specific indicators where they do not. Define IYCF benchmarks to determine progress and achievement considering intervention timeframes. Encourage consistent IYCF indicator use across implementing partners and in surveys. Repeat assessments or parts of a baseline assessment as part of monitoring IYCF interventions. Use annual surveys to determine impact of these interventions.

Other indicators

Such indicators include immunisation and nutrition programme coverage rates (especially for measles), Vitamin A, Iodine or other micronutrient deficiencies, disease morbidity, trauma experience, infant and under-5 death rates and cause of death where appropriate.

Micro-nutrient deficiencies

If there is Vitamin A, iodine, zinc or iron deficiency before a crisis, the crisis will exacerbate the deficiency. There may be outbreaks of pellagra, beriberi, scurvy or other micro-nutrient deficiency diseases. If people with these deficiencies attend health centres, it is probably indicative of a population-wide problem. Indirect assessment of micro-nutrient deficiencies involves estimating nutrient intakes at the population level and extrapolating deficiency risk.

To do this, review available data on food access, availability and utilisation (see Food security and nutrition assessment standard X) and assess food ration adequacy (see Food security – food transfers standard X). Direct assessment, where feasible, involves measuring clinical or subclinical deficiency in individual patients or a population sample. For example, measuring haemoglobin through surveys in which the prevalence of anaemia can serve as a proxy measure of iron deficiency.

Interpreting levels of undernutrition

Determining whether undernutrition need intervention requires detailed analysis. This should consider the reference population size and density as well as morbidity and mortality rates (see Essential health services standard x). It also requires reference to:

- health indicators;
- seasonal fluctuations;
- IYCF indicators;
- pre-crisis levels of undernutrition;
- levels of micronutrient deficiencies (see Appendix X: Measures of the public health significance of micronutrient deficiencies);
- the proportion of severe acute malnutrition in relation to global acute malnutrition; and
- a gender analysis of different nutrition levels for males and females.

A combination of complementary information systems may be the most cost-effective way to monitor trends. It may be appropriate to apply decision-making models and approaches which consider several variables including food security, livelihoods, and health and nutrition (see Food security and nutrition assessment standard X).

Wherever possible, local institutions and populations should participate in monitoring activities, interpreting findings, and planning responses.

Decision-making

Decisions to implement general food distribution or other preventative or immediate treatment interventions in the acute phase of a crisis do not need to wait for the results of in-depth analyses. They should lead to quick actions based on findings and the existing capacity to respond.

References and further reading

1. *Reference to LEGs Assesment Checklist (Pages 47 – 51)*
2. *Tier ranking from the IWA interim ISO standards-*
3. <http://cleancookstoves.org/technology-and-fuels/standards/iwa-tiers-of-performance.html>
4. Food security cluster urban group tools and pilot projects:
<http://fscluster.org/page/urban-food-security>
5. Preparedness guidance:
<http://documents.wfp.org/stellent/groups/public/documents/resources/wfp251892.pdf>
6. Food Security Cluster Core Indicators Handbook <http://fscluster.org/programme-quality-working-group/document/fsc-core-indicator-handbook>
7. CaLP 2013: Minimum Standard for Market Analysis (MISMA)
8. https://www.unicef.org/protection/alternative_care_Guidelines-English.pdf
9. Please reference the Food Security and Nutrition guidance note of IASC GBV Guidelines, 2015, available at www.ggbvguidelines.org
10. <http://www.helpage.org/resources/publications/?ssearch=nutrition&adv=0&topic=0®ion=0&language=0&type=0>
11. UN General Assembly (2010) Guidelines on Alternative Care of Children, UN Doc. A/RES/64/142
12. UN OCHA (2014) Humanitarian Civil-Military Coordination: A Guide for the Military. Available from: <https://docs.unocha.org/sites/dms/Documents/UN%20OCHA%20Guide%20for%20the%20Military%20v%201.0.pdf>
13. UN OCHA (2015) UN-CMCoord Field Handbook. Available from: <https://www.unocha.org/legacy/what-we-do/coordination-tools/UN-CMCoord/publications>
14. MISMA
15. Household Economy Approach (HEA)

2. Prevention and treatment of malnutrition

Malnutrition may be chronic or acute. Chronic malnutrition cannot generally be reversed or treated. Acute malnutrition, which might be triggered in a crisis, can be prevented and corrected with appropriate nutrition interventions.

Long-term health consequences of malnutrition include restricted physical and cognitive development. Nutrition services can therefore reduce morbidity and mortality rates in affected populations. Interventions are unlikely to be effective without understanding the underlying causes of malnutrition, which are usually complex. A multisectoral response is therefore essential to addressing all the causes and their interactions.

Community-based Management of Acute Malnutrition (CMAM) includes several components:

- inpatient care for people who present Severe Acute Malnutrition (SAM), with medical complications and all infants under six months old with SAM;
- outpatient care for children with SAM without medical complications;
- community outreach; and
- other context-specific services or programmes for individuals with moderate acute malnutrition (MAM).

This section includes three standards, addressing moderate acute malnutrition (MAM), severe acute malnutrition (SAM) and micronutrient deficiency.

There are a number of ways to address moderate acute malnutrition. In disasters, supplementary feeding is often the primary strategy for prevention and treatment of moderate acute malnutrition and prevention of severe acute malnutrition. This may be blanket (for prevention) or targeted (for treatment) depending on the levels of acute malnutrition, vulnerable population groups and risk of an increase in acute malnutrition. The indicators in management of acute malnutrition and micronutrient deficiencies standard 1 refer primarily to targeted supplementary feeding.

Blanket Supplementary Feeding Programmes (BSFP) are recommended in contexts where food insecurity is high (and therefore need to expand intervention beyond MAM cases), and when accompanied by general food distribution targeting affected households. While there are no defined impact indicators for blanket supplementary feeding, monitoring of coverage, adherence, acceptability and rations provided are important.

A variety of approaches are used for severe acute malnutrition care. Community-based management of acute malnutrition should be the preferred approach where conditions permit. Programmes addressing acute malnutrition should encompass community mobilisation (including effective communication, active case-finding, referral and follow-up), outpatient treatment for severe acute malnutrition without medical complications and inpatient management for those with medical complications or young infants.

Micronutrient deficiencies are difficult to identify in many contexts. While clinical signs of severe deficiencies may be easiest to diagnose, the greater burden on the health and survival of populations may be subclinical deficiencies. Assume that micronutrient deficiencies are exacerbated by the disaster when they have already been prevalent in the population. Tackle these deficiencies using population-wide interventions and individual treatment. Emergency conditions exacerbate micronutrient deficiencies which is linked to stunting, which can result from a lack of access to the appropriate micronutrients and macronutrients during the first 1000 days (from conception to 2 years). Children who are wasted and stunted have the highest risk of morbidity and mortality. Unlike wasting, stunting develops through a slow cumulative process and may not be evident for some years. Chronic malnutrition cannot generally be reversed or treated, but it can be prevented. In the long term, extended micronutrient deficiencies impact on child development, brain development, learning capacities, etc. An integrated approach is needed to prevent malnutrition, which includes blanket supplementary feeding programmes.

Prevention and treatment of malnutrition. Standard 2.1:

Moderate acute malnutrition

Prevent and manage moderate acute malnutrition

Key action 1: Establish clearly defined and agreed strategies, objectives and criteria for set-up and closure of interventions.

Key action 2: Maximise access and coverage of SAM interventions through community engagement from the beginning.

Key action 3: Establish admission and discharge protocols of individuals, based on nationally and internationally accepted anthropometric criteria.

- Discharge criteria should be consistent with national guidelines (or, if not available, international guidelines).
- Specify the discharge criteria when reporting performance indicators (see What else do I need to know 5).

Key action 4: Link the management of moderate acute malnutrition to the management of severe acute malnutrition and existing health services.

- Maintain links to therapeutic care, health systems (including seasonal malaria prevention), HIV and tuberculosis (TB) networks and food security programmes including food, cash or voucher transfers.
- Refer children with malnutrition to stimulation programmes to reduce the chance of developmental disability and to enhance child development.

Key action 5: Provide dry rations or suitable ready-to-use supplementary food rations, unless there is a clear rationale for on-site feeding.

- Provide rations, on a weekly or biweekly basis in preference to on-site feeding.
- Consider household composition and size, household food security and the likelihood of sharing.
- Provide clear information on how to hygienically prepare and store supplementary food, and how and when to consume it.

Key action 6: Emphasise protecting, supporting and promoting breastfeeding, complementary feeding and hygiene.

- Admit breastfeeding mothers of acutely malnourished infants under six months to supplementary feeding, independent of maternal nutrition status.
- Provide clear information on the importance of continued breastfeeding for children under 24 months.
- Suggest adding “Ensure that the household food needs of acutely malnourished infants are being met.

Key indicators
<p><i>Percentage of the target population less than one day's return walk (including time for treatment) from the programme site for dry ration supplementary feeding programmes and no more than one hour's walk for on-site supplementary feeding programmes.</i></p> <ul style="list-style-type: none"> • >90% of target population can access dry ration supplementary feeding site within one day • >90% of target population can access on-site programmes within one hour
<p><i>Percentage of affected population with access to treatment services</i></p> <ul style="list-style-type: none"> • >50% in rural areas. • >70% in urban areas • >90% in formal camps
<p>The proportion of discharges from targeted supplementary feeding programmes who have died, recovered and defaulted.</p> <ul style="list-style-type: none"> • Died: <3 percent. • Recovered: >75 percent. • Defaulted: <15 percent >75%.

What else do I need to know?

Supplementary feeding

There are several ways to deal with moderate acute malnutrition. In crises, supplementary feeding is often the primary strategy for prevention and treatment of moderate acute malnutrition. This may be blanket (for prevention) or targeted (for treatment), depending on the levels of acute malnutrition, vulnerable affected people and risk of an increase in acute malnutrition. Blanket Supplementary Feeding Programmes (BSFP) are recommended in contexts where food insecurity is high and requires a general intervention beyond MAM cases, and when accompanied by general food distribution targeting affected households. While there are no defined impact indicators for blanket supplementary feeding, monitoring of coverage, adherence, acceptability and rations provided are important. Assess availability of supplementary foods on national or international markets (*see 'delivering through Markets annexe'*) and factor in potential pipeline constraints into your programme planning.

Treatment or prevention

Take a targeted approach to supplementary feeding to treat acute malnutrition, or a blanket approach to prevent it. The decision regarding which approach to take will depend on:

- levels of acute malnutrition and size of the affected population;
- risk of increased morbidity;
- risk of decreased food security;
- population displacement and density;
- capacity to screen and monitor the affected population using anthropometric criteria; and
- available resources and access to the disaster-affected people.

Targeted supplementary feeding generally requires more time and effort to properly screen and monitor individuals with acute malnutrition, but it also requires fewer food resources. A blanket approach generally requires less staff expertise but more food resources.

Effective community mobilisation

Effective community mobilisation will support the population's understanding and effectiveness of the programme. Involve the affected people in deciding where to locate programme sites. Consider at risk groups who may face difficulties in accessing sites. Contemplate exit strategies or plans for longer-term support through the existing health system from the outset.

Coverage

"Coverage" refers to the proportion of individuals who need treatment and are receiving treatment. When reviewing coverage, consider:

- the acceptability of the programme;
- location and accessibility of programme sites;
- security situation;
- frequency of distributions;
- waiting time;
- service quality;
- extent of mobilisation;
- Availability of male and female nutrition staff;
- extent of home visiting and screening; and
- admission criteria alignment on coverage.

Coverage assessment methodologies are costly and require specially trained staff. There is often a need to find simple mechanisms to gauge coverage levels in situations where coverage surveys are not practical or feasible. Consult the existing national guidance when deciding which method is appropriate. Routine

monitoring of admission data is a good way to measure programme coverage. In the absence of significant changes in the programme area like population movement, use of a new treatment product or protocol, there might be no need to conduct a coverage assessment on an annual basis. Routine programme data like screening, referrals and admissions can be used to estimate coverage.

Programme admission criteria

Individuals who do not meet anthropometric criteria defining acute malnutrition may benefit from supplementary feeding. For example, people living with HIV or TB, people discharged from care but requiring therapeutic support to avoid relapse, individuals with other chronic diseases, or persons with disabilities. Adjust monitoring and reporting systems if such individuals fall outside of anthropometric criteria.

Monitoring discharged individuals ending treatment

The number of discharged individuals includes those who have recovered, died, defaulted or not recovered. Individuals referred for complementary services (such as health services) have not ended the treatment and will either continue treatment or return to the treatment later. Do not include individuals transferred to other sites or who have not ended the treatment in discharge statistics.

If individuals join a nutrition programme following discharge from therapeutic care, report them as a separate category, to avoid biasing results. If an individual develops acute malnutrition symptoms as a result of other factors such as disability, lip/ palate or surgical problems, include them in programme reporting.

Calculate discharge statistics as follows:

- Percentage of discharges recovered = Number of individuals recovered/ Total number of discharged x 100%
- Proportion of discharges died = Number of deaths/Total number of discharged x 100%
- Proportion of discharges defaulted = Number of defaulters/Total number of discharged x 100%
- Proportion of discharges non-recovered = Number of individuals not recovered/Total number of discharged x 100%

In addition to the indicators outlined above, monitoring systems should include:

- the population's participation;
- acceptability of the programme (the default and coverage rate could be used as a proxy measure of this);
- the quantity and quality of food;
- coverage;
- reasons for transfers to other programmes (particularly children whose nutritional status deteriorates to severe acute malnutrition); and
- number of individuals admitted and in treatment.

Consider external factors such as:

- morbidity patterns;
- levels of undernutrition in the population;
- level of food insecurity in households and in the population;
- complementary interventions available to the population (including general food distributions or equivalent programmes); and
- the capacity of existing systems for service delivery.

Investigate causes of defaulting and failure to adequately respond to treatment with an ongoing analysis of how gender norms and practices may influence access to treatment as well as treatment default and recovery.

Health inputs and considerations

Targeted supplementary feeding programmes are an important contact point for disease screening and referral. Programmes should consider the capacity of existing health services, and ensure provision of:

- antihelminthics;
- vitamin A supplementation;
- iron and folic acid combined with malaria screening and treatment;
- zinc for treatment of diarrhoea; and
- immunisations.

See also: Health Chapter, control of communicable disease standard and child health standards.

In areas of high HIV prevalence, consider whether the quality and quantity of the supplementary food ration should be adjusted.

IYCF

Moderately malnourished mothers can successfully breastfeed and need adequate nutrition support to protect their own nutritional status. Mothers should receive supplementary feeding rations, skilled breastfeeding support on exclusive breastfeeding and advice on safe, nutritious and responsive complementary feeding. Refer acutely malnourished infants under six months for skilled breastfeeding support and inpatient care as necessary.

Rations

Vulnerable people, such as people with difficulties moving or feeding, may require programme adaptations to meet their specific needs.

<p>Prevention and treatment of malnutrition. Standard 2.2: Severe acute malnutrition</p> <p>Severe acute malnutrition is treated.</p>
<p>Key action 1: Establish from the outset clearly defined and agreed criteria for set-up or increased support to existing services and for scale-down or closure.</p>
<p>Key action 2: Include inpatient care, outpatient care, referral and population mobilisation components in the management of severe acute malnutrition.</p>
<p>Key action 3: Provide nutritional and medical care according to nationally and internationally recognised CMAM guidelines for the management of severe acute malnutrition.</p>
<p>Key action 4: Establish discharge criteria that includes both anthropometric and other indices.</p>
<p>Key action 5: Investigate and act on causes of default and non-response or an increase in deaths, including reasons for any death.</p>
<p>Key action 6: Address IYCF with particular emphasis on protecting, supporting and promoting breastfeeding, complementary feeding and hygiene promotion.</p>
<p>Key indicators</p>
<p><i>Percentage of the target population less than one day's return walk (including time for treatment) to the programme site.</i></p> <ul style="list-style-type: none"> • >90% of the target population.
<p><i>Coverage of treatment services</i></p> <ul style="list-style-type: none"> • >50% in rural areas, • >70% in urban areas • >90% per cent in a camp situation <p>(See what else do I need to know 2).</p>
<p><i>The proportion of discharges from therapeutic care who have died, recovered and defaulted.</i></p> <ul style="list-style-type: none"> • Died: <10 per cent. • Recovered: >75 per cent. • Defaulted: <15 per cent.
<p>What else do I need to know?</p> <p>Programme design</p> <p>Design programmes that build on and support existing health system capacity wherever possible. Base them on existing capacity at health facility and community levels, the numbers and geographical spread of disaster-affected individuals and the security situation.</p>

Programme components

Programmes addressing the management of severe acute malnutrition should provide inpatient care for individuals with medical complications, and all infants below six months of age with acute malnutrition. Inpatient care may be through direct implementation or referral. Programmes should provide decentralised outpatient care for children with no medical complications. Link programmes with other relevant services, such as:

- supplementary feeding,
- HIV and TB networks;
- rehabilitation;
- primary health services; and
- food security programmes including food or cash-based assistance.

Outpatient programme sites should be close to the targeted population to reduce the risks and costs associated with travelling with young children, and the risk of displacement.

Coverage

Coverage assessment methodologies, including challenges and factors that affect programme coverage are the similar in both severe acute malnutrition and moderate acute malnutrition programmes. (Prevention and management of malnutrition standard 1, Food Security and nutrition chapter).

Guidelines

Adhere to national guidelines where they exist. In the absence of national guidelines or where they do not reach international normative standards, adopt international standards (or guidelines based on those standards). Find the internationally accepted guidelines in the References and further reading section.

Admission criteria

Admission criteria should be consistent with national and international guidance (see Appendix X: Measuring acute malnutrition, and References and further reading). Admission criteria for infants below six months, and groups whose anthropometric status is difficult to determine, should include clinical and breastfeeding status. Individuals who are (or are suspected to be) HIV-positive, those who have TB, or are chronically ill should have equal access to care if they meet the criteria for admission. People living with HIV who do not meet admission criteria often require nutritional support. Such support is better offered outside the context of treatment for severe acute malnutrition in crises. Provide these individuals and their families with a range of services including community home-based care, TB treatment centres and prevention of mother to child transmission programmes.

Discharge criteria and recovery

Discharged individuals must be free from medical complications. In addition, they should have regained their appetite and have achieved and maintained appropriate weight gain without nutrition-related oedema (for example, for two consecutive weighings). Calculate mean weight gain separately for individuals with and without nutritional oedema. Breastfeeding is especially important for infants under six months as well as for children to twenty-four months. Non-breastfed infants will need close follow-up. Adhere to discharge criteria in order to avoid the risks associated with premature discharge.

CMAM guidelines specify the average length of stay for treatment and are aimed at shortening recovery periods. Adhere to the existing national guidelines when calculating the mean length of stay as these depend on the context. HIV and TB may result in some malnourished individuals failing to respond to treatment. Consider options for longer-term treatment or care with health services and other social and community support services for malnourished individuals who fail to respond to treatment (See Health standard XX).

Performance indicators for the management of severe acute malnutrition

Performance indicators for the management of severe acute malnutrition should combine inpatient and outpatient care outcomes without double counting (that is, removing transfers between the two components). Where this is not possible, adjust the interpretation of outcome rates accordingly. For example, programmes should expect better performance indicators where implementing outpatient care alone, and should strive for the indicators as outlined for combined care when implementing inpatient care alone. The population of discharged individuals for severe acute malnutrition is made up of those who have recovered, died, defaulted, or not recovered (see Management of acute malnutrition and micronutrient deficiencies standard X).

Individuals who are referred to other services (for example, medical services) have not ended treatment. Where programmes report for outpatient treatment only, report transfers to inpatient care when assessing performance. Factors such as HIV clinical complexity will affect mortality rates where a proportion of the admitted are HIV positive. Though performance indicators have not been adjusted for these situations, their consideration is essential during interpretation. In addition to discharge indicators, assess age and sex disaggregated data of new admissions, number of children in treatment and coverage rates when monitoring performance. Investigate and document causes of readmission, proportion of readmissions, deterioration of clinical status, defaulting and failure to respond on an ongoing basis. Adapt the definition of these to guidelines in use and whenever feasible, disaggregated by sex and age.

Health inputs

All severe acute malnutrition programmes should include systematic treatments according to national or international guidance. They should also include a referral mechanism for managing of underlying illness such as TB and HIV. In areas of high HIV prevalence, malnutrition programmes should consider interventions that seek to avoid HIV transmission, and that support maternal and child survival. In settings where HIV infection is common (HIV prevalence more than 1%), children with malnutrition should be tested for HIV, in order to establish their HIV status and to determine their need for antiretroviral drug treatment. Effective referral systems for TB and HIV testing and care are essential.

Breastfeeding support

Infants who are admitted for inpatient care tend to be among the most unwell. Mothers need skilled breastfeeding support as part of nutritional rehabilitation and recovery, particularly for children below six months and mothers with disabilities.

Provide sufficient time and resources such as a designated private area (breastfeeding corner) to target skilled support and enable peer support. Breastfeeding mothers of severely malnourished infants under six months should receive a supplementary food ration regardless of their nutritional status. If those mothers meet the anthropometric criteria for severe acute malnutrition, admit them for treatment.

Psychosocial support

Emotional and physical stimulation through play is important for children with severe acute malnutrition during the rehabilitation period. Caregivers of such children often require social and psychosocial support to bring their children for treatment. This may be achieved through mobilisation programmes, which should emphasise stimulation and interaction, for treatment and prevention of future disability and cognitive impairment (see Protection Principle X on page XX). Enable all caregivers of severely malnourished children to feed and care for their children during treatment through the provision of advice, demonstrations and health and nutrition information. Attention should be paid to the impact of treatment on the caregivers and other siblings to ensure adequate child care arrangements, avoid family separation, minimise psychosocial distress and maximise the potential treatment adherence.

Women- and child-friendly treatment sites

Establish women and child friendly treatment sites. In coordination with child protection and GBV partners, establish referral pathways and information sharing protocols, and provide training to nutrition staff

regarding the provision of supportive and confidential referral for caregivers or children exposed to physical, sexual or emotional violence, exploitation or abuse.

Prevention and treatment of malnutrition. Standard 2.3:

Micronutrient deficiencies

Micronutrient interventions complement public health and other nutrition interventions to reduce common diseases associated with emergencies.

Key action 1: Collect information on pre-crisis situation to determine the most common micronutrient deficiencies.

Key action 2: Train health staff in how to identify and treat micronutrient deficiencies.

Key action 3: Establish procedures to respond effectively to the types of micronutrient deficiencies from which the population may be at risk.

Key indicators

Percentage of targeted/affected population whose micronutrient needs are met using evidence-based interventions.

- >90%

Number of micronutrient interventions that complement public health interventions to reduce common diseases associated with emergencies. Example include Vitamin A (to manage measles) and zinc (to manage diarrhoea).

- National/context specific standards.

What else do I need to know?

Diagnosis of clinical micronutrient deficiencies

Diagnosis of clinical micronutrient deficiencies is sometimes possible through simple examination. When clinical indicators of these deficiencies are incorporated into health or nutritional surveillance systems, train staff to conduct the assessment. Case definitions are problematic. In crises, determine them through the response to supplementation by individuals who present themselves to health staff.

Treatment of micronutrient deficiencies

Treatment of micronutrient deficiencies should involve active case-finding and the use of agreed case definitions and guidelines for treatment. Case-finding and treatment should occur within the health system and within feeding programmes. Where the prevalence of micronutrient deficiencies exceeds public health thresholds, blanket treatment of the population with supplements may be appropriate (see Appendix 5: Measures of the public health significance of micronutrient deficiencies). Scurvy (Vitamin C deficiency), pellagra (niacin deficiency), beriberi (thiamine deficiency) and ariboflavinosis (riboflavin deficiency) are the most commonly observed epidemics to result from inadequate access to micronutrients in food aid-

dependent populations. Address deficiencies by population-wide interventions as well as individual treatment.

Subclinical micronutrient deficiencies

Subclinical micronutrient deficiencies can have adverse health outcomes but identification requires biochemical examination. An exception is anaemia, for which a basic test is available and is easily undertaken in the field.

Public health measures to control micronutrient deficiencies

- Vitamin A supplementation with vaccination for 6-59 months;
- Deworm all children (12-59 months old);
- Ensure iodised salt is included in the food basket or consider iodised oil supplements;
- Ensure provision of iron-containing multiple micronutrient products for children 6-59 months;
- Ensure provision of daily iron-containing multiple micronutrient supplements for pregnant and lactating women.

If multiple micronutrient products containing iron are not available, provide daily iron and folic acid supplements (according to WHO guidelines 2016 regimen) to pregnant and postpartum (up to 45 days) women. In addition, UNHCR and other technical humanitarian organisations recommend that salt is fortified with iodine, oil with vitamin A and D, and wheat and maize flour with multi-micronutrients. Use sex-disaggregated indirect indicators to assess the risk of deficiencies in the affected population, and determine the need for improved dietary intake or the use of supplements (see Food security and nutrition assessment standard X)

Prevention

Control of diseases is critical in the prevention of micronutrient deficiencies. Such diseases include acute respiratory infection, measles, parasitic infections such as malaria, and diarrhoea, which deplete micronutrient stores (see Essential health services – child health standards X). Preparedness for treatment will involve the development of case definitions and guidelines for treatment, and systems for active case-finding.

3. Infant and Young Child Feeding

Appropriate and timely support of infant and young child feeding in emergencies (IYCF-E), saves lives and protects child nutrition, health, and development. Inappropriate infant and young child feeding practices undermine maternal health and increases both mother and child's vulnerability to undernutrition, disease, and death. Crises increase risk. The youngest children are most vulnerable.

Some infants and young children are particularly vulnerable, including:

- those from populations with medium or high HIV prevalence.
- Separated and unaccompanied children including orphans;
- low birth weight (LBW) infants;
- children with disabilities, in particular those with feeding difficulties;
- children under two years not breastfeeding;
- acutely malnourished infants and young children; and
- Infants and children of depressed mothers.

IYCF concerns actions and interventions to protect and support the nutritional needs of both breastfed and non-breastfed infants and young children 0–23 months. Priority interventions include:

- breastfeeding protection and support;
- management of artificial feeding for infants with no possibility to breastfeed; and
- enabling appropriate and safe complementary feeding.

Support of pregnant and breastfeeding women is central to the well-being of their children.

“Exclusive breastfeeding” means an infant receives no liquids other than breastmilk, and no solids, except for necessary micronutrient supplements or medicines. It guarantees food and fluid security in infants for the first six months and provides active immune protection. Breastfeeding ensures optimal brain development and continues to protect the health of older infants and children, especially in contexts where WASH conditions are lacking. Breastfeeding also protects maternal health by delaying menstruation and protecting against breast cancer. Protect, promote and support early initiation of exclusive breastfeeding in all newborn infants. Integrate the 10 Steps to Successful Breastfeeding in maternity services from the Baby Friendly Hospital Initiative (BFHI). Key interventions include skin-to-skin contact, kangaroo care for low birth weight and premature infants, and delayed umbilical cord cutting

The key actions in this section are guided by the principles of The Operational Guidance on Infant and Young Child Feeding in Emergencies (OG- IYCF-E). The OG is a product of an interagency Working Group whose aim is to provide concise, practical guidance on how to ensure appropriate IYCF-E and the International Code of Marketing of Breastmilk Substitutes (“the Code”)

Food security and nutrition, infant and young child feeding. Standard 3.1:

Policy guidance and coordination

Policy guidance and coordination ensure safe, timely, and appropriate infant and young child feeding.

Key action 1: Establish IYCF-E coordination authority within the emergency coordination mechanism and ensure collaboration across sectors.

- Wherever possible, government is the lead coordinating authority.

Key action 2: Include the specifications of the Operational Guidance on IYCF-E in relevant national and humanitarian organisation policy guidance in preparedness.

- Encourage governments to apply the Operational Guidance on IYCF-E in their national and international preparedness plans and emergency responses
- Where there is no policy, develop guidance in collaboration with national authorities.
- Strengthen relevant national policies wherever possible.

Key action 3: Support strong, harmonised, timely communication on IYCF-E at all response levels.

- If an IYCF-E policy is in place, inform relevant actors, donors, and media about it shortly after onset of the emergency.
- Communicate with affected populations about services available, IYCF-E practices, as well as feedback and complaints mechanisms
- Provide targeted messages to aid providers and the media about IYCF-E policies and practices

Key action 4: Mitigate and manage potential risks associated with inappropriate donations of breastmilk substitutes (BMS), other liquid milk products, feeding bottles and teats.

- Ensure that you fully understand and appropriately apply the International Code of Marketing of Breastmilk Substitutes
- Ensure strict targeting and use, procurement, management and distribution of BMS. This must be based on needs and risk assessment, data analysis and technical guidance.
- Plan any BMS distribution in close consultation with the coordination authority.

Key indicators

Number of national or humanitarian organisation policies adopted that address IYCF-E in emergencies and reflect the specifications of the Operational Guidance on IYCF-E.

- 100% during preparedness or within four weeks of the emergency onset.

Designation of a lead coordinating authority on IYCF-E in place all the time.

- Within 72 hours after the emergency onset.

Designation of a body for reporting on code violations and dealing with donations of breastmilk substitutes, liquid milk products, bottles, and teats.

- Within 72 hours after the emergency onset.

What else do I need to know?

Policy

Key policy documents that inform emergency programmes include the Operational Guidance on IYCF-E and the International Code. Ideally such guidance is in the preparedness phase policy. Early in an emergency response and in the absence of a clear policy, issue an interagency joint statement between government, humanitarian organisations and across sectors. This statement should be endorsed by relevant authorities who can provide context-specific rapid guidance.

Coordination

Wherever possible, establish the capacity to coordinate IYCF-E within the coordination mechanism of an emergency response.

Communication with the affected population, responders, and media

Communications include messaging about services available and about IYCF practices; adapted messaging for groups providing assistance; press releases; messaging for different media; and feedback and complaint mechanisms for the affected population. Consider the need to support caregivers who are grandparents, living with HIV, single parents, child-headed households or siblings and caregivers with disabilities when generating messages.

International Code of Marketing of Breastmilk Substitutes

Ideally, the Code applies in all contexts and should be enacted into legislation during the preparedness phase and enforced during the emergency response. In the absence of national legislation, implement the Code provisions at a minimum. The Code does not restrict the availability of BMS, feeding bottles or teats; it only restricts their marketing and distribution. The Code does not prohibit the use of BMS during emergencies. The Code governs their procurement and distribution. The Code intends to protect artificially fed babies by ensuring safe use of BMS based on impartial, accurate information. Common Code violations in emergencies derive from labelling issues and untargeted distribution. During emergencies report Code violations to UNICEF, WHO, and local authorities.

Artificial feeding

In emergencies, all BMS must comply with Codex Alimentarius and the Code. Access to adequate WASH services is essential to minimise the risks of artificial feeding in emergencies. The distribution system for BMS supplies will depend on the context, including the scale of intervention. Do not include infant formula and other BMS in general or blanket distributions. Do not distribute dried liquid milk products and liquid milk as a single commodity.

Donations

Do not send or solicit donations of BMS, complementary foods and feeding equipment such as bottles, teats, and breast pumps. Implement strong communication in this regard in the early phase of a response. Target communication at groups outside the official coordination mechanisms, such as the general media, the military and voluntary groups. Report offers of or actual donations and untargeted distributions of BMS, complementary foods, and feeding equipment to the coordinating authority.

Food security and nutrition, infant and young child feeding. Standard 3.2: Multisectoral support to IYCF-E response

Mothers and caregivers of infants and young children have access to timely and appropriate feeding support that minimises risks, is culturally sensitive and optimises nutrition, health and survival outcomes.

Key action 1: Prioritise pregnant and breastfeeding women for access to food, cash, or voucher transfers and other supportive interventions.

Key action 2: Enable access to skilled breastfeeding counselling for pregnant and breastfeeding mothers.

- Document capacity for IYCF-E including the number of available counsellors, trained health workers, and other support services and their capacity.

Key action 3: Target mothers of all newborns with support for early initiation of exclusive breastfeeding.

- Consider including useful and simple guidance to exclusive breastfeeding in maternity services (see also references and Toolbox)
- Protect, promote and support exclusive breastfeeding in infants 0-5 months of age and continued breastfeeding in children aged six months to two years and beyond.
- Where mixed feeding is practised in infants 0-5 months, support transitioning to exclusive breastfeeding.

Key action 4: Provide appropriate BMS, feeding equipment, and associated support to mothers and caregivers whose infants require artificial feeding.

- Explore the safety and viability of relactation, and wet nursing where infants are not breastfed by their mother. Consider the cultural context and service availability in such situations.
- If these options are not acceptable to caregivers, or not feasible to deliver safely and sustainably, access to an assured appropriate BMS supply is necessary.
- When BMS supply is provided, it should include an essential package of support with cooking and feeding equipment, minimum WASH standards, and access to healthcare services.
- Infant formula is the appropriate BMS for infants 0-5 months of age. Give preference to ready-to-use infant formula (RUIF) in liquid form, since it does not require preparation and carries fewer safety risks than powdered infant formula.

Key action 5: Support timely, safe, adequate and appropriate complementary feeding.

- Assess if household foods are suitable for complementary foods for children.
- Provide context-specific advice and support on complementary feeding.
- Ensure access to feeding equipment and cooking supplies, with considerations for children with feeding difficulties.
- Coordinate with WASH services to enable access of families with young children to minimum WASH standards.

Key action 6: Provide feeding support to particularly vulnerable infants and young children.

- Consider populations with medium or high HIV prevalence, separated and unaccompanied children including orphans, low birth weight (LBW) infants, children with disabilities with feeding difficulties, children under two years of age not breastfeeding, and those acutely malnourished. Be aware that children of mothers with depression tend to be at higher risk of malnutrition.
- Support activities around infant stimulation and early child development care practices within nutrition programmes.
- Mothers living with HIV should breastfeed for at least 12 months and may continue breastfeeding for up to 24 months or longer while being supported for ART adherence. In circumstances in which ARV drugs are unlikely to be available, such as acute emergencies, breastfeeding of HIV-exposed infants is also recommended to increase survival.
- Choose the strategy that gives infants the greatest chance of HIV-free survival, balancing risks of HIV transmission versus non-HIV causes of child death, and support mothers and caregivers accordingly.

Key action 7: Provide micronutrient supplements as necessary.

- For children aged 6-59 months, multiple micronutrient supplements may be necessary to meet nutrition requirements where fortified foods are not provided. Vitamin A supplements are recommended.
- In malaria-endemic areas, provide iron in any form, including MNPs, and always in conjunction with malaria diagnosis, prevention and treatment strategies.
- Do not provide iron to children who do not have access to malaria-prevention strategies.
- Provide daily supplements to pregnant and breastfeeding women, including one daily requirement of multiple micronutrients to protect maternal stores and breastmilk content, whether the women receive fortified rations or not.
- Continue iron and folic acid supplements when already provided.

Key action 8: Anticipate and assess the impact of human and animal infectious disease outbreaks on IYCF.

Key indicators

Percentage of breastfeeding mothers who have access to skilled counselling

- National or context-specific standards. (100% of 0-5 months)

Percentage of caregivers who have access to Code-compliant supplies of appropriate BMS and associated support for infants who require artificial feeding.

- National or context-specific standards.

Percentage of caregivers who have access to timely, appropriate, nutritionally adequate and safe complementary foods for children 6 to 23 months.

- National or context-specific standards.

What else do I need to know?

IYCF-E Assessment and Monitoring

Assess the needs and priorities for IYCF emergency response and monitor impact of IYCF-E interventions (see FSN assessment standard 2).

Multisectoral collaboration

Collaborate across sectors to protect, promote and support recommended IYCF practices, as well as minimise risks of prevalent practices. Key opportunities include collaboration with sectors and themes covered in the Sphere Handbook.

Sectoral entry points to identify and support IYCF include:

- ante-natal and post-natal care;
- immunisation points;
- growth monitoring;
- PMTCT;
- HIV treatment services;
- acute malnutrition treatment;
- community health;
- mental health and psychosocial support;
- WASH services;
- places of employment; and
- agriculture extension work.

Target groups

- Disaggregate assessment and programme data for children under five years by age and sex as follows: 0-5 months, 6-11 months, 12- 23 months, 24–59 months and the proportion of pregnant and lactating women. Identify and establish services to provide for the nutritional and care needs of children with disabilities, separated and unaccompanied infants and young children. Refer separated and unaccompanied children to child protection partners.

Breastfed infants

- Ensure birth registration of newborns within two weeks of delivery. Coordinate with other sectors (such as health, food security and social protection) to facilitate service access. Planning and resource allocation should allow for skilled breastfeeding support in managing more difficult situations. Difficult situations could include stressed populations, acutely malnourished infants under six months, populations where mixed feeding is common, and infant feeding in the context of HIV.

Non-breastfed infants

- In all emergencies, intervene to protect and support infants and young children who are not breastfed to meet their nutritional needs and minimise risks. The consequences of not breastfeeding are influenced by the age of the child. The youngest children are most vulnerable to the infectious disease environment. They depend on access to assured supplies of appropriate BMS, fuel, and equipment; and WASH conditions.

Infant formula

- Appropriate use, careful storage and hygiene of feeding utensils remains essential for RUIF to minimise risks. RUIF is more expensive and bulky to transport and store. In children over six months of age, use alternative liquid milks. Possibilities for alternative liquid milks are pasteurised full-cream animal liquid milk from a cow, goat, sheep, camel or buffalo; Ultra High Temperature (UHT) liquid milk; fermented liquid milk; or yogurt as a BMS. Use of infant formula in children over six months of age will depend on pre-emergency practices, resources available, sources of alternative liquid milks, adequacy of complementary foods, and humanitarian organisation policy. Indications for BMS use may be short or

longer term (see Operational Guidance on IYCF-E). Follow-on, growing-up liquid milks, and toddler liquid milks marketed to children over six months of age are not necessary.

- Target the supply of infant formula to infants requiring it. This can be determined by individual level assessment by a qualified health or nutrition worker, and with individual level follow-up and support. Provide infant formula for as long as the infant needs it, until the child is breastfeeding or until at least six months of age. Make sure the provision of BMS to children who need it does not encourage breastfeeding mothers to use it also. Where individual level assessment is not possible due to restricted access to those affected, consult with the coordinating authority and technical humanitarian organisations for advice on assessment and targeting criteria. Do not use feeding bottles. They are difficult to clean. Encourage and support cup feeding. Conduct morbidity surveillance at individual and population levels, with a focus on diarrhoea.

Complementary feeding

- Complementary feeding includes continued breastfeeding or access to an appropriate BMS, complementary food access, and advice or counselling on practices. Tools are available to help with nutrient gap analysis.
- Key considerations in determining complementary feeding response include pre-existing and existing nutrient gaps; seasonality; socio-cultural aspects; food security; current access to appropriate foods; quality of locally available complementary foods including commercial products; compliance of available products to the Code; proportion of non-breastfed infants and children; reports of children with disabilities; maternal nutrition; WASH conditions; the nature and capacity of existing markets and delivery systems; and national legislation related to food and drugs, particularly importation.
- Complementary feeding interventions will depend on the context, objectives, and timeframe of the response. Options include the following: cash-based assistance. to purchase locally available fortified and nutrient-rich foods; distribution of nutrient-rich household foods or fortified foods; provision of multiple-micronutrient fortified foods to children 6-23 months; home fortification with micronutrient supplements, such as micronutrient powders (MNP) or other supplements; livelihood programmes and safety net programmes.

Micronutrient supplementation

- For children aged 6-59 months, multiple micronutrient supplements may be necessary to meet nutrition requirements where fortified foods are not provided. Other interventions may be needed to improve complementary foods and feeding practices. Examples of malaria-prevention strategies are provision of insecticide-treated bed nets and vector-control programmes, prompt diagnosis of malaria illness, and treatment with effective anti-malarial drug therapy. For pregnant and lactating women, iron and folic acid or multiple micronutrient supplementations should be provided in accordance with the latest guidance.

Pregnant and breastfeeding women

- Ensure food needs of pregnant and breastfeeding women are adequately met, including by modifying food, cash or voucher transfer value to meet their specific needs. If there are shortfalls, target PLW with fortified food. Micronutrient supplementation should be in accordance with WHO recommendations on doses and timing.
- Organise psychosocial support for distressed mothers and link with referral mental health services as necessary. Arrange for appropriate support to mothers with disabilities.

- Identify and target nutrition and IYCF counselling support to adolescent mothers, and enable sensitive access to family planning services including support from other members of the household. Consider linking incentives for IYCF to existing cash-based assistance programmes.

HIV and infant feeding

- Knowing the sub-national recommendation should be part of emergency preparedness. Breastfeeding mothers living with HIV should breastfeed for at least twelve months and may continue breastfeeding for twenty-four months or longer while being fully supported for anti-retroviral therapy retention and adherence. Breastfeeding should only stop following the provision of a nutritionally adequate and safe diet to the child. Where ARV drugs are unlikely to be available, breastfeeding HIV-exposed infants is recommended in emergencies. Breastfeeding provides infants born to mothers living with HIV a greater chance of HIV-free survival. Perinatal prophylaxis for HIV exposed infants is recommended.
- Prioritise accelerated access to ARVs (see Essential health services - sexual and reproductive health standard X). Counsel breastfeeding HIV uninfected mothers, wet nurses or those whose HIV status is unknown to breastfeed exclusively for the first six months of life. After the first six months, introduce complementary foods while continuing breastfeeding for 24 months or beyond. Infants already established on replacement feeding require urgent identification and support.
- Consult with existing national and sub-national policies and assess whether they are in line with the latest WHO recommendations. Determine if they are appropriate for the new emergency context, considering the change in risk exposure to non-HIV infectious disease; the likely duration of the emergency; whether replacement feeding is possible; and the availability of ARVs. Updated interim guidance may need to be issued. Communicate with health providers and HIV-exposed mothers regarding feeding recommendations and associated risks.

Public health emergencies

In public health emergencies take steps to mitigate and limit risks related to interrupted access to health and feeding support services, decreased household food security and livelihoods, disease transmission risks via breastfeeding; and maternal illness and death. Refer to WHO guidance where needed for Ebola and Zika virus guidance.

GBV and Nutrition

Nutrition, gender inequality and GBV are often interrelated. Domestic violence in particular can pose a considerable threat to the health and well-being of women and their children, including child survival. Nutrition staff should be sensitized to the importance of providing supportive and confidential referral for caregivers or children exposed to GBV or child abuse, and should reach out to GBV specialists where possible. Other elements to integrate include counselling, working to establish women and child friendly treatment sites, and regular monitoring of default rates and failure to respond to treatment. Consider including a caseworker as part of nutrition staff who is specialized in GBV case management.

4. Food Security

Food security ‘exists when all people, at all times, have physical and economic access to sufficient, safe, and nutritious food [and the means with which to cook that food] that meets their dietary needs and food preferences for an active and healthy life.’ (World Food Summit, 1996).

Food security interventions in humanitarian crises should aim to meet short-term needs and reduce the need for people to adopt potentially damaging coping strategies. In addition, responses should protect and restore livelihoods, stabilise or create employment opportunities and contribute to restoring longer-term food security and should not have negative impacts on natural resources and the environment.

Responding to urban food security and nutrition in a crisis requires a different approach. Urban areas generally have higher rates of obesity, street food consumption, dependency on markets and vulnerability to market price fluctuation. Urban households may contain multiple people living together, each earning an income. Acute malnutrition rates may seem below the emergency thresholds, but the absolute numbers of malnourished people are often higher than in rural areas.

Links with nutrition

Food security consider the resources to meet the food needs of both the general population and specific vulnerable people at increased nutritional risk (children under 5, people living with HIV /AIDS, older people, people with chronic illnesses, for instance). Any response aimed at the treatment of malnutrition will have a limited impact if it does not meet these food needs. Those who recover from malnutrition and return to a context of inadequate food intake will deteriorate again.

Cash-based assistance

Food security and livelihoods responses should systematically aim to be market-based. That is, they should work through or support local markets.

Cash-based assistance is a form of market-based intervention (cross-reference to text box on cash-based assistance in the introduction), comprising two main modes:

- Cash transfers – assistance in the form of money (either physical currency/cash or e-cash) to people receiving assistance (individuals, households or communities).
- Vouchers – a paper, token or e-voucher that can be exchanged for a set quantity or value of goods. Vouchers are denominated either as a cash value (for example, \$15) or predetermined commodities or services (for example, 5 kg maize or milling of 5kg of maize), or a combination of value and commodities.

Prerequisite or qualifying conditions are activities or obligations that must be fulfilled before receiving cash-based assistance. Both cash and vouchers can be conditional.

Restrictions are limitations on what a transfer can be spent on after a person receives it. Vouchers are by their nature more restrictive than cash transfers.

While their objectives and design may differ, cash-based assistance modes use markets to provide those receiving assistance with purchasing power to meet basic needs (for example, immediate food needs). They are also used to support the purchase of productive assets enabling people to resume economic activity. In food security and livelihoods programming, an understanding of market functionality also underpins decisions on the appropriateness of local, national or regional procurement. Market-based programming also includes interventions which support markets (cross-reference to ‘Delivering through markets annex’), such as through grants to traders for re-stocking.

To best achieve programme objectives, the choice of response option (in-kind food, cash, vouchers or market support) requires situational and response analysis. Situational analysis should include disaggregated needs assessment (priority needs and preferences over time, including seasonality, market assessment,

financial service provider assessment and risk and opportunity assessment). Response analysis should then aggregate this assessment information to determine the appropriateness and feasibility of different response options. This analysis should include household preferences, cost efficiency and effectiveness, and risk analysis including protection concerns.

To promote food security, and improve nutrition, resource transfers could be entirely unrestricted cash; entirely vouchers (as restricted cash); entirely in-kind; or any combination of these. Results monitoring and feedback from recipients guide further course correction including adjustments to the transfer modalities over time.

Vulnerable households mostly spend their cash income on food. The fungibility of cash-based assistance can enable people receiving assistance to better manage their overall resources beyond food consumption, depending on the value of the transfer provided. All humanitarian sectors need to work with other technical sectors and partners, to analyse basic food and non-food needs, markets, and the overall capacities of each financial ecosystem to deliver joint transfers.

Collaborative response analysis will guide the targeting, transfer value, and any potential conditions of the various partners depending on programme objectives. However, the food sector shall remain focused on results (food security) rather than on inputs (cash delivery). Cash is a way to deliver assistance, but it is not an end in itself.

Below, there are three sub-sections focusing on food security intervention: general food security, food assistance, and livelihoods responses. All food security interventions must be based on a thorough food security assessment (Standard 1.1).

Food security. Standard 4.1: General food security

People receive humanitarian food assistance that ensures their survival, upholds their dignity, prevents the erosion of their assets and builds resilience.

Key action 1: Based on food security assessment data, initiate measures to support, protect, promote and restore self-reliance on food.

- Base responses on sound analyses of needs and capacities, response benefits, associated risks/costs, and people's coping strategies.
- When choosing food assistance, carefully consider both in-kind and cash-based options for the food basket, including groups with special needs that are based on their gender, age and disability.

Key action 2: Consider long-term perspectives from the outset and develop transition and exit strategies for all food-security-related programmes.

- Plan additional responses with a longer-term perspective and integrate them with responses from other sectors.

Key action 3: Ensure that people receiving assistance have access to appropriate coping and livelihoods support (including providing necessary knowledge, skills and services).

- Interventions should influence policies as well as strengthen institutions and services.
- Interventions should not have a negative impact on natural resources or the wider environment.

<ul style="list-style-type: none"> Encourage the restoration of natural resources, building resilience and reducing the risk of future crises.
<p>Key action 4: Protect, preserve and restore the natural environment from further degradation.</p> <ul style="list-style-type: none"> Consider the impact of cooking fuel collection on the environment (see What Else Do I Need to Know). When environmental risks are high, cash based assistance should ensure that it does not compromise fragile environmental conditions (for example, funding income generating activities that contribute to deforestation or soil erosion).
<p>Key action 5: Monitor to determine the level of acceptance and access to interventions by different groups and individuals and ensure that support is equitable.</p> <ul style="list-style-type: none"> Disaggregate the number of affected people by disability, sex and age (and in some cases cultural differences and livelihoods groups) before determining the level of participation of different groups in food assistance programs.
<p>Key indicators</p>
<p><i>Percentage of households with acceptable food consumption score</i></p> <ul style="list-style-type: none"> FSC thresholds >35 (>42 if oil and sugar are provided).
<p><i>Percentage of targeted households with acceptable Household Dietary Diversity Score (HDDS)</i></p> <ul style="list-style-type: none"> At least 3 or more main food groups are regularly consumed (IPC).
<p><i>Percentage change in average Coping Strategy Index (CSI) by administrative area, livelihood, or overall</i></p> <ul style="list-style-type: none"> Use baseline as reference.

What else do I need to know?

Response options

Food assistance is the most common initial response to acute food insecurity. Consider other types of response including food subsidies, temporary fee waivers, employment programmes, productive support to livelihoods, destocking, fodder provision and support to markets.

Markets

Food security interventions should systematically aim to be market-based. That is, working through or supporting local markets. Market analysis should inform whether food security needs can use markets through cash-based assistance, or local procurement. When markets are functioning and accessible and there are no serious risks of inflation, the priority may be to re-establish normal market arrangements and revitalise economic activities that provide employment. Food Security interventions should offer advantages in supporting livelihoods, reducing future vulnerability and upholding dignity for the affected population. This is particularly important for at-risk groups such as women, girls and boys, older people and people with disabilities. Humanitarian actors should analyse markets holistically and consider how other actors are using and supporting markets." See 'Delivering through markets' annex.

Long-term perspective

While meeting immediate needs is a priority in the initial stages of a crisis, such responses should preserve and protect assets, recover assets lost through crisis, and increase resilience to future threats. This means systematically considering how to use or support local markets to meet food security needs"

Context

Monitor the wider food security situation to assess the continued relevance of an intervention, determine when to phase out activities, introduce modifications or new projects and identify any need for advocacy. Base the evaluation on established Development Assistance Committee criteria recorded by the OECD, which measure appropriateness, connectedness, coherence, coverage, efficiency, effectiveness and impact.

Exit and transition strategies

Consider exit and transition strategies from the outset, particularly where the response may have long-term implications. For example, initial provision of free services makes it difficult to resume providing them on a paid basis. Before closing a programme or making the transition to a new phase, there should be evidence of improvement or that other better-equipped actors can take responsibility. In the case of food assistance, it may mean understanding the existing or planned social protection or long-term safety-net systems and designing food assistance programmes that either:

- (i) Coordinate with them to the extent possible; or
- (ii) Lay the foundation for a future social protection system while advocating for the establishment of systems that address chronic food insecurity.

At-risk groups

Use community-based risk assessments and other participatory monitoring to detect and deflect locally driven strategies that endanger particular groups or individuals. For example, distributing fuel and/or fuel-efficient stoves may reduce the risks of physical and sexual assault for women and girls. Supplemental cash transfers, especially to particularly at-risk households or individuals (for example, women- and child-headed households, households with people with disabilities) can reduce risk of sexual exploitation and child labour

Community support structures

Design and plan community support structures together with users, so that they are appropriate and adequately maintained and, where possible, remain beyond the life of the intervention. Consider the specific needs of at-risk individuals during the design. For example, consider that separated or

unaccompanied girls and boys may miss out on the information and skills transfer that takes place within a family set-up. (CHS 4.3)

Livelihoods support

Livelihood responses include interventions that restore, protect or promote (i) primary production, (ii) income and employment, (iii) access to market goods and services. In urban areas, access to different economic activities may be defined by factors such as household composition, skill levels, physical abilities and education among others.

Environmental impact

People living in camps require cooking fuel, which may accelerate local deforestation. Consider options such as fuel distribution, efficient stoves, alternative energy (Moving Energy Initiative) and the potential environmental benefits associated with making vouchers more specific to environmentally friendly goods and services (types of fuel and food). Look for opportunities to conduct sensitisation that will change previous food and cooking customs that may have caused environmental degradation. Planning should take into consideration trends concerning climate change. Activities that provide relief in the short term and reduce crisis risk in the medium and long term should be prioritized. For example, destocking reduces pressure on pasture during a drought, making more grazing available for surviving livestock. (Link to Shelter Standard 2.2. on environmental sustainability)

Access and Acceptability

Ease of access and the acceptability of activities to participants partly determines participation. Implement participatory design strategies targeting all members of the affected population. While some food security interventions target the economically active, ensure that all responses are accessible to all at-risk people. Constraints may limit participation, and may include:

- reduced capacity to work;
- a heavy workload at home;
- pregnancy, feeding and caring for children; and
- illness and disability.

Overcoming constraints involves identifying and mitigating activities aligned with the capacities of the constrained groups or setting-up appropriate support structures.

Urban settings

Household food expenditure indicators are more complicated to use in urban settings, particularly in slums and poor neighbourhoods. For example, the Food Expenditure Share and its established thresholds may be less accurate in urban contexts and might be too high since non-food expenses, such as rent and heating, are relatively higher.

References

1. Integrated Food Security Phase Classification (IPC) 2008 – Technical Manual Version 1.1
2. <http://www.safefuelandenergy.org/issues/food-security-nutrition.cfm>
3. <https://mei.chathamhouse.org> (Moving Energy Initiative)
4. Global Alliance for Clean Cookstoves (<http://cleancookstoves.org/impact-areas/humanitarian/>)
5. Food security and livelihoods interventions for older people in emergencies - <http://www.helpage.org/resources/publications/?search=food+security&adv=0&topic=0®ion=0&language=0&type=0>
6. CBA Programme Quality toolbox

5. Food assistance

Food assistance aims to ensure the consumption of sufficient, safe, and nutritious food in anticipation of, during, and in the aftermath of a humanitarian crisis. When food consumption would otherwise be insufficient or inadequate to avert excessive mortality, malnutrition it is appropriate to provide food assistance. It may also be used to avoid the adoption of negative coping mechanisms.

Food assistance programmes improve food availability, nutrition awareness, and feeding practices. Food assistance can also protect and strengthen the livelihoods of affected people. This can prevent or reverse negative coping mechanisms that could have harmful consequences. Examples of negative coping mechanisms include sale of productive assets, over-exploitation or destruction of natural resources, or the accumulation of debt.

A wide range of tools can be used in food assistance programmes, including:

- general food distributions;
- direct provision of in-kind food (food transfers);
- cash-based assistance for purchase of food;
- provision of relevant services and inputs; and
- transfer of skills or knowledge.

General food distributions provide support to those who need the food most. Discontinue these distributions when people receiving assistance recover the ability to produce or to access their food through other means. Transitional arrangements may be needed, including conditional cash transfers or livelihood support.

People with specific nutrient needs may require supplementary food in addition to any general ration. This includes children aged 6–59 months, older people, persons with disabilities, and pregnant or breastfeeding women. In many situations, supplementary feeding plays a critical life-saving function.

On-site feeding is undertaken only when people do not have the means to cook for themselves. This can be necessary immediately after a crisis, during population movements, or where insecurity would put recipients of take-home rations at risk. It can also be used for emergency school feeding, although take-home rations may be distributed through schools. Consider that children out-of-school will not access these distributions; plan outreach mechanisms for these children.

Commodity management for food assistance requires good supply chain management and logistics capabilities. Management of any cash delivery system needs to be robust and accountable, with systematic monitoring” Cross-reference to ‘Delivering through markets’ annex.

<p>Food Assistance Standard 5.1:</p> <p>General nutrition requirements</p> <p>The nutritional needs of the affected people are met.</p>
<p>Key action 1: Use levels of access to adequate quantity and quality of food to determine if the nutrition situation is stable.</p> <ul style="list-style-type: none"> Assess the level of access on a frequent basis since it is likely to decline. Measure access to food with analytical tools such as the food consumption score or dietary diversity tools.
<p>Key action 2: Design food and cash-based transfers on the basis of the standard initial planning requirements for energy, protein, fat and micronutrients, adjusted as necessary to the local situation.</p> <ul style="list-style-type: none"> Design general food rations using ration planning tools Establish agreement on the average quantities of food accessible to the affected population. Plan rations to make up the difference between the nutritional requirement and what people can provide for themselves. Where people have no access to any food at all, the distributed ration should meet their total nutritional requirements.
<p>Key action 3: Protect, promote and support the population's access to appropriate nutritious foods and nutritional support.</p> <ul style="list-style-type: none"> Ensure that nutritional needs of particular population groups are addressed: <ul style="list-style-type: none"> children aged 6–24 months; older people; pregnant and breastfeeding women; households with chronically ill members, including people living with HIV and TB; and people with disabilities, in particular persons with difficulties feeding, people with specific impairments
<p>Key indicators</p>
<p><i>Prevalence of malnutrition among children <5 years disaggregated by gender and sex; (from 24 months on, disaggregated by disability using the UNICEF Module on Child Functioning and Disability)</i></p> <ul style="list-style-type: none"> Use WHO Classification System (GAM < 1 5%)
<p><i>Percentage of targeted beneficiaries attaining the minimum food consumption threshold</i></p> <ul style="list-style-type: none"> Food consumption score >35 (or > 42 if oil and sugar are provided)
<p><i>% of targeted households with Household Dietary Diversity Score.</i></p> <ul style="list-style-type: none"> Use IPC guidelines (Regularly 2 to 3 or more food groups consumed)
<p><i>% of targeted households with reliable food sources</i></p> <ul style="list-style-type: none"> 100% of minimum food energy needs met (2,100 Kcal for adults)

What else do I need to know?

Measuring access to food

Measuring approaches should consider a number of variables including food security, access to markets, livelihoods, health and nutrition. This will allow to determine if the situation is stable or declining and if food interventions are necessary.

Transfer modalities

Use appropriate transfer modality (cash, vouchers, or in-kind) or a combination to ensure food and nutrition security. Where cash-based assistance is used to ensure food and nutrition security, agencies need to consider (based on response option analysis): complementary food distributions; or supplementary food distributions to meet the needs of specific groups. Need to consider adequacy of markets to serve particular nutritional needs, and use specific methodologies including 'the minimum cost of a healthy diet' assessment tool.

Design of food rations

Aside from the energy content of the diet, consideration of protein, fat and vitamins and minerals in food ration planning is essential. If a ration is designed to provide all the energy content of the diet, then it must contain adequate amounts of all nutrients. If a ration provides only part of the energy requirement of the diet, then design it using one of two approaches:

- If the nutrient content of the other foods available to the population is unknown, design the ration to provide a balanced nutrient content that is proportional to the energy content of the ration.
- If the nutrient content of the other foods available to the population is known, design the ration to complement these foods by filling nutrient gaps.

A number of ration planning tools are available, for example NutVal.

Specific population groups

Include adequate and acceptable food for young children 6-59 months in the general ration, such as fortified blended food. Consider providing fortified foods (or manual blenders) for people with chewing or swallowing difficulties and information on how to modify food texture. When determining eligibility for assistance ensure consultation with at-risk groups. Whenever there are changes in rations, share information with entire communities to minimize resentment and also limit the risk of household violence against women who may be blamed for reduced rations. Also consider needs of people living with HIV and TB (who need additional calories), people with disabilities including children with eating difficulties.

Link with Health standards

Meeting key food indicators prevents the deterioration of the nutrition status of the general population when adequate public health measures are also in place to prevent diseases such as measles, malaria and parasitic infection (REF. Health Standards XX).

Nutritional quality

Ensuring adequate nutrient content of food assistance rations may be challenging in situations where there are limited food types available. Additionally, an inadequate supply of fuel with which to cook can lead to coping mechanisms which are damaging to food security, for example, undercooking food or swapping food for fuel.

Options for improving the nutritional quality of the ration include provision of fortified staple commodities, and/or the provision of fresh foods, including animal source foods through the distribution of vouchers, in order to ensure dietary diversity. In addition, IYFC messages should be provided to ensure

that optimal breastfeeding as well as complementary feeding practices are promoted”. (link to Nutrition standard....xxx) .

Measuring utilisation of food rations

Key indicators address access to food but do not quantify food utilisation. Direct measurement of nutrient intake would impose unrealistic requirements for information collection. Indirect measurement is a good alternative, using information from various sources. These sources might include monitoring food availability and use at the household level, assessing food prices, food availability and cooking fuel in local markets, examining food assistance distribution plans and records, assessing any contribution of wild foods and conducting food security assessments.

Food allocation within households may not always be equitable

Appropriate distribution and delivery mechanisms may help contribute to improved food allocation within the households, as well as the choice of food and discussion with groups of the affected population (considering age, sex, disability, marginalized groups). (Ref CHS 4.3)

Older people are particularly affected by disasters

Risk factors that reduce access to food and can increase nutrient requirements include chronic disease and disability, isolation, large family size, cold, and poverty. Within a household, older people’s food needs may not be prioritized. Older people should be able to access food sources (including food transfers) easily. Foods should be easy to prepare and consume and should meet the additional protein and micronutrient requirements of older people.

People living with HIV may face greater risk of malnutrition due to a number of factors.

These include reduced food intake due to appetite loss or difficulties in eating, poor absorption of nutrients due to diarrhoea, parasites or damage to intestinal cells, changes in metabolism, and chronic infections and illness. The energy requirements of PLHIV increase according to the stage of the infection. Milling and fortification of food or provision of fortified, blended or specialist food supplements are possible strategies for improving access to an adequate diet. In some situations it may be appropriate to increase the overall size of any food ration. Refer malnourished people living with HIV-AIDs to targeting feeding programmes, when available.

Persons with disabilities

Persons with disabilities may be at particular risk of separation from immediate family members and usual caregivers in a disaster. They also may face discrimination. Make efforts to determine and reduce these risks by ensuring physical access to food, developing mechanisms for feeding support (for example, provision of manual blenders, spoons and straws, developing systems for home visiting or outreach) and ensuring access to energy-dense and nutrient-dense foods. In addition, consider that children with disabilities are less likely to be enrolled in schools, missing school-based food programmes.

Caregivers and those they are caring for may face specific nutritional barriers

For example, they may have less time to access food because they are ill or caring for the ill. They may have a greater need to maintain hygienic practices. They may have fewer assets to exchange for food due to the costs of treatment or funerals and they may face social stigma and reduced access to community support mechanisms. It is important to support caregivers in the care of vulnerable individuals. Use existing social networks to train selected members of the population to take on responsibilities in these areas.

Food Assistance Standard 5.2:

Food quality, appropriateness and acceptability

The food items provided to recipients are of appropriate quality, acceptable, and support efficient and effective use at the household level.

Key action 1: Select foods at the point of purchase or donation that conform to the national standards of the host government and other internationally accepted quality standards.

- Assess availability of food commodities on national or international markets (see 'Delivering through Markets annexe'). Select these foods at the point of purchase or donation.
- Perform random sample testing on food stocks.
- When planning to use imported food, understand and respect national regulations concerning the receipt and use of Genetically Modified (GMO) foods.
- Factor in potential pipeline constraints into your programme planning. Continuously monitor the availability of food on market.

Key action 2: Choose appropriate food packaging

- Label food packages in languages that will be understood by recipients.
- Include the date of production, country of origin, expiry or "best before" date, nutritional analysis, and cooking methods.

Key action 3: Develop a plan of action for responsible use of packaging.

- Use minimal packaging
- Use biodegradable packaging where possible
- Provide receptacles that can be reused, recycled or re-appropriated.
- Use locally appropriate materials
- Dispose of waste to prevent polluting the local environment

Key action 4: Assess physical, financial and safe access to water, fuel, stoves and food storage facilities.

- This will help determine the most appropriate and acceptable food items to provide.
- Whenever possible, choose familiar food over unfamiliar food.
- A fuel assessment should inform food selection.
- When crises prevent access to cooking facilities, provide ready-to-use foods. Without cooking facilities, unfamiliar food and special emergency rations are acceptable

Key action 5: Provide food preparation instructions in accessible formats and in the local language.

- This is particularly important for food items that may be less familiar or less commonly used

Key action 6: Provide access to adequate milling and processing facilities when wholegrain cereal is provided.

- Meet milling costs to recipients using cash or vouchers or the less-preferred approach of providing additional grain or milling equipment

Key Action 7: Ensure that affected people have access to culturally important food items, including condiments.
Key Action 8: Transport and store food in appropriate conditions. Use best practices in storage management, with systematic checks on food quality.
Key indicators
Percentage of affected population that report that food provided is of appropriate quality and meets local preferences.
Percentage of affected population that report the mechanism to receive food was appropriate.
Percentage of households that reported that food items were easy to prepare and store. (CHS 1.1)
Number of complaints or reports received from persons receiving assistance related to food quality <ul style="list-style-type: none"> Measure 15 days after a distribution, calculate as a percentage of total complaints received.
Percentage of food losses reported by the programme. Food losses can be reported at warehouses and final distribution points. Food losses can be due to poor packaging in the distribution cycle. <ul style="list-style-type: none"> < 0.2% of total tonnage.
What else do I need to know? <p>Food quality</p> <p>Foods must conform to the food standards of the recipient government. Food must also conform to the Codex Alimentarius standards about quality, packaging, labelling, and fitness for purpose. When food is not of the quality required for its intended use, it is unfit for the purpose. This is true even if it is fit for human consumption. An example is when the quality of flour may not enable baking at household level even if it is safe to consume. Phytosanitary certificates or other inspection certificates must accompany locally purchased and imported foods. Fumigation should use appropriate products and follow strict procedures. Ensure that independent quality surveyors inspect large quantity consignments. Use them when there are doubts or disputes about quality.</p> <p>Ensure that host governments remain involved at all times. Obtain information on age and quality of food consignments from supplier certificates, quality control inspection reports, package labels, and warehouse reports. If food assistance is sourced locally, it should be sustainable and not further strain local natural resources</p> <p>Food packaging should be:</p> <ul style="list-style-type: none"> sturdy convenient for handling, storage, and distribution; not a hazard for the environment; and accessible for people with mobility difficulties, including older people, some children, and persons with disabilities. <p>If possible, packaging should allow direct distribution without remeasuring or repacking. Food packaging should not carry any messages that are politically or religiously motivated or divisive in nature. Minimise potential threats by packaging and managing empty packages such as sacks and tins. Ready-to-use foods packaging, such as foil wrappers, may require specific controls for safe disposal.</p> <p>Humanitarian organisations have a responsibility to ensure that the local environment does not become littered with packaging from the food or other items distributed or bought with cash or vouchers. Where litter occurs, community clean-up campaigns should be regularly organised. These campaigns should be part of community mobilisation and awareness-raising, rather than as Cash for Work. The mode of transport</p>

should be appropriate and reliable, and with no risk of contamination of the food. (Link to WASH, solid waste management).

Food choice

While nutritional value is the primary consideration when choosing a food basket, the commodities should be familiar to the recipients. They should also be consistent with religious and cultural traditions, including any food taboos for pregnant or breastfeeding women. In many settings, women and girls are primarily responsible for food preparation should participate in consultations on food choice. Ensure support to men who are single heads of households, grandparents and youth in charge of their siblings without support, as access to food could be at risk. In assessment reports and requests to donors, explain food choices (inclusion and exclusion), referencing gender and other considerations.

Cash Based Assistance

Cash should be used where markets are able to supply appropriate and acceptable food commodities. Preferences should be systematically considered, building on established interaction with markets. If new food is introduced, ensure that training and sensitisation is conducted.

Food storage and preparation

People's ability to store food should inform the choice of foods offered. Ensure that people receiving assistance understand how to avoid public health risks and prevent environmental degradation. Fuel efficient stoves or alternative fuels can be provided.

Wholegrain cereal has the advantage of a longer shelf life, and may have a higher value to recipients. Where household-level grinding is traditional, or there is access to local mills, distribute wholegrain. Provide facilities for low-extraction commercial milling that removes germ, oil, and enzymes that cause rancidity. Low-extraction commercial milling greatly increases shelf life, although it also reduces protein content. Milled whole maize has a shelf life of only six to eight weeks so milling should occur shortly before consumption. Milled grain normally requires less cooking time. Milling requirements can sometimes expose women or adolescent girls to increased risk of exploitation. This should be taken into consideration if whole grains are to be distributed (e.g. consider supporting women-run mills).

Infant feeding

Free or subsidised infant formula, liquid milk powder, liquid milk, or liquid milk products should not be distributed as a single commodity in a general food distribution. These items should also not be distributed in a take-home supplementary feeding programme. Any interventions involving liquid milk should be in accordance with the Operational Guidance on IFE, the International Code of Marketing of BMS and subsequent relevant WHO resolutions.

Urban settings

Urban households are likely to eat a more diverse range of foods than rural ones, but the quality of their diet may be limited. To address this challenge, it is important to examine the nutrient adequacy within urban households.

Storage areas

Should be dry and hygienic, adequately protected from weather, and uncontaminated by chemical or other residues. Secure storage areas against pests, such as insects and rodents. Where appropriate, use Ministry of Health officers to certify the quality of food supplied by vendors and traders.

<p>Food Assistance Standard 5.3:</p> <p>Targeting, distribution and delivery</p> <p>Food assistance targeting and distribution is responsive, timely, transparent, and safe.</p>
<p>Key action 1: Identify and target food assistance recipients based on need, and consultations with appropriate stakeholders.</p> <ul style="list-style-type: none"> • Select agents involved in targeting for their impartiality, capacity, and accountability. • Targeting approaches should be clear, publicised, and accepted by both recipient and non-recipient populations to avoid creating tensions and doing harm. • Initiate formal registration of households to receive food as soon as it is feasible. Registration should be updated as necessary.
<p>Key action 2: Design efficient and equitable food or direct cash/voucher distribution methods and distribution points in consultation with partner organisations, local groups, and recipients.</p> <ul style="list-style-type: none"> • Support the rights and dignity of the affected population. • Promote active participation by at-risk, potentially vulnerable and marginalised groups. • Plan to include at-risk groups and individuals in the distribution lists. Include vulnerable groups and individuals in the distribution lists • Consult women and men, including adolescents and youth, separately if necessary
<p>Key action 3: Design electronic cash/voucher delivery systems that are safe, accessible and effective</p> <ul style="list-style-type: none"> • See <i>‘Delivering through markets’ annex</i>.
<p>Key action 4: Locate distribution points where they are accessible, safe and most convenient for the recipients.</p>
<p>Key action 5: Provide recipients with advance details of the distribution plan and schedule, and the quality and quantity of the food ration or the cash/voucher value and what it is intended to cover.</p> <ul style="list-style-type: none"> • Schedule distributions in a way that respects people’s traveling and working time, and that prioritises at-risk groups as appropriate • Disseminate information on food, cash and voucher distribution through a diversity of communication channels to ensure it reaches wider segments of the affected population.
<p>Key indicators</p>
<p>Percentage of inclusion and exclusion errors minimised.</p> <ul style="list-style-type: none"> • Aim for < 10%
<p>Percentage of the targeted households that report that the distance to the final distribution points or markets (in case of vouchers or cash) is appropriate (CHS 2.1)</p> <ul style="list-style-type: none"> • Maximum walking distance to a Final Distribution Point < 5Kms one way • Targeted households receive advance notification of the distribution date, time, location, quantities, and description of items to be received.

Percentage of targeted households that can cite key messages related to the food assistance programme.

- Aim for at least 50% of targeted households
- A predistribution script containing key messages is available and in use before each distribution.

What else do I need to know?

Targeting

Ensure that targeting tools and methods are adapted to context. Targeting should span the intervention, not just the initial phase. Finding the right balance between exclusion errors, which can be life-threatening and inclusion errors, which are potentially disruptive or wasteful, is complex. In rapid onset crises, inclusion errors are more acceptable than exclusion errors. General food distributions may be appropriate in crises for all households that have suffered similar losses, or where a detailed targeting assessment is not possible, due to lack of access. People living with HIV may be targeted for supplementary food to increase their daily caloric intake and support adherence to ART. Targeting of people living with HIV must be done in a way that ensures no stigma or discrimination. Usually the most effective way to provide supplementary food for people living with HIV is through health centres where they receive care and treatment. Lists of people living with HIV should never be publicised or shared. People living with HIV can be included as part of distributions targeted at “people with chronic diseases” in order not to single out those with HIV. In most contexts community leaders should not be involved as targeting agents for people living with HIV.

Targeting agents

Include local elders with the ability to represent the following populations:

- at-risk groups, such as women and girls, older people, and people with disabilities;
- locally elected committees, women’s groups and humanitarian organisations;
- local and international NGOs;
- youth organisations;
- organisations of persons with disabilities; and
- local governmental institutions.

Organisations should develop direct contact with the affected population, while avoiding community gatekeepers.

The registration processes

In camps, registration can be challenging, especially where displaced people do not have identification documents. Lists from local authorities and community-generated household lists may be useful if an independent assessment proves them accurate and impartial. Encourage affected women to assist in the design of the registration processes and to help if they wish to do so. Include at-risk individuals on distribution lists, especially those people with reduced mobility.

If registration is not possible in the initial stages of a crisis, complete it as soon as the situation has stabilised. Establish a complaints and response mechanism for the registration process that is accessible to women, girls, older people, and persons with a disability. Women have the right to be registered in their own names. Where possible, consult both men and women, separately if necessary, on the question of who should physically collect assistance (or be a recipient of Cash Based Assistance) on behalf of the household informed by a risk assessment.

Make special provision for single-headed, as well as child- and youth-headed households and separated or unaccompanied children, so that they can safely collect assistance on behalf of their households. Establish child care adjacent to distribution sites to enable single-parent households and women with young children to collect assistance without leaving their children unattended. In contexts where there are polygamous households, treat each wife and her children as a separate household. Make provisions to allow other wives to claim their food and cash as a separate family unit.

Distribution of ‘dry’ rations

General Food Distributions normally only provide dry rations. People cook the rations in their homes. Ensure that required fuel is available and that its collection does not negatively affect the environment. Recipients might include an individual or a household ration-card holder, a representative of a group of households, traditional and women leaders, or leaders of a community-based targeted distribution. The frequency of distribution should consider the weight of the food ration and the recipients' means to carry it home safely. Specific action may be necessary to ensure that older people, separated and unaccompanied children, pregnant and breastfeeding women and persons with disabilities can collect and retain their entitlements. Other community members may assist or provide weekly or two-week rations. Attempts to target at-risk groups should not add to any stigma that they already experience.

Distribution of 'wet' rations

In an exceptional situation, general food distribution may be a cooked meal or ready-to-eat food during the initial period of a rapid onset crisis. These rations may be appropriate when people are on the move, or when carrying food home would put people receiving assistance at risk of theft or violence, abuse or taxation. Use school meals and food incentives for education personnel as a distribution mechanism in an emergency.

Distribution points

Locating distribution points should take the following into consideration: the terrain; the proximity to other sources of support, such as clean and safe water; toilets; medical services; shade; shelter; child-friendly spaces, and safe spaces for women and girls, and accessibility of facilities and information. Furthermore, armed checkpoints and military activity must be considered. Take care to minimise risk to civilians, and establish safe access to aid. Roads to and from distribution points should be clearly marked, accessible, and frequently used by other members of the community. Consider the practicalities and costs of transporting commodities.

Access to distribution points

The frequency of distributions and the number of distribution points should be decided upon based on the time it takes recipients to travel safely to and from distribution points. This should not be more than 5 kms (one-way) and take no more than one day. Develop alternative means of distribution to reach those who are at a greater distance or isolated, and individuals with mobility difficulties. Access to distribution is a common source of anxiety for marginalised and excluded populations in a crisis.

Scheduling distributions

Schedule distributions at times that allow travel to distribution points and back home during daylight hours. Avoid an overnight stay for people receiving assistance as it carries additional risks. Schedule distributions to minimise disruption to everyday activities, particularly for women and adolescent girls who are already time-poor. Consider establishing fast track or prioritisation lines for at-risk groups. Consider setting up a child friendly desk staffed with one social worker who can register any unaccompanied and separated children.

Safety during food, voucher and cash distributions

Tensions can run high during distributions. Take steps to ensure that all those entitled to distribution can participate without risk. Steps to minimise such risks include proper crowd control, supervision of the distributions by trained staff, and the guarding of distribution points by the affected populations themselves. If necessary, involve the local police. Sensitise police officials and officers to the objectives of the food transfers. Carefully plan the site layout at distribution points, considering the elderly and those with mobility limitations. Inform all food distribution teams about appropriate values, policies, and expected conduct, including penalties for sexual and child abuse. Include female guardians to oversee off-loading, registration, distribution, and post-distribution of food. (CHS 8.2)

Information dissemination

Communication channels include printed, audio, SMS and voice messages. Prominently display ration information at distribution points in formats accessible to people who cannot read or who have communication difficulties. Accessible formats could be written in the local language, drawn pictorially, or spoken so that people are aware of their entitlements. Inform recipients about:

- The ration plan, specifying the quantity and type of food rations, or the cash/voucher value and what it is intended to cover and reasons for any differences from earlier plans.
- The distribution plan, consisting of the day, time, location, and frequency. Include any changes.
- The nutritional quality of the food and, if needed, special attention required by recipients to protect its nutritional value.
- The requirements for the safe handling and use of the foods.
- Specific information for optimum use of food for children.
- The appropriate ways for recipients to obtain more information on the programme, and the process for complaints.

Changes to the food basket

Discuss within the distribution committee any changes in the food basket or ration levels caused by insufficient availability of food. Convey these changes to the recipients through distribution committees, community leaders, and through representative organisations. Jointly develop a course of action before distributions. The distribution committee should inform people of changes, the reasons behind the changes and the date and plan for resuming normal rations. Consider the following options:

- Reduce the rations to all recipients.
- Give a full ration to vulnerable individuals and a reduced ration to the general population.
- As a last resort, postpone the distribution.

Monitoring of distribution and delivery

Check that arrangements for distributions are in place. These arrangements include registration, security, and dissemination of information. The arrangements should be sensitive to gender, age, and disability. Randomly weigh rations collected by households to measure the accuracy and equity of distribution. Interview recipients and ensure that the interview sample includes an equal number of women and men, including adolescents and youth, as well as people with a disability and older people. Random visits by an interview team made up of at least one male and one female can help determine the acceptability and usefulness of the ration. These visits can identify people who meet the selection criteria but who are not receiving food. Such visits can also discover the receipt of food from elsewhere, its source and its use. The visits can identify possible use of force to take possessions, recruitments, or sexual or other exploitation. (Cross Reference with Delivering through Markets)

Food Assistance Standard 5.4: Food use Storage, preparation, and consumption of food is safe and appropriate at both household and community levels.
Key action 1: Protect people receiving assistance from inappropriate food handling or preparation. <ul style="list-style-type: none"> • Inform food recipients of the importance of food hygiene. • Train staff in safe storage and handling of food, the preparation of food, and the potential health hazards of improper practices when distributing cooked food.
Key action 2: Consult with and advise persons receiving assistance. <ul style="list-style-type: none"> • Provide accessible information on storage, preparation, cooking, and consumption of the food that is distributed. • Discuss the implications of a targeted provision for vulnerable people and respond to the issues that may arise.
Key action 3: Ensure that households have safe access to appropriate cooking utensils, fuel, fuel-efficient stoves, drinking water, and hygiene materials.
Key action 4: For individuals who cannot prepare food or cannot feed themselves, ensure access to caregivers who can prepare appropriate food and administer feeding, where necessary.
Key action 5: Monitor intra-house utilisation of food resources and take appropriate action.
Key indicators

Percentage of households able to store and prepare food safely
Average number of key food hygiene messages that the targeted population can describe. <ul style="list-style-type: none"> Household members to describe at least three key messages.
Percentage of targeted households that report having access to appropriate cooking utensils, fuel, potable water, and hygiene materials. <ul style="list-style-type: none"> Thresholds established in advance either via a baseline or secondary data.
Percentage of households that demonstrate equitable intra-house food distribution/sharing.
Thresholds established in advance either via a baseline or secondary data.

What else do I need to know?

Food hygiene

Crises may disrupt people's normal hygiene practices. It may be necessary to promote food hygiene and actively support measures compatible with local conditions and disease patterns. Stress the importance of washing hands before handling food; avoiding contamination of water; and taking pest-control measures. Inform food recipients how to store food safely at the household level. Reference Wash Standard XX

Information-sharing and feedback collection

Develop mechanisms for sharing information and collecting feedback from people receiving assistance, particularly women. Develop programs that hold males in the household accountable for food use and safety. Challenge inequitable gender norms around domestic responsibilities. Schools, safe learning and child-friendly spaces are suitable locations for dissemination of instructions about food. Develop accessible formats or diagrams for people with varied communication requirements. (chapters 5.3)

Cooking methods

Carry out a cooking assessment to understand what available cooking methods exist, including types of stoves and the fuel used for cooking. When necessary, provide or subsidise appropriate fuel, or establish a wood harvesting programme with special consideration for the safety of women and girls. For information on water access, quantity, quality, and facilities, see WASH Standards XX. For information on cooking and eating utensils and water containers, see Household Items/Habitable Shelter Standards XX.

Food processing and storage

Access to food processing facilities, such as cereal grinding mills, enables people to prepare food in the form of their choice and saves time for other productive activities. Heat, cold, and moisture influence the storage of perishable foods. Where the context offers access to perishable food items, consider appropriate facilities to store these, such as watertight containers, coolers, and freezers. Individuals who may require assistance with storage, cooking and feeding include young children, older people, people with disabilities and people living with HIV. Outreach programmes or additional support and follow-up may be necessary to support some people with reduced capacity to provide food to dependents (for example, parents with disabilities).

Intrahouse food use monitoring

Humanitarian organisation should monitor and assess intra-house use of food on a regular basis. At the household level, food commodities can either be consumed as intended or be traded or bartered. The goal of the barter could be to access other more preferred food items, non-food needs or required services such as payment of school fees or medical bills. This intra-household allocation assessment should also monitor food use by sex, age, and disability, as well as appropriateness and adequacy.

The use of cash and vouchers

It is important to factor in and manage the risk of panic-buying when households receive cash or vouchers. Prepare traders and people receiving assistance before distribution, at distribution, and post distribution. For example, consider if food will be available throughout the month or it would be better to stagger distributions over the course of a month. Vouchers can be issued in small denominations redeemable on a weekly basis, where appropriate. The same principle should apply to cash that is redeemable through ATMs or other forms of digital payments.

References and further reading (draft)

1. ACF Emerging Good Practices in Use of Fresh food voucher guidance; http://www.actionagainsthunger.org/sites/default/files/publications/ACF_Fresh_Food_Voucher_Good_Practice_Guide_2012.pdf
2. Codex Alimentarius. Standards, Guidelines and Advisory Texts (www.fao.org/fao-who-codexalimentarius/standards/en/)
3. FAO Food Safety and Quality: <http://www.fao.org/food/food-safety-quality/home-page/en/>
4. FAO Save Food: Global Initiative on Food Loss and Waste Reduction – Extent, Causes and Reduction (<http://www.fao.org/food/food-safety-quality/home-page/en/>)
5. Save the Children UK ‘Cost of Diet’ methodology: <http://www.savethechildren.org.uk/resources/online-library/the-cost-of-the-CBA-Program-Quality-Toolbox>
6. The NUTVAL Tool - <http://www.nutval.net/2007/05/downloads-page.html>
7. <http://www.safefuelandenergy.org/about/index.cfm>
8. Infant and young child feeding standards
9. INEE Minimum Standards for Education.
10. UNHCR cash and protection guidance; CaLP transfers guidance
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12. WFP – Revolution: From food assistance to Food Transfers 2010
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21. WHO Guideline on Researching Violence Against Women <http://www.who.int/reproductivehealth/publications/violence/9241546476/en/>
22. Minimum Standards for Child Protection in Humanitarian Assistance.
23. UNICEF; Including children with disabilities in humanitarian action. Nutrition booklet. <http://training.unicef.org/disability/emergencies/index.html>
24. UNICEF. Module on Child Functioning and Disability. <https://data.unicef.org/topic/child-disability/module-on-child-functioning/>

6. Livelihoods

People's ability to protect their livelihoods will depend on their vulnerability to crises. Understanding vulnerabilities before, during and after a crisis makes it easier to provide appropriate assistance and identify how communities can rehabilitate and improve their livelihoods.

People rely on the stability of a combination of factors to maintain their livelihood, including activities; financial and physical assets; resources; skills; political system; markets and economic conditions, and social networks.

Crises triggered by prolonged political instability and insecurity, economic collapse or conflict can disrupt and restrict livelihood activities and market functionality. Those affected may lose their jobs or have to abandon their land or water. They may also lose essential assets that had to be abandoned, or were destroyed, contaminated, or taken by warring parties.

In the initial stages of such crises, providing help to meet basic survival needs is the priority. However, over time, other actions must be taken to rehabilitate and strengthen the systems, skills and capacities that will enable affected people to rebuild their livelihood.

Those who produce food need access to land, water, livestock, support services and markets that can support production. They should have the means to continue production without compromising other resources, people and systems.

In urban areas, livelihoods can vary enormously. For example, household composition, skills, physical abilities and education will determine ability to participate in different economic activities. Generally, the urban poor have a less diverse range of coping strategies when faced with food insecurity than their counterparts in rural areas. For example, they cannot access land to grow their food, and intergenerational support networks tend to be weaker in urban contexts.

To re-establish livelihoods, it is important to bring together those who are directly affected and those influencing the creation of an enabling environment. Together, these two groups should identify the needs, priorities and preferences of a livelihood intervention. This should go hand in hand with an appropriate analysis of labour, services and associated product markets. All livelihoods interventions should aim to use and/or support local markets. (Cross-reference to MERS handbook)

Livelihoods Standard 6.1: Primary production Primary production mechanisms receive protection and support.
Key action 1: Provide production inputs/assets to farmers. <ul style="list-style-type: none"> Where markets are functioning and/or can be supported to recover, preference is for cash or vouchers to give farmers flexibility to select preferred inputs, seeds or livestock species. Introduce new technologies after a crisis if they have been tested in or adapted to similar contexts. Determine how producers use or spend cash on inputs.
Key action 2: Deliver inputs that are locally acceptable, conform to appropriate quality norms and are on time for best season use. <ul style="list-style-type: none"> Favour local crop varieties that are already in use and in demand for the upcoming season (consumption and/or sale).
Key action 3: Introduce inputs and services with care not to exacerbate vulnerability or increase risk for recipients or create conflict.
Key action 4: Involve the males and females of affected and host population in action planning ensuring the meaningful participation of men and women.
Key action 5: Train crop and livestock farmers in better management practices.
Key action 6: Minimise the negative consequences of extreme seasonal or other abnormal price fluctuations on markets. <ul style="list-style-type: none"> Assess and stimulate the market and demand for locally produced crops, vegetables and other agricultural products where possible.
Key indicators
<i>Percentage change in the number of productive assets owned or accessed by a targeted population (households, communities, productive associations).</i>
<i>Percentage of households reporting that they have access to adequate storage facilities for their produce.</i>
<i>Percentage of targeted populations that transition through/leave a food assistance programme once they have enough productive assets to resume/strengthen their livelihoods.</i>
<i>Percentage change in the targeted population's production compared to a normal year.</i>
<i>Number of households with improved physical access to functioning markets due to programme interventions.</i>
What else do I need to know? Production strategies Crop and livestock production strategies must have a reasonable chance of developing and succeeding. Influences on success include: <ul style="list-style-type: none"> access to sufficient natural resources and financial capital; existing livelihood skills;

- community preferences/priorities;
- environment and social considerations;
- the scalability of livelihood interventions;
- availability of labour;
- access to good quality and appropriate varieties of seeds that are adapted to local agro-ecological conditions; and
- productive animals, which represent a crucial food security asset.

Ensure the diversification of livelihood activities within a local area, while preventing over-use of natural resources. Environmental damage not only increases the risk of a crisis, but contributes to tensions between communities. Livelihoods interventions should be climate change smart where possible, for example seeds that are more resistant to future climatic changes, or supporting livelihoods activities that are climate smart, for example duck instead of chicken farming in flood prone areas.

Energy

Consider energy needs for mechanised labour, food processing, cold chains for food preservation, communication, and efficient burning devices.

Improvements

Consider introducing improved crop varieties, livestock or fish-stock species, new tools, fertilisers or innovative management practices. Strengthen food production based on the maintenance of pre-crisis patterns and/or links with national development plans.

New technologies

Producers and local consumers must understand and accept their implications for local production systems, cultural practices and the natural environment. When introducing new technologies, provide appropriate community consultations, information and training, and ensure access for groups at risk of discrimination (women, older people, minorities, people with disabilities, etc.). Wherever possible, coordinate with private and government livelihoods experts. Make efforts to ensure ongoing support and future accessibility to the technology. Most importantly, assess the commercial viability of the technology.

Cash-based assistance or credit

These can be provided to use at seed and livestock fairs. Be sure to understand the potential implications of a chosen support mechanism on affected people's nutrition: assess whether the mechanism allows people to produce nutrient-rich food themselves, or whether they earn cash which they then use to purchase food. Assess the feasibility of Cash-Based Assistance for the purchase of production inputs, taking into account the local availability of goods, access to markets and the existence of a safe, affordable and gender sensitive cash transfer mechanism.

Seasonality and price fluctuations

Time the provision of agricultural inputs and veterinary services to coincide with the relevant agricultural and animal husbandry seasons. For example, the provision of seeds and tools must precede the planting season. Emergency destocking of livestock during drought should take place before excess livestock mortality occurs. Restocking should start when the likelihood of recovery is high, for example, following the next rainy season. When necessary, provide food for seed/input protection. Ensure that these inputs are sensitive to the different capacities, needs and risks of various groups including women and persons with disabilities. Extreme seasonal price fluctuations adversely affect impoverished agricultural producers who sell their produce when prices are at their lowest (usually just after harvest). These fluctuations also have a negative impact on livestock owners who have to sell during drought. Conversely, consumers who

have little disposable income cannot afford to invest in food stocks. They depend on small but frequent purchases. As a result, they buy food even when prices are high (for example, during drought).

Seeds

Farmers and local agricultural experts should approve specific varieties. Seeds should suit the local agro-ecology and farmers' own management conditions. They should also be disease-resistant and withstand potentially harsh weather conditions due to climate change. Test the quality of seeds originating from outside of the region and check that they are appropriate for local conditions. Give farmers access to a range of crops and varieties in any seed-related intervention. This allows them to work out what is best for their particular farming system. For example, farmers growing maize may prefer hybrid seeds to local varieties. Comply with government policies regarding hybrid seeds. Do not distribute genetically modified (GMO) seeds without the approval of local authorities. Make farmers aware of what they are getting if the aid contains GMO seeds. When farmers use vouchers or seed fairs to access seed, do not prevent them buying seeds of their choice from local, formal suppliers. Farmers may prefer traditional varieties, which are adapted to the local context. These will definitely be available at a lower price meaning they get more seeds for the same voucher value.

Security risks

Providing free inputs may disturb traditional social support, compromise redistribution mechanisms, push the private sector out of business. This can create tensions as well as jeopardise future access to inputs.

Primary food production may not be viable if there is a shortage of vital natural resources over the long term. It is also not feasible if there is a lack of access for certain populations (for example, landless people).

Promoting production that requires increased (or changed) access to locally available natural resources may heighten tensions within the local population. This can cause conflicts that may in turn restrict access to water and other essential needs.

Supply chain

Obtain inputs and services for food production, such as veterinary services and seeds, through existing local, legal and verifiable supply chains. To support the local private sector, use mechanisms such as cash or vouchers that link primary producers directly to suppliers. When designing local purchasing systems, consider the availability of appropriate inputs and suppliers' ability to increase supply. Assess the risk of inflation and the sustainability of the quality of inputs. Monitor and mitigate the negative effects of responses, including large localised food purchases and distribution, on market prices. Give careful consideration to the effects of both local food purchases and imports on local economies before a response.

Monitoring of cash-based assistance

Monitor if the project aim is being reached and that producers actually plant the seeds and use tools, fertilisers, nets and fishing gear as intended. Review the quality of the inputs in terms of their performance, their acceptability and producer preferences. Evaluate how the project has affected food availability at household level. For example, consider the quantity and quality of food that is being stocked, consumed, traded or given away. Where the project aims to increase production of a specific food type (animal/fish products or protein-rich legumes) investigate the households' use of these products. Include an analysis of the benefit to different members of the household such as women, children, older people, and people with disabilities.

Post-harvest storing

A significant proportion of produce (estimated average of 30%) is unusable after harvest. Support the affected population with post-harvest activities such as handling, storage, processing, packaging,

transportation and marketing. Advise and enable them (where possible) to store their harvest to avoid moisture and Aflatoxins from fungi. Enable them to process their crops, especially cereals.

Livelihoods Standard 6.2: Income and employment

Women and men receive equal access to appropriate income-earning opportunities where income generation and employment are feasible livelihood strategies. (Ref MERS Employment Standards).

Key action 1: Base decisions regarding income-generating activities on a gender sensitive market assessment.

- Ensure that participation in income-earning opportunities does not undermine childcare or other caring responsibilities, as this could increase the risk of undernutrition and of other public health risks.

Key action 2: Choose types of payment (cash, voucher, food or a combination) based on a participatory analysis.

- Understand local capacities, safety/protection benefits, immediate needs, equitable access, existing market systems and the affected person's preferences.

Key action 3: Base the level of payment on the type of work, local rules, objectives for livelihoods restoration and local labour rates.

- Coordinate with other humanitarian organisations.
- Consider safety-net measures such as unconditional cash and/or food transfers for households that cannot participate in work programmes.
- To the extent possible use cash transfers over vouchers or in-kind payments.

Key action 4: Promote the adoption and maintenance of inclusive, safe and secure working environments.

- Mitigate the risk of sexual harassment, discrimination, exploitation and abuse in the workplace for women, girls and other at-risk groups.

Key action 5: Promote collaborations with the private sector and other stakeholders to create sustainable employment opportunities and provide capital resources to facilitate livelihood recovery.

Key action 6: Choose environmentally sensitive options for income generation if there is support from market or business data and/or they do not contravene other good practices for for-work opportunities.

- Base decisions regarding income generation on an environmental assessment
- Ensure debris to be cleared does not contain hazardous materials. Cash for work should not involve any clearance at industrial or waste management sites.
- Conduct activities such as tree planting, camp clean-up and environmental rehabilitation through food/cash for work programmes to increase the engagement of displaced and host populations in their surrounding environment.
- Promote the production of environmentally friendly construction materials as an income-generating activity
- Train and encourage composting of biodegradable waste for use as fertiliser.

Key indicators

<p>Percentage of the target population who improve their net income during a defined period.</p> <ul style="list-style-type: none"> • Define the income threshold in advance using either a baseline or secondary information.
<p>Percentage of households with access to credit.</p> <ul style="list-style-type: none"> • Define the income threshold in advance using either a baseline or secondary information.
<p>Percentage of the targeted population who diversify their income-generating activities and therefore increase their net income by a specified amount.</p>
<p>Percentage of the targeted population employed (or self-employed) in sustainable livelihoods activities for a defined period of time.</p> <ul style="list-style-type: none"> • To show sustainability, employment should last a defined period of time (6 – 12 months).
<p>Percentage of the affected population with physical and economic access to functioning markets and/or other livelihood support services (formal or informal)</p>

What else do I need to know?

Appropriateness of initiatives

A gender sensitive labour and market analysis is fundamental to justify and define activities. Use existing tools to understand markets and economic systems. Food security interventions should be based on how markets are functioning currently, how they functioned pre-crisis and their potential for improving the living conditions for poor people. Discuss alternatives or adaptations for certain groups (such as pregnant women, youths, people with disabilities or older people) within the targeted group. Include an analysis of their skills, experience and capacities, as well as potential risks and mitigation strategies. Understand how different groups of the affected population (gender, minorities, etc.) may have restricted access to markets and livelihood opportunities, and support them in getting access. Consider logistical obstacles and cultural norms that may prohibit some people from accessing certain types of work.

Safety-net measures

The effect of a crisis on some households may prevent participation in employment and income-generating activities. Combine safety-net measures with a plan to provide links to existing social protection systems include host those implemented by the government. Recommend new safety nets where needed. Delivery of safety-net measures must support the fair distribution of resources (for example, ensuring that women and girls have direct access to resources where appropriate). Monitor for and address potential tensions in households caused by targeted support to women and girls. At the same time, devise and implement a strategy that will enable safety net recipients to transition to safe and sustainable income-generating activities.

Payments

Implement remunerated work programmes only after having carried out an appropriate level of market analysis. Payment may be in cash or in food (or a combination of these) and should enable food insecure households to meet their needs. As part of decent employment, agencies should advocate for Cash-Based payments whenever feasible. Rather than compensation for any work in the community, make payment an incentive to directly self-benefit. Consider people's purchasing needs and the impact of giving either cash or food for other basic needs (such as school, health services and social obligations). Decide on the type and level of payment case-by-case.

Purchasing power

Provision of cash may have positive multiplier effects in local economies. It could also cause local inflation for key goods. Food distribution could also affect the purchasing power of people receiving assistance: the 'purchasing power' associated with a given food or food basket influences whether the assistance recipient's household eats or sells it. Some commodities are easier to sell for a good price than others, for example, oil versus blended food. Establish an understanding of household food sales and purchases when assessing the wider impact of food distribution programmes.

Types of payments

Ensure equal remuneration for work of equal value for groups at risk of discrimination. Follow acceptable guidance for setting payment levels. Consider the impact of resale values on local markets where payment is in-kind and provided as an income transfer. New income-generating endeavors should enhance the range of income producing sources. They should not replace existing ones. Remuneration should not have a negative impact on local labour markets, for example by causing wage rate inflation, diverting labour from other activities or undermining essential public services.

Safety at work

Use practical procedures for minimising health risk or treating injuries. For example, provide training, protective clothing and first-aid kits, where necessary. Minimise the risk of exposure to communicable

diseases and HIV. Establish safe access routes to work sites. Ensure routes are well-lit or provide workers with torches. Use early warning systems (such as bells, whistles, radios and other devices) and encourage security norms, such as travelling in groups or avoiding travel after dark. Ensure that all participants are aware of emergency procedures and can access early warning systems. Tools are available to help people assess risks to their livelihoods.

Household and family duties

Consider providing care facilities for people that need such support. Speak regularly with affected people, including women and men, to learn their preferences and priorities regarding income generation, cash for work (CFW) opportunities and other household and family needs. Discuss workloads and increased tensions in the home due to changes in traditional gender roles and women's increased control over assets. Develop strategies for addressing these concerns. CFW activity schedules should take into account the daily routines of men and women. They should also consider their existing skills to ensure that both men and women have equal opportunities to participate fully. Programmes should not adversely affect access to other opportunities, such as other employment or education. Programmes should not divert household resources away from existing productive activities. Participation in income generation should respect national laws on the minimum employment age. This is usually not less than the age of completion of compulsory schooling.

Household food security

Fair payment means that the income generated significantly contributes to the establishment and maintenance of household food security. Learn about the individual household management of cash or food transfers (See FSN livelihood standard X, on monitoring cash provision). Distribution can either exacerbate or diffuse existing tensions and affect the food security of household members differently particularly women and girls. Provide environmentally sensitive options for income generation if there is support from market or business data and/or they do not contravene other good practices for for-work opportunities. For example:

- Conduct environmental activities such as tree planting, camp clean-up and environmental rehabilitation through food/cash for work programmes. Though temporary, these activities will increase the engagement of displaced and host populations in their surrounding environment.
- Ensure that any debris to be cleared does not contain hazardous materials. CFW should not involve any clearance at industrial or waste management sites.
- Promote the production of environmentally friendly construction materials as an income-generating activity and do so in vocational training.
- Train and encourage composting of biodegradable waste for use as fertiliser. Consider the accessibility and safety of the working environment.

Private sector

The private sector can play an important role in facilitating livelihood protection and recovery. Where possible, establish links/partnerships to foster the creation of employment opportunities. These relationships can also help to establish and grow micro, small and medium enterprises. Business and tech incubators can provide financial capital and opportunities for knowledge transfer.

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