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Guidance for the Prevention of Malnutrition in Humanitarian Settings in Eastern and Southern Africa

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Contents

Acronyms

ANC	Antenatal care
BEP	Balanced energy and protein
BMS	Breastmilk substitutes
BSF	Blanket supplementary food
CHNW	Community health and nutrition worker
DHIS	District health information system
ECD	Early childhood development
ECE	Early Childhood Education
FAO	Food and Agriculture Organization
GBV	Gender-based violence
GFA	General food assistance
GFD	General food distribution
HCT	Humanitarian cash transfer
HEB	High energy biscuit
HMIS	Health management information system
HRP	Humanitarian response plan
IFA	Iron and folic acid
IFAS	Iron and folic acid supplementation
IMNCI	Integrated management of newborn and childhood illnesses
IPC	Integrated phase classification
IYCF-E	Infant and young child feeding in emergencies
MMP	Multiple micronutrient powder
MMS	Multiple micronutrient supplementation
MoA	Ministry of Agriculture
MoE	Ministry of Education
MoH	Ministry of Health
MQ-LNS	Medium quantity lipid nutrient supplement
MUAC	Mid-upper arm circumference
PBWGs	Pregnant and breastfeeding women and adolescent girls
SBC	Social and behaviour change
SNF	Supplementary nutritious foods
SQLNS	Small supplements for the prevention of malnutrition in early childhood
SRH	Sexual and reproductive health
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UPF	Ultra-processed food
VAS	Vitamin A supplementation
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization
WHZ	Weight-for-height z-score

1. Background

Countries in Eastern and Southern Africa (ESA) face repeated shocks and stresses, including political and economic instability, conflict, food insecurity, disease outbreaks and climate hazards including droughts, floods, and cyclones. Many populations experience both chronic and acute vulnerabilities that make them highly susceptible to the impacts of shocks and stresses. If underlying vulnerabilities are not adequately addressed, the risk of malnutrition increases, especially among young children and pregnant and breastfeeding women and girls (PBWGs), leading to increased risk of child morbidity and mortality, and negative impacts throughout the life cycle and into the next generation.

The ESA region faces high burdens of malnutrition, including wasting, stunting, micronutrient deficiencies and rapidly rising rates of overweight and obesity. An estimated 28 million children under 5 years of age in the region experience stunted growth[1] while 13 million experience wasting, 4 million of which experience severe wasting.[2] Over 50 per cent of severely wasted children in ESA live in Ethiopia, South Sudan and Somalia – the three countries in the region most affected by humanitarian emergencies.[2] Maternal undernutrition is also extremely widespread, with 33 per cent of adolescent girls and women aged 15-49 years experiencing anaemia, surging to 43 per cent in Somalia.[3] School-age children and adolescents are also vulnerable.

An estimated 8 per cent of children aged 5-19 years in ESA experience underweight and 33 per cent of adolescent girls experience micronutrient deficiencies.[4] Overweight (including obesity) is also on the rise across all age groups, affecting 5 per cent of children under 5,[1] 10 per cent of school aged children and adolescents[4] and 32 per cent of women.[3]

Food insecurity and poor-quality child diets are a significant driver of all forms of malnutrition. Child food poverty is common in ESA, where 67 million children under 5 years of age (76 per cent) live in child food poverty, 25 million of whom live in severe child food poverty, meaning that they consume foods from two or less food groups per day (usually only staple foods and breastmilk).[5] Child food poverty is estimated to account for around half of cases of child wasting and one third of cases of child stunting.[5] Child food poverty is often exacerbated in humanitarian settings due to population movement, disruption of food supply chains and escalating food prices, putting nutritious foods further out of the reach of vulnerable populations.

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Poor child care and feeding practices and reduced access to services also drive malnutrition in humanitarian settings. Just over half of infants under 6 months (56 per cent) are exclusively breastfed in ESA and four out of ten children aged 6-23 months regularly consume no vegetables or fruits.[5] Already fragile health, social protection, education and water, sanitation and hygiene (WASH) systems are often disrupted and weakened in humanitarian settings and in many countries, national services are not built to adapt and expand in response to escalating needs, leading to vast gaps in care.

Humanitarian nutrition responses traditionally focus on finding and treating wasted children and the provision of a narrow set of prevention services through the health system. This typically includes nutrition counselling, education and messaging, vitamin A supplementation with deworming and sometimes additional micronutrient supplementation. However, this approach fails to adequately and holistically address the underlying drivers of nutrition vulnerability, including poverty, lack of access to nutritious foods and lack of access to multi-sectoral nutrition services. Nutrition counselling or information is also frequently generic and not tailored to the context of the emergency. As a result, caregivers receiving nutrition information and counselling are often unable to implement this advice, and overall prevention efforts fall short of preventing a deteriorating nutrition situation.

Effective humanitarian nutrition responses must deliver a multi-system package of interventions to address nutrition vulnerability to prevent all forms of malnutrition, alongside the early detection and treatment of child wasting for where prevention fails. Not only is this a more effective approach, but also a more efficient and sustainable approach. This is critical in the context of severe funding cuts. This focus on prevention is in line with the updated WHO recommendations on the prevention and management of wasting and nutritional oedema in infants and children under five years, Global Action Plan on Child Wasting and the UNICEF-WFP Joint Action to Stop Wasting (JASW) partnership and contributes to the Humanitarian Development and Peace Nexus.

UNICEF's commitments to prevent malnutrition in humanitarian settings are also described in the UNICEF nutrition strategy 2020-2030 and UNICEF's Core Commitments for Children (CCCs) which emphasize the need to prevent all forms of malnutrition in children under 5 years of age, school-age children and adolescents and PBWGs before, during and after humanitarian emergencies.

2. Purpose and scope of guidance

The purpose of this guidance is to support UNICEF country offices, Governments, other United Nations (UN) agencies and implementing partners to develop context-specific packages of multi-sectoral interventions to prevent malnutrition in humanitarian settings in ESA. Table 1 presents a list of possible interventions targeted at different stages of the life course, drawn from multiple existing guidance documents listed in Annex 3. Interventions are intended to run alongside the early detection and management of child wasting, according to WHO guidance, Global Action Plan on Child Wasting and UNICEF-WFP JASW partnership. Table 2 presents a list of enabling actions that can be taken during preparedness, response and recovery stages to support these interventions. Actions should be implemented in keeping with the principles described in Section 3, contextualized based on local needs and capacities, as described in Section 4, and implemented by multiple agencies in collaboration, described in Section 7.

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3. Principles

The following principles should be applied when implementing interventions to prevent malnutrition in humanitarian settings:

- **Act before malnutrition rises:** For maximum effectiveness, the timing of prevention interventions must align with increasing levels of nutrition vulnerability, i.e. factors that contribute to malnutrition, rather than increasing levels of malnutrition. Responses that react to increases in child wasting, or late responses, cost more and risk loss of life.
- **Engage with and ensure accountability to affected populations:** This means behaving ethically towards the communities and populations being served and engaging with them to hear their views and respond appropriately. Transparent communication and community feedback are crucial.
- **Abide by humanitarian principles and global humanitarian standards**: As laid out in UNICEF's CCC, actors must abide by the humanitarian principles of humanity, impartiality, neutrality, independence, and globally agreed humanitarian standards including Sphere, Inter-Agency Network for Education in Emergencies Minimum Standards (INEE) and Minimum Standards for Child Protection in Humanitarian Action (CPMS).
- **Strengthen the Humanitarian Development and Peace (HDNP) nexus:** This means linking immediate relief with long-term development and peace building efforts to build community resilience and use resources efficiently. This requires actors to engage with affected communities to define solutions, and to leverage and strengthen national systems wherever possible.
- **Proactively engage in localization:** This means ensuring that Governments and local actors are engaged in planning for and responding to crises and have control over the decisions that affect them. This requires the strengthening of national and sub-national institutions and advocacy for the greater participation of women, indigenous groups and young people in local governance.

- **Use a multi-system approach to address the underlying causes of malnutrition:** Informed by UNICEF's conceptual framework on maternal and child nutrition, actors in multiple systems (food, health, social protection, WASH and education) must collaborate through joint planning and coordinated service delivery to address the multifaceted determinants of maternal and child nutrition. This requires multi-agency and sectoral coordination, convergence and complementarity.
- **Target prevention actions at population level:** Targeting prevention interventions based on individual nutrition outcomes (e.g. child wasting) will not prevent malnutrition before it occurs and can result in loss of life. Packages of prevention interventions should be targeted to the most nutritionally vulnerable populations at different stages of the life course.
- **Monitor, evaluate, and continuously adapt interventions according to changing needs:** Crisis situations change rapidly and therefore interventions must be built to adapt. For example, routine nutrition counselling messages may quickly become irrelevant in a crisis where nutritious foods become unaffordable or unavailable. In this situation, counselling messages should be adapted to reflect the prevailing context and delivered alongside support that makes it possible to put messages into practice, e.g. cash transfers and/or the provision of food supplements.

4. Tailoring to context

Given the wide variation in contexts, meaningful impact requires that a combination of prevention interventions are tailored to suit local needs, diets, cultural practices, systems capacities, available resources, and ongoing or planned humanitarian programmes. This means tailoring the programme to the local context at the design stage and throughout the project cycle.

To tailor prevention actions according to nutrition needs, consider:

- **Nutrition vulnerabilities:** Assess pre-existing levels of nutrition vulnerability, including nutrition outcomes (stunting, wasting, micronutrient deficiencies, overweight and obesity) and nutrition contributing factors, prior to the crisis. Nutrition contributing factors can relate to foods (e.g. minimum diet diversity/ child food poverty and food insecurity), services (e.g. coverage of nutrition, WASH and social protection services, disease prevalence), practices (e.g. infant and young child feeding), poverty and social norms. National data can be complemented with data from the Nutrition Vulnerability Analysis (NVA), Integrated Phase Classification (IPC) Protracted Food and Nutrition Crises, Acute Malnutrition, and Acute Food insecurity analyses, or other multisectoral risk profiles.
- **Nature and impact of the crisis:** Analyse the nature of the current shock or crisis and crisis drivers, including likely future scenarios based on risk projections (e.g. seasonality and climate shocks and stresses, conflict trends, political instability, market disruptions and prices, displacement patterns). Determine how the crisis may exacerbate nutrition vulnerabilities and create new nutrition risks. For example, market assessments can help to determine the impact of the crisis on food markets and likely effects on food and nutrition security.
- **Nutritionally vulnerable groups:** Identify which groups are most at risk of malnutrition in the current situation according to stage in the lifecycle. Give special consideration to pregnant and breastfeeding women and girls (PBWGs), infants and young children, adolescent girls, and populations with additional vulnerabilities including internally displaced persons, refugees and host populations, people with disabilities, and socially excluded, remote and underserved populations.

To tailor prevention actions according to existing capacities and resources, consider:

- **National capacities and existing services:** Identify preventive services being routinely delivered through national health, social protection, education and other systems. Assess the extent to which these services have been disrupted by the crisis, the level of domestic crisis management capacity and what support is provided by development partners.
- **Humanitarian response capacities and resources:** Map capacities to deliver preventive services within the humanitarian response, coordinated by the IASC Nutrition Cluster or Nutrition Sector coordination and other relevant clusters (e.g. the Cash Working Group and Food Security Cluster). Consider capacities of partner agencies, the scope and coverage of services, implementation modalities, and readiness to scale. Take stock of the existing financial, technical, and logistics resources available for prevention activities, and identify key resource and capacity gaps that need to be addressed.

5. Framework of interventions to prevent malnutrition in humanitarian settings

This section describes possible interventions to prevent malnutrition in humanitarian settings, targeted at different stages of the life course and across multiple nutrition influencing sectors and systems. Figure 1 provides an overview of interventions across sectors and systems, and Table 1 provides a detailed list. Actual packages of interventions should be tailored to the context, as outlined in Section 3. While actions are organised by the sector or system most likely to deliver them, this may change in humanitarian settings depending on system capacities.

Interventions are intended to be implemented by multiple stakeholders, including governments, UN agencies (including UNICEF, WFP, WHO, FAO, and UNHCR), the World Bank and implementing partners, as described in Section 7. All partner actions should strengthen the national response and contribute to the Humanitarian Needs and Response Plans (HNRP), and should be coordinated through the IASC-endorsed country-level cluster system where activated and sectoral coordination mechanisms, ideally led by government. Annex 2 provides a list of elements to consider when setting up a framework to monitor delivery.

Figure 1: Summary of interventions to prevent malnutrition in humanitarian settings

Orange – In situations with high nutrition and food insecurity (e.g. IPC acute malnutrition 4 or above)

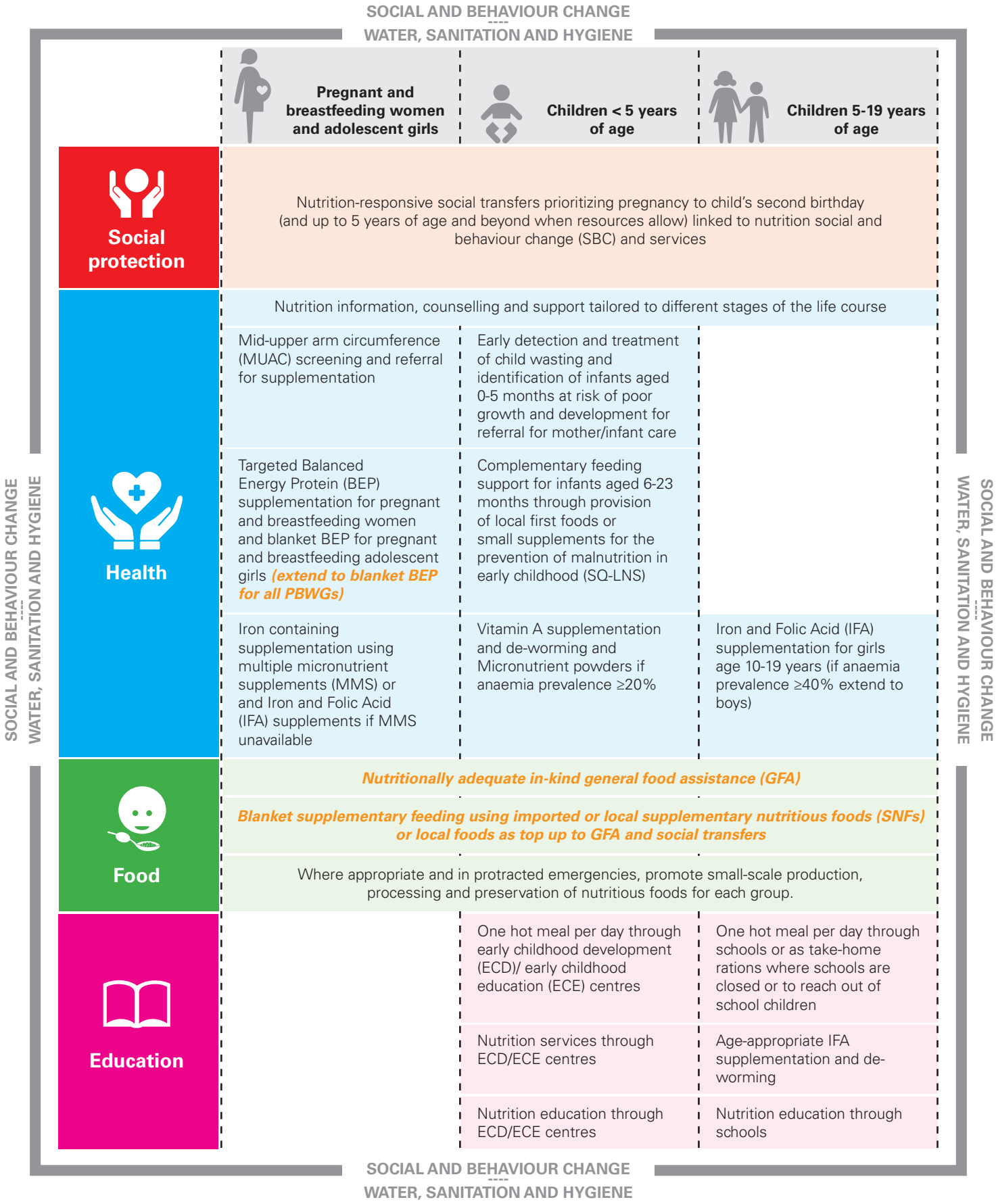

Table 1: Interventions to prevent malnutrition in humanitarian settings

Focus group	Interventions
Children under 5 years of age	
Children aged 6-59 months	**Health:** • **Nutrition education and counselling and skilled breastfeeding support in safe spaces** for mothers, caregivers and family members to support optimal care and feeding practices. This should be integrated with psychosocial and mental health support; counselling on water, sanitation and hygiene (WASH) and early childhood development (ECD); and promotion of health services including vaccinations and integrated management of newborn and childhood illness (IMNCI) activities. • **Screening** for wasting and rapid referral for supplementation and treatment. • **Micronutrient supplementation:** provide vitamin A supplementation and deworming; if anaemia prevalence ≥20% or anticipated to be high, provide multiple micronutrient powders (MNP)[6] (but do not use MNPs for children aged 6-23 months if using SQ-LNS*). • **Macronutrient supplementation:** provide local first foods or small supplements for the prevention of malnutrition in early childhood (SQ-LNS) (but do not give MNPs to children receiving SQ-LNS*). Macronutrient supplementation should prioritize young children in the complementary feeding period (6-23 months of age) but can be extended to children aged 24-59 months where needed and resources allow.
	Food: • **General food assistance:** Where markets are not functional, provide nutritionally adequate in-kind general food assistance (GFA) to meet basic household food and nutrition needs including children under 5 years of age. • **Blanket supplementary feeding:** In situations of high food and nutrition insecurity where GFA and social protection are not enough to prevent malnutrition, provide blanket supplementary feeding for children under 5 years of age using imported or local supplementary nutritious foods (SNFs), or local foods. • **Support for home food production:** If appropriate, in protracted emergencies, promote the small-scale production, processing and preservation of nutritious foods for children, e.g. through climate smart home gardening, small animal husbandry and/or fisheries, alongside social and behaviour change (SBC) to support consumption by children.
	Social protection: • **Nutrition-responsive social protection:** Target cash transfers (or vouchers or food transfers where markets are dysfunctional) to all pregnant women and children under 2 years. Where resources allow, including all children under 5 years of age. Ensure transfer size is sufficient to support nutritious diets, or provide cash or in-kind top ups, and link cash delivery to nutrition SBC and services.
	Education: • **Nutrition services through early childhood development (ECD)/ early childhood education (ECE) centres** including healthy meals for children, nutrition counselling and education and nutrition screening alongside emergency ECD materials/kits. ECD/ECE centres can also include mother-baby corners, child friendly spaces and creches in humanitarian settings.

Focus group	Interventions
Infants aged 0-5 months	**Health:** • **Nutrition education and counselling and skilled breastfeeding support in safe spaces** for mothers, caregivers and family members to support optimal infant care and feeding practices. This can be integrated with psychosocial and mental health support; counselling on WASH and ECD and promotion of health services including vaccinations and Integrated Management of Neonatal and Childhood Illness (IMNCI) activities. • **Specialized support to caregivers of non-breastfed infants** including skilled breastfeeding support for re-lactation and wet nursing. Where required, establish a secure and timely supply of an appropriate breastmilk substitute (BMS). In the event of public health emergencies (Ebola, Mpox outbreaks), consider the use of ready-to-use infant formulae for non-breastfed infants only when necessary and based on global recommendations.[7,8] • **Implement the 2023 WHO wasting recommendations for mother-infant pairs**[9] to identify infants aged 0-5 months at risk of poor growth and development and refer mother and/or infant for adequate care, including maternal mental health services where required. • **SBC** strategies to support optimal breastfeeding, care and parenting practices.
	Social protection: • **Nutrition-responsive social protection:** Target cash transfers (or vouchers or food transfers where markets are dysfunctional) to all pregnant women and children under 2 years of age. Where resources allow, including all children under 5 years of age. Ensure transfer size is sufficient to support nutritious diets, or provide cash or in-kind top ups, and link cash delivery to nutrition SBC and services.
School-age children and adolescents	
Children aged 5-19 years	**Education:** • **School meals:** Provide one hot, nutritious meal per day at school. Where schools are closed or to reach out-of-school children, provide take home rations or meals in the community, especially when GFA is not provided or is insufficient. Target all children aged 5–19 years where possible, prioritizing primary school-aged children if resources are limited. • **Nutrition education** delivered in and outside of schools to support healthy diets and care in humanitarian settings, integrated with WASH, psychosocial and mental health, and sexual and reproductive health (SRH) education and support.
	Food: • **General food assistance:** Where GFA is provided, ensure that food rations cover the caloric and micronutrient needs of children aged 5-19 years, limiting ultra-processed foods (UPFs) and prioritizing fortified staples and fresh foods. Ensure that a designated adult collects rations for adolescent-headed households to prevent school dropout during distributions.
	Social Protection: • Nutrition-responsive social protection: Include school-age children and adolescents in cash transfer programmes where resources allow, especially where schools are closed, school meals are unavailable, and/or families lose livelihoods. Ensure transfer size covers the cost of a nutritious diet for children aged 5-19 years, or provide cash or in-kind top ups, and link to the delivery of nutrition SBC and services.

Focus group	Interventions
Specific to children aged 5-9 years	**Education and/or health:** • **Micronutrient supplementation and deworming:** If anaemia prevalence is ≥20% provide iron and folic acid supplements (IFA): if prevalence is 20-40% provide weekly IFA for three months on and three months off throughout the school year; if prevalence is ≥40% provide daily IFA for three consecutive months in a year), or provide MNPs (90 sachets over 6 months)[10] for example added to school meals. Provide deworming medication to all children (If worm infection prevalence is 20%-50% provide annually; if worm infection prevalence is >50% provide biannually). Follow recommendations on prevention, diagnosis and treatment of malaria in malaria endemic areas.[11] • **Child protection:** Integrate child protection and gender-based violence (GBV) services with nutrition services.
Specific to children and adolescents aged 10-19 years	**Education and/or health:** • **Micronutrient supplementation and deworming:** If anaemia prevalence is ≥20% provide iron and folic acid supplements (IFA) for girls delivered through schools, clinics or the community (if prevalence is 20-40% provide weekly IFA; if prevalences is ≥40%, provide daily IFA). If anaemia prevalence is ≥40%, extend supplementation to boys weekly (or intermittent dosing if weekly not feasible). Follow global recommendations for IFA supplementation of pregnant adolescent girls.[12] • **Sexual and reproductive health:** Inform and empower adolescent girls to prevent adolescent pregnancy and early marriage through formal or informal education, peer support groups, or adolescent-friendly sexual and reproductive health (SRH) services. • **Child protection:** Integrate gender-based violence (GBV) services with delivery of adolescent-friendly nutrition services.
Pregnant and breastfeeding women and adolescent girls (PBWGs)	
Health: • **Macronutrient supplementation:** In contexts of high nutrition and food insecurity (IPC acute malnutrition 4 and above), provide balanced energy protein (BEP) supplements to all PBWGs regardless of nutrition status. In contexts of medium nutrition vulnerability, provide targeted BEP to pregnant and breastfeeding women with low MUAC (<23 cm) and all pregnant and breastfeeding adolescent girls regardless of nutrition status. • **Micronutrient supplementation:** Provide multiple micronutrient supplements (MMS) to all PBWGs in humanitarian settings, or IFA supplements where MMS is unavailable. • **Nutrition education and counselling:** Provide nutrition education and counselling to PBWGs in safe spaces. • **Screening** for PBWGs using mid-upper arm circumference (MUAC) and rapid referral of identified cases for supplementation. • **Malaria:** Follow recommendations on prevention, diagnosis and treatment of malaria in malaria endemic areas.	
Food: • **General food assistance:** Where markets are not functional, provide nutritionally adequate in-kind GFA to ensure that households can meet basic food and nutrition needs including those of PBWGs. • **Blanket supplementary feeding:** In situations of high food and nutrition insecurity where GFA and social protection are not enough to prevent malnutrition, provide blanket supplementary feeding for PBWGs with imported or local supplementary nutritious foods (SNFs) or local foods. • **Support for home food production:** If appropriate, in protracted emergencies, promote the small-scale production, processing and preservation of nutritious foods, e.g. through climate smart home gardening, small animal husbandry and/or fisheries, alongside SBC to support consumption by PBWGs.	
Social protection: • **Nutrition-responsive social protection:** Target cash transfers (or vouchers or food transfers where markets are dysfunctional) to all PBWGs as well as children under 2 years extended to 5 years of age where resources allow. Ensure transfer size is sufficient to support nutritious diets, or provide cash or in-kind top ups, and link cash delivery to nutrition SBC and antenatal care (ANC) services.	

Interventions
Cross-cutting
WASH: Converge the above actions with delivery of safe water supply, sanitation and hygiene services (geographical convergence to reach the same populations) and ensure integration of WASH and nutrition services where appropriate and feasible (e.g. distribution of WASH kits at nutrition sites, especially for those children admitted to and exiting from wasting treatment).
Social and behaviour change (SBC): Provide coordinated, multi-sectoral SBC interventions to prevent malnutrition, ensuring that messages and strategies are specific to the emergency environment and related constraints, including availability of foods and multi-sectoral services.

6. Enabling actions

Actions are needed within multiple systems to create an enabling environment for the interventions described in Table 1. Enabling actions are described in Table 2, although this list is not exhaustive and should be contextualized. Table 2 lists many of these possible enabling actions across the recognized system building blocks, although this list is not exhaustive and should be contextualized as described in Section 4. Actions are divided by preparedness, response and recovery, but there is likely to be overlap depending on context and needs.

Table 2: Framework of enabling actions to prevent malnutrition during emergency preparedness, response and recovery

BUILDING BLOCK ONE: Leadership, policy and governance

Phase	Action
Preparedness	**Cross-cutting:** • Include in nutrition emergency coordination mechanisms actors responsible for the delivery of multi-sectoral interventions to prevent malnutrition. • Embed actions to prevent malnutrition within overall and sectoral (health, food, social protection, education and WASH) emergency preparedness policies and plans. • Develop nutrition risk-informed and shock responsive strategies, emergency response plans and standard operating procedures within relevant systems/sectors (health, food, social protection, education and WASH).
	Sector-specific: • **Health:** Develop national policy and guidance to protect breastfeeding from unethical marketing practices in humanitarian settings in line with the International Code on the Marketing of Breastmilk Substitutes, subsequent World Health Assembly resolutions and international guidance; develop technical guidance to prevent malnutrition in the context of public health emergencies; develop policies, standards and guidance on nutrition supplementation through humanitarian supply chains (including SQLNS, local 'first foods', BEPs). • **Food:** Develop guidelines to regulate food donations to maximise nutritious and safe foods and minimize ultra-processed foods; develop plans and strategies to support household food availability during crises (including nutrient dense foods for children in national food reserves, emergency food assistance and household food production). • **Social protection:** Ensure national social protection policies and plans are shock-responsive and designed to prevent malnutrition among emergency-affected populations (through targeting strategy, transfer size and synergies with nutrition services). • **Education:** Ensure that national education policies and plans include contingency plans to ensure continued delivery of school meals/ take home rations and nutrition services during crises including through schools, ECD and ECE centres. • **WASH**: Include the prevention of malnutrition as an objective in emergency WASH policies and plan to target nutritionally vulnerable populations with WASH interventions in humanitarian settings.

Phase	Action
Response	**Cross-cutting:** • Coordinate multi-system/sectoral malnutrition prevention actions through the nutrition emergency coordination mechanism and technical working groups to foster convergence, collaboration, complementarity, joint planning and action. • Ensure regular coordination between nutrition and other sector emergency coordination platforms (health, food security and WASH clusters and cash working group), UN agencies (UNICEF, WFP, FAO, WHO and UNHCR), and humanitarian, development, resource and implementing partners.
	Sector-specific: • **Health:** Monitor and regulate unsolicited donations of breastmilk substitutes (BMS) in line with the International Code of Marketing of Breastmilk Substitutes. • **Food:** Implement and enforce regulations on food donations in humanitarian settings. • **Social protection:** Ensure nutrition actors are engaged in the cash working group to support the design and implementation of Humanitarian Cash Transfers (HCTs) to prevent malnutrition. • **Education:** Include education sector leaders in nutrition emergency response coordination platforms to coordinate school-based nutrition actions.
Recovery	**Cross-cutting:** Ensure policies and plans include mechanisms to fold emergency-affected populations back into national programmes to receive ongoing support to prevent malnutrition, e.g. join the national social assistance programme, or include in national social or health registries to receive health and other social services.

BUILDING BLOCK TWO: Financing

Phase	Action
Preparedness	**Cross-cutting:** • Advocate for the development of national and sector-specific (health, food, social protection, education, WASH) contingency funds and finance mechanisms designed to prevent malnutrition, e.g. drawdown mechanisms/triggers linked to nutrition vulnerability indicators. • Advocate for flexibility within national and sector-specific budgets to allow for adapted modes of nutrition service delivery in humanitarian settings. • Develop clear, multi-agency and sector narratives on the cost of nutrition inaction and life-saving potential of costed anticipatory action to prevent malnutrition in humanitarian emergencies. • Establish mechanisms for the real-time tracking of multi-sectoral nutrition financing in humanitarian settings and develop frameworks to hold actors to account for prompt dispersal and effective use of emergency nutrition funds.
Response	**Cross-cutting:** • Coordinate multi-sectoral and multi-agency advocacy and communication on the cost of nutrition inaction and life-saving potential of interventions to prevent malnutrition in humanitarian emergencies to influence the prioritization of humanitarian resources, including with inter-cluster coordination bodies. • Integrate nutrition prevention actions into delivery of HNRPs, flash appeals, and funding mechanisms such as the Central Emergency Response Fund (CERF), Common Humanitarian Fund (CHF), advocating for dedicated nutrition funding lines that include malnutrition prevention actions. • Align sectors and agencies to carry out joint resource mobilization efforts to support the prevention of malnutrition including joint appeals, funding proposals and donor engagement strategies. • Track nutrition financing in humanitarian settings, including multi-sectoral spending on malnutrition prevention actions, and hold actors accountable for prompt use of nutrition funds.
Recovery	• Advocate for resource mobilization for ongoing national services to support populations who continue to be affected and re-prioritize and re-orientate existing resources as needed.

BUILDING BLOCK THREE: Supplies

Phase	Action
Preparedness	**Cross-cutting:** • Strengthen nutrition supply chains for commodities to prevent malnutrition (micronutrient and macronutrient supplements, complementary foods and general food assistance). This includes strengthening systems for integrated forecasting (based on modelling systems to identify nutrition needs), costing, procurement, storage (including contingency stocks), delivery end-user monitoring and last mile supply monitoring. • Preposition and develop strategic stockpiles of nutrition supplies for the prevention of malnutrition in strategic locations, and/or modalities and systems to enable rapid deployment of supplies in humanitarian settings. • Prepare contingency plans for the use of alternative supplies when existing modes of service delivery are disrupted (e.g. home rations instead of school meals when schools close; food transfers instead of cash transfers for short periods if markets become dysfunctional). • Develop guidance and systems for the use of nutrition commodities for the prevention of malnutrition in different systems in humanitarian settings (including social protection system where food transfers will be used).
	Sector-specific: Food: Map local producers of nutrient-dense food products and assess suitability for use in humanitarian supply chains. Strengthen practices with identified producers to meet global and national food standards, production capacity and mechanisms to scale production in anticipation of humanitarian emergencies and set up agreements.
Response	**Cross-cutting:** Support timely delivery and monitoring of nutrition communities for the prevention of malnutrition through the appropriate platforms in strategic locations within each system.
Recovery	**Cross-cutting:** • Reintegrate supply chain management and information back into national systems if parallel systems were used.

BUILDING BLOCK FOUR: Information

Phase	Action
Preparedness	**Cross-cutting:** • Coordinate multiple sectors to develop an agreed set of national nutrition vulnerability indicators to inform anticipatory response before malnutrition occurs in humanitarian settings and integrate into early national warning systems to trigger action. • Strengthen national and sub-national nutrition information eco-systems (including digital systems across multiple sectors and systems) to collect, analyse and use agreed multi-sectoral information to inform malnutrition prevention actions in humanitarian settings. • Facilitate data-driven decision-making by improving data sharing protocols (e.g. review, update, and/or create data sharing agreements) and create a culture of evidence-based programme adaptations (e.g. through regular review mechanisms).

Phase	Action
	Sector-specific: • Health: Enhance and leverage national health information systems to collect and report nutrition data to support malnutrition prevention and prevention service coverage, including for PBWGs as well as young children, including through DHIS2, and other Health Management Information Systems (HMIS). • Social protection: Enhance and leverage social registries and social protection information systems to collect and report nutrition vulnerability indicators and build inter-operability with nutrition information systems. • Education: Enhance education management Information systems (including ECE) to collect data on delivery of malnutrition prevention services through education platforms. • Food: Strengthen systems readiness to conduct market assessments to assess food availability and prices during humanitarian emergencies, including for nutritious foods.
Response	**Cross-cutting:** • Monitor agreed nutrition vulnerability indicators and the delivery of malnutrition prevention services across different sectors using data from national systems, recent and geographically relevant assessments and Integrated Phase Classification (IPC) analyses where available. If data gaps exist or data are outdated, previous assessments can serve as baselines. • Ensure that nutrition vulnerability indicators are included in methods to identify hotspots to support prioritization of vulnerable groups. • Where feasible, integrate nutrition vulnerability questions into other data collection platforms used during the response using digital technologies to support real-time data collection wherever possible. • Regularly update shared emergency nutrition information system and use within programme feedback mechanisms to ensure malnutrition prevention actions remain responsive to changing needs and capacities.
Recovery	**Cross-cutting:** • Reintegrate any parallel systems into established national information systems including HMIS and use the learning to strengthen the system.

BUILDING BLOCK FIVE: Workforce

Phase	Action
Preparedness	**Cross-cutting:** • Assess the capacities of and linkages between workforces in multiple systems including at community-level to deliver actions to prevent malnutrition in humanitarian settings and strengthen national workforces as needed. • Strengthen capacities and linkages between different workforces in preparation for humanitarian emergencies, paying particular attention to community-level roles (e.g. of community health and nutrition workforces, social welfare workers, and agricultural extension workers). This might include the development of protocols and referral pathways between staff cadres to support delivery of a package of multi-sectoral services.
	Sector-specific: Health: Build and strengthen national community health and nutrition workforces and associated groups and networks to support prevention activities, including protocols for task shifting to increase coverage of prevention services.

Phase	Action
Response	**Cross-cutting:** Monitor needs and bring in surge capacities to support malnutrition prevention actions across different systems as needed. Tap planned additional capacities and/or boost with partner-supported staff.
Recovery	**Cross-cutting:** • Rebuild national workforce capacities and reintegrate tasks back into national workforces where parallel systems were used.

BUILDING BLOCK SIX: Service delivery

Phase	Action
Preparedness	**Cross-cutting:** • Support the design of modalities and mechanisms across each system (health, social protection, food, education, WASH) to rapidly scale and deliver malnutrition prevention actions in anticipation of humanitarian emergencies. • Develop emergency nutrition SBC and counselling strategies and messages based on possible emergency contexts, considering constraints that populations are likely to face putting messages into practice.
	Sector-specific: Health: Develop additional modalities to reach emergency-affected populations with actions to prevent malnutrition, e.g. through mobile health and nutrition teams, find and treat campaigns, tele-nutrition, task shifting to CHNWs and use of implementing partners.
Response	**Cross-cutting:** • Use guidance on accountability to affected populations and SBC strategies to ensure that children, adolescents, caregivers and vulnerable communities participate in decisions that affect them and use their views to review and inform malnutrition prevention actions across multiple sectors. • Ensure that service delivery is inclusive and responsive to the needs of women, adolescents, children with disabilities, displaced populations, refugees, host communities, and remote populations. • Work with Gender-based violence (GBV) actors to build synergies between nutrition and GBV support services. • Coordinate the delivery of multiple sector prevention actions through geographical convergence/ co-location, and use of common implementing partners.
	Sector-specific: • Social protection: Promote universal targeting of nutrition-responsive social protection to nutritionally vulnerable stages of the life course and avoid targeting based on individual nutrition status.
Recovery	**Cross-cutting:** • Rebuild national systems to support the delivery of multiple services to prevent malnutrition where systems have been affected by humanitarian emergencies. • Reintegrate routine malnutrition prevention services back into national systems, adapting back to routine modalities where needed, and use lessons learned during the response to strengthen national systems. • Adapt the delivery of services to help prevent malnutrition in populations who continue to be affected, especially in protracted emergency situations and among refugees/ permanently displaced populations.

7. Partnerships to support collaborative action

The gravity and scale of humanitarian emergencies necessitate that national governments, and key partners including UNICEF, WHO, WFP, FAO, Global Nutrition Cluster (GNC), Non-Governmental Organizations (NGOs) and Civil Society Organizations (CSOs) act decisively and cohesively to prevent malnutrition. The following Table highlights the different roles and responsibilities of actors in humanitarian settings. Specific roles and responsibilities are country-specific and must be clearly defined according to the over-arching mandates of each agency, and capacities and resources under Government leadership.

Table 3: Stakeholder roles and responsibilities for preventing malnutrition in humanitarian settings

Stakeholder	Roles and responsibilities
Government	• Principal authority for national emergency preparedness, response and recovery. • Custodian of national emergency nutrition policies and standards including for malnutrition prevention. • Responsibility for mobilizing and rapidly allocating resources and implementing services for the prevention of malnutrition in humanitarian settings. • Lead actor and coordinator of national and international actors engaged in nutrition preparedness and response, with overall responsibility for ensuring that malnutrition prevention actions are adequately covered.
UNICEF	• Lead agency for global nutrition and champion of child nutrition rights including during humanitarian emergencies, through use of a multi-system (health, food, education, social protection and WASH) and life cycle approach. • Lead agency for nutrition coordination and the Global Nutrition Cluster. • Rapid deployment of nutrition interventions to prevent, detect and manage malnutrition during crises. • Lead support for emergency nutrition policies, technical guidance and programming. • Provider of last resort during emergency nutrition response and nutrition supplies pipeline manager for all essential nutrition supplies including for prevention.
WHO	• Global authority on health and lead of the Global Health Cluster. • Normative lead on public health nutrition and lead for development of normative health and nutrition guidance including in humanitarian settings. • Contributes to strengthening and integration of nutrition actions into health systems. • Technical support for the clinical, inpatient management of wasting.
WFP	• Global lead in fighting hunger and lead of the Global Food Security Cluster and Logistics Cluster. • Immediate delivery of emergency food assistance and social protection including school feeding to affected populations. • Rapid deployment of targeted and blanket supplementary feeding programmes to prevent malnutrition. • Scale up food security initiatives to build resilience during prolonged crises.

Stakeholder	Roles and responsibilities
FAO	• Global lead on food systems and agriculture. • Normative lead on food-based guidance including in humanitarian settings. • Takes rapid action to stabilize and strengthen local food systems in humanitarian settings. • Strengthens food systems through climate-resilient, emergency-responsive agriculture. • Provides urgent policy and technical support to safeguard access to nutritious foods in humanitarian settings.
Global Nutrition Cluster	• Humanitarian coordination body for emergency nutrition under the IASC. • Technical support for nutrition in emergency preparedness and contingency planning. • Lead on resource mobilisation to support nutrition response including prevention services. • Lead on management of nutrition information in humanitarian settings. • Supports delivery of timely, integrated, high-impact nutrition interventions by Cluster partners. • Builds cluster, national and local partner capacity and provides technical surge support.
NGOs and CSOs	• Critical frontline implementers of malnutrition prevention actions during emergency response as part of coordinated overall response and in line with global and national policies, standards and guidelines. • Strengthen community engagement and local response systems. • Provide real-time data and evidence to adapt and scale emergency prevention actions in humanitarian settings.
Private sector	• Can positively contribute to and support the prevention of malnutrition before and during humanitarian emergencies and support the rebuilding of national systems during recovery. • Must uphold child rights and comply with international rules and national standards and laws in humanitarian settings including avoiding actions that may negatively impact nutrition outcomes among affected populations. • Must engage in responsible business practices that protect access to affordable, nutritious foods and essential services in humanitarian settings and always; engagement of the commercial formula and ultra-processed food industries is therefore precluded.[13]

Annex 1: Nutrition supply computation guide

Target Group	Age Category	Intervention	Quantities Required	Duration/Frequency
Children	6-11 months	VAS	100,000 IU capsule	Every 6 months (2 doses/year)
	12-59 months	VAS	200,000 IU capsule	Every 6 months (2 doses/year)
	6-11 months	SQ-LNS	1 sachet/day per child	Daily for 3-6 months
	6-24 months	MQ-LNS	1 sachet/day per child	Daily for 3-6 months
	6-23 months	Egg powder	10-12/g/day per child	Daily for up to 6 months
	6-59 months	MNPs	1 sachet/day per child	Daily for 6 months (90 sachets)
	6-59 months	HEB (Emergency)	100g/day per child	Emergency rations 15-30 days
	6-59 months	BEP (Plumpy doz)	92g/day per child	Daily for 12 weeks
	12-23 months	Deworming	Albendazole 200mg	Every 6 months
	24-59 months	Deworming	Albendazole 400mg	Every 6 months
	5-9 years	Iron	1 tablet (45mg mg Fe)/week	If anaemia prevalence 20-40%, weekly for 3 months on, 3 months off throughout the school calendar year (i.e. two 13-week supplementation blocks in 12 months) (26 tablets).
		Iron	1 tablet (30–60 mg elemental iron) daily	If anaemia prevalence ≤40%, daily for three consecutive months in a year.
		MNPs	90 sachets over 6 months	If anaemia prevalence ≥20%
Adolescent Girls	10-19 years	IFA	1 tablet (60 mg Fe + 28mg FA)/week per girl	If anaemia prevalence 20-40%, weekly for 3 months on, 3 months off throughout the school calendar year (26 tablets tablets).
			1 tablet (30-60 mg elemental iron) daily	If anaemia prevalence ≤40%, daily for three consecutive months in a year.
Adolescent Boys	10-19 years	IFA	1 tablet (60 mg Fe + 2.8 mg FA)/week per boy	If anaemia prevalence ≤40%, weekly for 3 months on, 3 months off throughout the school calendar year.
Children and adolescents	5-19 years	Deworming	Albendazole 400mg	If worm infection prevalence is 20%-50% provide annually; if worm infection prevalence is >50% provide biannually.

Target Group	Age Category	Intervention	Quantities Required	Duration/Frequency
All pregnant women	Pregnant Women	MMS	1 tablet/day per woman	Daily for 6 months during pregnancy (180 tablets)
All pregnant women	Pregnant Women	IFA (Alternative)	1 tablet/day per woman	Daily throughout pregnancy (270 tablets)
Malnourished pregnant	Pregnant Women	BEP	200g/day per woman	Daily until delivery (if BEP is fortified and the daily ration for treatment provides at least 1 RDA of micronutrients, do not also give MMS)
After 1st trimester	Pregnant Women	Deworming	Albendazole 400mg	Single dose during pregnancy
Emergency context	Pregnant Women	HEB	100g/day per woman	Emergency rations 15-30 days
All breastfeeding women	Breastfeeding Women	IFA	1 tablet/day per woman	Daily for 6 months postpartum (180 tablets)
Malnourished breastfeeding	Breastfeeding Women	BEP	200g/day per woman	Daily for 6 months
Within 8 weeks delivery	Breastfeeding Women	VAS	200,000 IU capsule	Single dose postpartum
Emergency context	Breastfeeding Women	HEB	100g/day per woman	Emergency rations 15-30 days

Key Planning Parameters

- **Population Estimates and Supply Calculations:** When planning nutrition interventions in humanitarian settings, use standardized population estimates to determine supply needs. Children aged 6-59 months typically represent 20 per cent of the total affected population; pregnant women and breastfeeding approximately 4-5 per cent; and adolescents aged 10-19 years around 20 per cent. These estimates serve as the foundation for calculating intervention coverage and supply requirements, though local demographic data should be used when available to refine these calculations and ensure more accurate targeting.

- **Supply Chain Management and Logistics:** Effective supply chain management requires careful planning for buffer stock including last-mile delivery, and close in-country monitoring. Add 25-30 per cent to all supply calculations to account for pipeline breaks and unexpected demand fluctuations. Plan for potential three-month stock-outs and consider seasonal variations that may affect population movement and accessibility. Storage requirements vary by product type, with vitamin A supplements requiring temperature-controlled storage while tablets and sachets need dry storage conditions. Implement a first-in-first-out inventory rotation system and establish regular quality control protocols including expiry date monitoring to ensure product safety and efficacy throughout the supply chain.

- **Implementation and Service Delivery:** Successful implementation depends on comprehensive staff training covering proper dosage and administration protocols, and community engagement strategies to ensure cultural acceptance of interventions. Maximize efficiency by integrating nutrition services with existing health services, immunization campaigns, and antenatal care programmes wherever possible. Establish robust monitoring systems that track both coverage indicators and outcome measurements, while implementing safety protocols for adverse event reporting and management. These integrated approaches not only improve service delivery efficiency but also enhance community trust and program sustainability in humanitarian settings.

- Successful implementation of nutrition supplies in humanitarian settings requires strong, synergistic engagement between UNICEF and WFP, leveraging complementary mandates and operational capacities. The UNICEF-WFP Joint Action to Stop Wasting partnership ensures strong coordination, including clear referral systems between partners to avoid duplication across geographies, programmes and activities, including for supply chain management. It is paramount that all agencies involved engage in collective planning and coordination, hold regular discussions to clarify roles, agree on supply needs, and align on key actions related to the prevention of malnutrition. This unified approach is essential to avoid duplication, address gaps, and ensure that life-saving nutrition supplies reach the most vulnerable populations in a timely and efficient manner.

Annex 2: Information to support malnutrition prevention programme monitoring

The following table provides examples of information that can be used to monitor interventions to prevent malnutrition in humanitarian settings across life stages and systems. Examples are tailored for IPC AMN Phase 3+ situations and should be context-specific, streamlined for feasibility, and periodically reviewed. This can be complemented with data collected within other systems/ sectors.

System	Examples of information	Sources
Children aged 6-59 months		
Health	• Prevalence of wasting (Mid-upper arm circumference (MUAC)/ weight-for-height z-score (WHZ)) • Coverage of MUAC/WHZ screening • Coverage of nutrition education and counselling • Coverage of vitamin A supplementation and deworming • Coverage of multiple micronutrient powders • Coverage of complementary feeding support (local first foods and/or SQLNS supplementation)	• Mass screening or routine screening/ SMART surveys • National Health management information systems (HMIS)/District Health Information System (DHIS) 2 Programme data
Food	• Early childhood food insecurity experience scale (EC-FIES) • Coverage of general food assistance • Coverage of blanket supplementary feeding • Coverage of home food production programme support	• Small-scale survey • Government/WFP • Government/WFP • Programme data
Social protection	• Coverage of nutrition-responsive social transfer (cash/voucher/food) targeted to children under 5 years of age	• National social protection Management Information System (MIS)/ WFP/UNICEF
Education	• Prevalence of wasting (MUAC) • Coverage of MUAC screening through ECD and ECE centres • Coverage of healthy meals delivered through ECD and ECE centres • Coverage of nutrition education and counselling through ECD and ECE centres	• Programme data

System	Examples of information	Sources
Infants age 0-5 months		
Health	• Prevalence of wasting (MUAC) • Coverage of infant and young child feeding counselling • Coverage of ready-to-use infant formula (where applicable) • Extent of donations of breastmilk substitutes	• Mass screening or routine screening/ SMART surveys • National HMIS/ DHIS 2/ Programme data • Programme data • National monitoring (if system exists)/Programme data
Social protection	• Coverage of nutrition-responsive social transfer (cash/voucher/food) targeted to infants 0-5 months	• National social protection MIS/ WFP/UNICEF
School age children and adolescents age 5-19 years		
Health/ education	• Coverage of IFA • Coverage of MNPs • Coverage of deworming	• National HMIS/DHIS2/ Programme data
Education	• Coverage of school meals/ take home rations • Coverage of nutrition education (emergency-specific)	• Government/WFP/ UNICEF programme data • Programme data
Social protection	• Coverage of nutrition-responsive social transfer (cash/voucher/food) targeted to children aged 5-19 years	• National social protection management information system (MIS)/ WFP/UNICEF
Pregnant and breastfeeding women and girls		
Health	• Prevalence of maternal thinness (MUAC) • Coverage of MUAC screening • Coverage of nutrition education and counselling (alongside antenatal care (ANC)/ postnatal care (PNC)) • Coverage of Multiple Micronutrient Supplementation (MMS)/ Iron and Folic Acid (IFA) • Coverage of Balanced Energy Protein (BEP) supplementation	• Mass screening or routine screening/ SMART surveys • National HMIS/ DHIS 2/ Programme data
Food	• Food insecurity experience scale (FIES) • Coverage of general food assistance • Coverage of blanket supplementary feeding • Coverage of home food production programme support	• Small-scale survey • Government/WFP • Government/WFP • Programme data
Social protection	• Coverage of nutrition-responsive social transfer (cash/voucher/food) targeted to children under 5 years of age	• National social protection MIS/ WFP/UNICEF
Cross-cutting	• Coverage of nutrition Social and Behaviour Change (SBC)	• Programme data

Annex 3: Resources

A. General

Emergency Nutrition Network, *Compendium of Humanitarian-specific Guidelines and Policies*, ENN, Oxford, 2025.

Sphere Association. *The Sphere Handbook: Humanitarian charter and minimum standards in humanitarian response fourth edition*, Shere Association, Geneva, 2018.

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United Nations Children's Fund, *UNICEF Core Commitments for Children (CCCs)*. UNICEF, New York, 2022.

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Emergency Nutrition Network and United Nations Children's Fund, *A special compilation: Complementary feeding in emergencies*, ENN and UNICEF, Oxford, 2024.

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Infant Feeding in Emergencies Core Group, *IYCF-E and MAMI: Working together to support the continuity of quality, respectful care for at-risk infants under six months and their mothers in humanitarian contexts*, IFE Core Group, Oxford, 2024.

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United Nations Children's Fund, *Interim Recommendations on Nutrition and Mpox Case Management*, UNICEF, New York, 2025.

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United Nations Children's Fund, *Small Supplements for the Prevention of Malnutrition in Early Childhood (SQ-LNS)*, UNICEF, New York, 2023.

World Food Programme, *Adaptations of Food and Nutrition Assistance to People Living with HIV and TB and their Families in the Context of COVID-19*, WFP, 2020.

World Health Organization, *WHO Guideline on the use of multiple micronutrient powders for point-of-use fortification of foods consumed by children aged 6–23 months and children aged 2–12 years*, WHO, Geneva, 2016.

World Health Organization, *Guidelines for the Management of Pregnant and Breastfeeding Women in the Context of Ebola Virus Disease*, WHO, Geneva, 2020.

World Health Organization, *Guideline for complementary feeding of infants and young children 6–23 months of age*, WHO, Geneva, 2023.

World Health Organization, *WHO Guideline on the Prevention and Management of Wasting and Nutritional Oedema in Infants and Children Under Five Years*, WHO, Geneva, 2023.

C. Pregnant and breastfeeding women and girls

United Nations Children's Fund, *Home Fortification with Multiple Micronutrient Powders for the Prevention of Iron Deficiency Anaemia in Early Childhood*, UNICEF, New York, 2023.

United Nations Children's Fund, *Multiple Micronutrient Supplementation*, UNICEF, New York, 2022.

United Nations Children's Fund, *Prevention of Malnutrition in Women Before and During Pregnancy and while Breastfeeding*, UNICEF, New York, 2022.

United Nations Children's Fund, *Programme Guidance to Protect the Nutrition of Women and Adolescent Girls in Humanitarian Settings*, UNICEF, New York, 2024.

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Emergency Nutrition Network, *Towards a Practical Guide: A scoping review of nutrition programming, policy, and evidence for school-age children and adolescents in humanitarian contexts*, ENN, 2025.

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Food and Agriculture Organization, *Data Collection Modalities for Minimum Dietary Diversity-Women*, FAO, Rome, 2023.

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