Operational Guide for the Distribution of Micronutrient Powder 'Sprinkles' Through Community Health and Nutrition Promoters (CHNPs)

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Acronyms

CHP	Community Health Promoter
CHW	Community Health Worker
CMR	Crude mortality rate
DHS	Demographic and Health Survey
ECD	Early childhood development
FSL	Food security and livelihoods
IMR	Infant mortality rate
IYFC	Infant and young child feeding
KAP	Knowledge, attitudes, and practices
MNCH	Maternal, newborn and child health
MNP	Micronutrient Powder
MIYCN	Maternal, Infant, and Young Child Nutrition
MI	Micronutrient Initiative
MUAC	Mid-upper arm circumference
NGO	Non-governmental organization
PLW	Pregnant and lactating women
SBCC	Social and Behaviour Change Communication
UN	United Nations
UNICEF	United Nations International Children's Fund
U5MR	Under-five mortality rate
VHT	Village Health Team
WASH	Water, sanitation and hygiene
WHO	World Health Organization
Z	Z-score

Background

Despite improvements in maternal and child nutrition over the past two decades, malnutrition is still a problem in several low- and middle-income countries[1]. The first "1,000 days" are the critical period between contraception and age two – where sustained mineral and vitamin deficiencies can devastate the physical, cognitive, and behavioural development of a child[2]. Accelerating low-cost easily scalable nutrition programs have become the focus of the international development community and governments. Reducing malnutrition prevents other economic, social, and physiological problems associated with micronutrient deficiencies. In order to reduce nutritional deficiencies and stunting/wasting along with anemia rates in children from 6 months to 59 months, a systematic analysis of the country context is required to accurately assess the suitability of integrating MNP within existing IYCF programs.

The Ministry of Health Working Group on Micronutrient Powders (WG-MNP), BRAC Uganda, World Bank, and the Government of Japan through the Japan Trust Fund for Scaling Up Nutrition collaborated together to identify how low-cost solutions, such a micronutrient powders (MNP) could be distributed via community health workers to in order to address macro and micronutrient deficiencies and help prevent anemia in children 6 months to 12 years.

Aim

This document provides guidance to community health promoters and/or community-based workers involved in the distribution of nutrition commodities and services.

Scope

This document applies to any existing health-care worker (VHT, CHW, CHP) at the community level with an existing IYCF program. The scope is to provide information on how to integrate MNP within current IYCF practices and not as a stand-alone program.

Target populations

The first target users are Village Health Teams (VHT) and other community health and nutrition promoters. The target population for the MNP product are young children aged 6 months until 23 months of age and those 2-12 years. A special consideration is provided for children aged 6 months to 23 months. It is also important to note that the main audience for MNP is mothers and caregivers of children 6-23 months and children 2-12 years.

Target users of this guidance

This document is intended for policy-makers, decision-makers, and programs working in preventative community health, including governments, United Nations (UN) agencies, national and international non-governmental organizations (NGOs), donors, volunteer groups, and the private/business sector.

The document has been written to provide information for targeted users to learn how to integrate micronutrient information (MI) and/or MNP into IYCF and Maternal, Infant, and Young Child Nutrition

(MIYCN) programs. Recommended actions are directed at those with CHW/CHP coordination authority and mandated responsibilities, and those undertaking activities directly or indirectly affecting child nutritional health who also have key responsibilities and roles. The specific operational procedures will vary according to the context.

The OG-MNP is relevant across sectors and disciplines, particularly nutrition, but also health (including maternal, newborn and child health (MNCH); water, sanitation, and hygiene (WASH); food security and livelihoods (FSL); child protection; early childhood development (ECD); agriculture; and community health.

Layout

Beginning with a summary of key points, this document is organized into six practical steps, followed by a reference section with key resources (Section 8), and definitions (Section 9). References are listed as footnotes where numbered resources are listed. Infant and young child feeding practices is a cross-cutting theme; key actions are summarized in Box 1 and sections listed in Annex 1.

Key Points

1. Key provisions regarding MNP programming should be reflected in government, multi-sector and agency policies and should guide the overarching program structure (*Section 1*).
2. Sensitisation and training on MNP is necessary at multiple levels across sectors (*Section 2*).
3. Timely, accurate and harmonized communication to the affected population, health care workers, and the media is essential (*Section 3*). Appropriate and timely support of micronutrient powders (MNP) saves lives; protects child nutrition, health, and development; and benefits mothers.
4. Needs assessment and critical analysis should inform a context specific MNP response (*Section 4*).
5. It is essential to monitor the impact (actions and inactions) of MNP programming on IYCF practices including complementary diversified feeding practices, child nutrition and health; to consult with the affected population in planning and implementation; and to document experiences to inform future programming response (*Section 4*).
6. It is also important to consider the prevalent practices, the infectious disease environment, cultural sensitives, and expressed needs and concerns of mothers and caregivers when implementing MNP programming (*Section 5*).
7. Immediate action to protect recommended infant and young child feeding practices (IYCF) and minimize risk is necessary in the early stages of promotion, with targeted support to higher risk children (*Section 5*).
8. Multi-sector collaboration is essential to facilitate and complement MNP programming (*Section 5*).
9. In every program, it is important to ensure access to adequate amounts of appropriate, safe, complementary foods, and associated support for children to guarantee nutritional adequate above and beyond MNP sachets (*Section 5*).
10. Donations of MNP or providing MNP for purchase needs to ensure that MNP stock is well within expiry dates and overall procurement orders are purchased based on assessed needs (*Section 5*).
11. Infant and young child feeding practices (IYCF) is critical to efficient and appropriate MNP response (*Box 1*).

Practical Steps (1-5)

1. Support Government Ministries, Departments and Agencies to endorse or develop policies

1.1 Governments and agencies should have up-to-date policies which adequately address all of the following elements of an MNP program: promotion and support of breastfeeding; complementary feeding practices; the nutrition needs of young children; and compliance with the World Health Organization (WHO) infant and child feeding practices[3]. Additional context-specific provisions may be necessary, such as for people living with disabilities, refugees or internally displaced persons (IDP), and children experiencing severe or acute malnutrition. Provisions may exist as a standalone policy and/or may be integrated into other relevant policies.

1.2 In early planning of MNP programs, consult national and sub-national policies and procedures related to vitamin and mineral supplementation in children 5 and under, upholding relevant legislation and international standards.

1.3 Develop missing and update existing policy guidance in close collaboration with government authorities. And seek to strengthen relevant nation/sub-national policies. This should be led by Ministry of Health in consultation with other relevant UN agencies and national/regional/global technical working groups. First and foremost, in-country policies relevant to nutritional supplementation and IYCF should be followed.

1.4 Disseminate key policy guidance to all relevant implementers across sectors, including media groups, private sector, donors, and volunteer groups (see 3.7).

1.5 *The WHO MNP Guidelines (2016)*[4] expresses recommendations regarding the use of MNPs in children 6-23 months and children aged 2-12 years. This document sets out the responsibilities of manufactures and distributors of products covered by *the WHO MNP Guidelines*, health workers, national governments, and concerned organizations when using MNPs for point-of use fortification. This guideline outlines the basic requirements for any MNP programming and must be considered for any MNP distribution program including community health promoters (CHPs).

2. Train Staff

2.1 Sensitize relevant personnel **across program** to support MNP, including those dealing directly with affected women and children; those in decision-making positions; those whose operations affect IYFC; and those mobilizing resources. Target groups for sensitization include community health workers, area coordinators, program lead and managers, internal communications team, internal logisticians, monitoring and evaluation officers, among others working on the program.

2.2 Sensitize relevant personnel **across sectors** to support MNP in the program locations, including those dealing directly with affected women and children; those in decision-making positions; those whose operations affect IYCF; and those mobilizing resources. Target groups for sensitization include government staff, district and national Ministry of Health staff, health care workers, nutritionist, pharmacists, program managers, communication teams, media, among other key stakeholders relevant to the specific context.

2.3 Train personnel on MNP contextualizing it within the larger context of IYCF. Target personnel include staff and volunteers delivering the program services and support at the community level. This

includes community health workers, area coordinators, program lead and managers, and any other key programmatic staff. MNP programs embedded in more multi-sectorial programming might include training with government staff; private sector (i.e. pharmacists, drug and/or food supplement importers, etc.); and other NGOs, etc.

2.4 Adapt and prioritize **training context** to address the identified needs, cultural expectations and personal experiences of mothers and/or caregivers of children 6 to 23 months and staff; capacity gaps; the target audience; and time available. Depending on the MNP program outcomes more specialist capacity may be needed. At a minimum, staff and CHPs in contact with mothers and/or caregivers and children 6-23 months should be trained to embedded MNP information within the larger IYCF context[5], including ability to conduct nutrition screening, and on referral pathways for more specialist support[6].

2.5 Undertake sensitization and training in **IYCF**. Integrating MNP into large IYCF components into existing curricula and trainings and collaborate with national and regional academic and training institutions on context development and delivery. Include basic concepts around IYCF and MNP in trainings (including refreshers) for all relevant program delivery people and key stakeholders. Integrate lessons learned from previous IYCF programming into training packages.

2.6 Identify and use existing national expertise and networks, such as on breastfeeding counselling and support; anemia prevention; infectious disease management; early childhood development; etc. Sources of national contacts include Ministry of Health; Unicef and WHO country offices; World Alliance for Breastfeed Action (AWBA) [7]; FSN Network[8]; and other IYCF support organizations; CDC Nutrition[9]; and national groups on IYCF and/or MNP.

3. Co-ordinate MNP Program into an Existing Community-based Health Program

3.1 Ensure there is capacity to coordinate MNP within existing community health team operations. Assess and support development of capacity as initial stage prior to rolling out MNP programming. Determine or clarify responsibilities and roles in IFYC plus MNP programming. Country and regional offices have a key responsibility in ensuring the field staff have the required capacity to train and oversee MNP programming. Assessment of internal capacity to add MNP within existing IYCF and/or community-based health promotion programming is the first stage.

3.3 Program management must ensure adequate coordination and mechanisms are in place[10]. This may recruitment of additional staff, trainers, and/or collaboration with another agency or agencies. Country/regional/global technical support mechanism of working groups may be identified or formed to support implementation.

3.4 The level of coordination for MNP program, including whether a dedicate program support person is required will depend on the context. Wherever possible, support existing program capacity building by integrating MNP as an extension program working with existing country-level structures and mechanisms.

3.5 Coordination provides context-specific, technically informed direction on MNP program; identifies critical vulnerabilities and response of gaps and actions to ensure these are quickly addressed; and monitors the adequacy of the program. In close collaboration with field-staff, senior program management include:

i. Undertake contextual analysis of existing baseline data to immediately inform program strategy and community needs. If necessary, conduct an early/multi-sector/rapid needs

assessment; generate context-specific indicators; a situational analysis; and ascertain the need for MNP programming[11].

ii. Ensure MNP programs are embedded within larger IFYC programs or contexts.

iii. Develop and oversee implementation of a communication strategy.

iv. Develop a context-specific implementation plan, drawing on IYCF plans where they exist and in collaboration with other key stakeholders, as deemed necessary.

v. Determine and actively seek the necessary resources and partner capacity to support action plan implementation.

vi. Coordinate increased IYCF support and complementary feeding knowledge in staff and key stakeholders

vii. Coordinate the procurement process, following any national regulations and, where necessary, importation taxes and clearances, with an WHO approved MNP supplier. Emphasis should be on the creation of a regular and stable supply of product with as long-as-possible shelf life.

viii. Coordinate the disbursement process of MNPs to the field including developing, where necessary, distribution and restocking to CHPs.

ix. Mitigate and manage risks regarding incorrect use of MNP, by hosting community sensitization workshops and/or targeted media messaging.

x. Provide adapted refresher trainings to key project staff including CHPs on MNP, IYCF, infectious disease prevention and WASH.

xi. Be alert, to avoid and manage conflicts of interest, such as when cooperating with the private sector and when securing funding for MNP programs. Develop interim guidance as necessary to ensure adequate safeguards.

xii. Monitor the MNP response effort, collecting programmatic data using SMART objectives and ensuring all collected data corresponds with the overarching program indicators.

3.6 Coordinate with other sectors to identify opportunities for multi-sector collaboration[12]. Examples could include other community health initiatives and/or livelihoods, early childhood education (ECD) programming to create coordinated collaboration. Actively participate in any relevant sector meetings and/or national technical working groups. Identify and engage through working independently of mainstream program structures, e.g. volunteer groups, religious institutions and civil society groups.

3.7 Ensure harmonized communication of MNP use and recommended usage strategies in line with national and WHO MNP point-of-use guidelines[4]. A communication strategy should provide a framework[13] with accompanying implementation plan. Key considerations should include messaging to target populations on services available, MNP, and IYCF practices; and if required press releases; monitoring media coverage; and adapted messaging for different media (e.g. radio, mobile phone, social media, etc.). An example Social and Behaviour Change Communication (SBCC) guide on MNP is included in Annex B.

3.8 In some programming, it may not be possible to meet all the provisions of the OG-MNP immediately, such as where access to those affected is limited or impossible, or organizational capacity is lacking to deliver the program. In such circumstances, the implementor should look at context-specific

guidance on appropriate actions and acceptable compromises. Adapted MNP programming must not fall short of following the WHO MNP point-of-use Gudielines[4].

3.9 The implementor is accountable for implementation of MNP program that adhere to international and relevant standards and benchmarks. The WHO MNP point-of-use Guideline[4] is an internationally recognized set of recommendations for point-of-use fortification of complementary foods with iron-containing MNP in infants and young children aged 6-23 months. The Program Brief by HF-TAG[14] provides recommendations on implementation schemes that outline minimum targets and upper tolerable standards for MNP sachets.

3.10 Gaps in MNP implementation should be address by the program manager in a timely manner. The creation of monitoring and evaluative feedback channels will enable a reflexive response of any challenges, mitigating them well in advance.

4. Assess and monitor

General

4.1 Assess the needs and priorities for MNP implementation and monitoring the impact and up-take of MNP on households and the wider community. Prioritize assessment of acute needs and difficulties that CHPs experience in promotion of and the sale and/or distribution of MNP. Gather qualitative and quantitative data in preparation phase, early needs assessment and representative surveys. Focus should be on gathering reliable, accurate, systematic and coordinated information from implementation sites. Triangulation of information sources is critical to ensuring that decisions are based on robust evidence. The level of MNP assessment that is possible per program will depend on a balance of factors including community location, capacity, time frame, and available resources.

4.2 Ensure MNP implementation monitoring data includes components to assess the needs and priorities related to the overarching umbrella of IYCF. Where possible, draw on and or include indicators relevant multi-sectorial data from water sanitation, and hygiene (WASH), IYCF, and/or health reports.

4.3 Disaggregate data for children under two years old by gender and by age as follows: 6-11 months, 12-23 months, and 24-59 months. Informed by the context, disaggregate key information such as ethnicity, location, etc. to enable equity analysis[15]. Data can also be disaggregated by gender of the primary caregiver to integrate a gender responsive program.

Early needs assessment

4.4 Use background information (secondary data) to develop an IYCF situation profile to inform early decision-making and program targets. If necessary, collate key information for justification of site selection for implementation locations.

4.5 Secondary data sources include government documents, NGO and UN country programs; Demographic Health Surveys (DHS) [16]; sub-national surveys; national institutions (ministries, local offices; etc.); Knowledge, Attitudes and Practices (KAP) studies; country profiles; WHO and UNICEF databases[17]; Nutrition Landscape Information System[18]; Comprehensive Food Security and Vulnerability Analysis (CFSVA); and Food Security and Nutrition Monitoring Systems (FSNMS).

4.6 Key information to consider includes

4.6.1 ***Contextual data***

i. Policy environment, including relevant national guidance on IYCF; training and/or registration regulations for community health promoters; policies and protocols related to IYCF; and other public health emergencies/infectious disease outbreaks; national food and drug legislation that affects the procurement of commodities.

ii. Prevalence of anemia rates in children as well as other child nutritional statuses including prevalence of acute malnutrition, stunting; and maternal nutritional status.

iii. Implementation site access and security difficulties, such as conflict-affected areas, seasonal flooding, etc.

iv. Estimated caseloads of children 6-23 months of age (disaggregated data; see 4.3) and pregnant and lactating women (PLW).

v. Prevalence and/or higher reports of higher risk young children (see 5.4).

vi. Household food security, including access to complementary foods that are age appropriate.

vii. Analysis of WASH environment including access to safe, clean drinking water and sanitation facilities for the disposal of human and infant/young child fecal matter. Analysis should also include awareness of the social norms and cultural practices on hygiene.

viii. Analysis of the existing health environment, including support offered by providers of antenatal, delivery and postnatal services; age and morbidity profile of admissions to acute malnutrition treatment programs for children 6-23 months; infectious disease morbidity rates (i.e. malaria; diarrhoea, etc.); crude mortality rate (CMR); infant mortality rate (IMR); and under-five mortality rate (U5MR)' coverage of existing IYCF programs; and support offered by social services and social protection mechanisms including other community, district, and national stakeholders.

ix. Identification and availability of supplementary support providers, such as breastfeeding mothers following IYCF guidelines; formally trained health workers; volunteer health promoters; trained counsellors; experienced women from the community; engaged male caregivers; community outreach workers; translators and interpreters.

4.6.2 ***IYCF data***

Community feeding practices, including the prevalence of breastfeeding initiation in newborns; early and exclusive breastfeeding in infants up to 6 months of age; complementary diversified feeding practices in combination with a continuation of breastfeeding until two years of age.

i. Population's knowledge and attitude of IYCF.

ii. Prevalent complementary feeding practices and types of complementary foods.

iii. Local perceptions of feeding practices including exclusive breastfeeding until 6 months of. age, commentary age-appropriate feeding in combination with continued breastfeeding until two years.

iv. Any other cultural and/or regional feeding practices for infants and young children.

4.6.3 ***MNP data***

Specific data related to evaluating the impact of MNP, including the knowledge, attitudes, and practices of caregivers (both male and female) about MNP; promotion and sales of MNP products, and current availability of MNP products currently in market and/or internationally available

i. Policy environment, including relevant national guidance on vitamin and mineral supplementation in young children 6-59 months; regulations and/or registration regulations for importation of micronutrient powder products; policies and protocols related to promotion and/or sales of micronutrient supplements for children 6-59 months; and; national food and drug legislation that affects the procurement (including importation regulations where applicable) of commodities.

ii. Scan of MNP products locally and/or internationally available. If multiple brands exist in implementation country it is suggested to undertake a cost-comparison and market analysis in order to determine the most suitable product for promotion through community-based health promoters.

4.7 Conduct a needs assessment to inform key program decisions. E.g. Target population, scale of problem, number of individuals, background and/or current knowledge gaps of community health workers, etc.

4.8 If a representative survey is not feasible and/or dataset does not exist, use alternative other data collection opportunities such as focus group discussions, individual interviews, community mapping, and market walks. Conduct at household or community level.

4.9 Aim to gather information for different population groups (by geography, child age, etc.). Use standard indicators[21] in addition to developing context-specific indicators as necessary.

Monitoring

4.10 Program strategies should include SMART objectives, expected outputs and outcomes. Special attention should be for developing process/output indicators that measure the quality, quantitative, coverage, and utilization of MNP; indicators that measure the promotion and awareness of MNP; and outcome indicators to describe the effect of the MNP program.

4.11 Disaggregate program data for children 6 -59 months by gender and age as follows: 6-11 months, 12-23 months and 24-59 months.

4.12 Use a combination of qualitative and quantitative indicators to measure behaviour change activities related to provision of MNP to young children 6-59 months. The MNP program must use appropriate culturally sensitive and contextualized assessment methods[22]. Inclusion of monitoring surveys can help measure impacts. In some cases, parts of baseline assessments can be repeated as part of monitoring.

4.13 Ensure that gender equality and equity are integrated into program activities. Where possible, use gender-sensitive indicators e.g. male to female ratio of caregivers who've purchased MNP.

4.14 Where possible integrate participatory approaches to engage target population groups, including in program design, planning, and feedback sessions.

4.15 Where possible, provide opportunities to engage key stakeholders (e.g. community leaders, village health workers, sub-county and district level health professionals) in the program planning and feedback of the MNP intervention, creating buy-in from other levels.

4.16 MNP programs should aim to measure the children's anthropometric measurements (height, weight, and mid-upper arm circumference (MUAC) in order to calculate the Z-score (Z) to assess stunting and wasting, as well as gain a sense of general nutritional status.

5. Procurement, Promotion, and support optimal MNP disbursement with integrated IYCF

Procurement of MNP supplies, equipment, and support

5.1 At the nation level, the Ministry of Health has a key responsibility to define and outline essential requirements and guidelines for IYCF programs. Any MNP program should be contextualized within IYCF.

5.2 Procurement of MNP is necessary, purchase enough but a limited supply of stock considering the product demand so as to not result in expired MNP stock.

5.3 Ensure any required materials for secure dry storage for additional stock is available.

5.4 Implement a monitoring system to account for all MNP stock to be verified against purchase orders and provision to community health workers for accountability.

MNP Stock Management

5.5 Plan appropriate procurement, distribution, targeting and use of MNP and any associated follow-up with caregivers.

5.6 Source MNP products from a recognized distributor ensuring the product meets the minimum requirements outlined by the WHO[4].

5.7 Funders of MNP should ensure that all provisions for contextualizing the MNP product within IYCF communications[4].

MNP Distribution to Community-base Workers

5.8 The distribution system for MNP will depend on the organization's strategy of providing for profit or by donation.

5.9 Any MNP distribution system should be contextualized to the context, including the scale of intervention; access points to mothers/caregivers; contact frequency; and transportation[4].

5.10 When MNP is distributed, ensure that IYCF counselling and support for complementary feeding is provided[16].

MNP Promotion to Community and other Stakeholders

5.12 Network with other sectors (e.g. agriculture, livelihoods, etc.) to ensure that the nutritional needs of the general population are met, giving special attention to promotion of and access to suitable complementary foods for children (and all community members).

5.13 Encourage mothers/caretakers to access health services when the child is sick or if they have any concerns related to the feeding or health of the child. Ensure sick children receive proper treatment and care under a licenced

5.14 Collaborate with private, non-government, and government sectors to maximize synergies and opportunities to support recommended IYCF polices and promote nutrition for all.

6. Minimize the risks of incorrect MNP use

7. Key Contacts

7.1 Report any MNP implementation inconsistencies to program manager and/or senior management teams.

7.2 Contact to related experts on MNP and/or IYCF include: UNICEF: nutrition@unicef.org; WHO: nutrition@who.int; as well as more local contextually informed individuals such as staff from the Ministry of Health: sngalombi@yahoo.com, academic professors, experienced technical consultants working nationally or regionally, etc.

7.3 Technical problems with procured MNP products should be directed either to the wholesaler (if purchasing through a third party) or directly with the manufacture (if purchasing directly).

Box 1: MNP Program Preparedness Actions

This is a summary of MNP program preparedness actions contained in Sections 1-5 of the OF-MNP. Specific sections are noted in Annex A.

Endorse or develop policies

1. Ensure MNP program is informed by relevant national polices, guidelines, and procedures.
2. Develop national/sub-national implementation plans on MNP.
3. Draft context-specific statements on MNP program(s) for rapid release.
4. Enact and/or adopt policies in line with the WHO MNP Point-of-Use Guidelines.
5. Update polices, guidelines, and procedures based on lessons learned from other MNP and/or IYCG programs.

Train staff

1. Identify and sensitize key personnel involved in planning and delivering the MNP program, including CHPs.
2. Forecast MNP capacity needs based on context-assessment and supply/demand of target population.
3. Identify training needs of CHPs and relevant program staff. Include key components of IYCF. Training should be adapted to the local context by adapting, where possible, existing curricula.
4. Orientate and train relevant staff on MNP program support. Include key components of IYCF and MNP within the staff training.
5. Map existing capacities for key areas, e.g. translators, and develop key contact list of existing national expertise.
6. Prepare orientation material for use on on-boarding new staff members and/or CHPs.
7. Updated training content based on lessons learned from previous context related IYCF and/or MNP programs.

Co-ordinate MNP Programs

1. Identify government leadership on IYCF and support capacity to strengthen awareness and understanding about MNP, as necessary.
2. Raise public and processional awareness regarding recommended IYCF practices and benefits alongside MNP.
3. Engage a variety of stakeholders to help disseminate targeted IYCF information in collaborative or parallel programs to help raise awareness of MNP within the larger IYCF context.
4. Allocate funding to support monitoring, evaluation, and learning.
5. Establish links with other sector focal points and coordination mechanisms especially health centres.

Assess and monitor

1. Conduct a situational assessment on maternal and child nutrition to inform early decision-making.
2. Ensure disaggregated data and recent reports are available for decision making.
3. Prepare key questions to include in a needs assessment.
4. Identify existing capacity to undertake IUCF assessments and surveys to evaluate the MNP intervention.
5. Support governments to develop policies and procedures to monitor MNP programs within IYCF programing.
6. Identify what monitoring and evaluation systems can be applied and/or adapted to provide rich data regarding MNP uptake and use.

Protect, promote, and support optimal MNP disbursement with integrated IYCF

1. Actively promote MNP within recommended IYCF policies.
2. Develop a plan for MNP intervention.
3. Identify key sector focal points in ministries and agencies to engage in programming.
4. Identify supply chain for an appropriate MNP product.
5. Examine national legislation related to food and drugs, particularly importation.
6. Anticipate likely need for and mechanisms to provide MNP to children 6-59 months.

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9. Definitions

Complementary feeding: The use of age-appropriate, adequate and safe solid or semi-solid food in addition to breast milk or a breast milk substitute in children aged 6-23 months.

Complementary food: Any food, whether industrially produced or locally prepared, suitable as a complement to breast milk or to a BMS, that is used to feed children 6-23 months of age. Note this term is also used to describe foods that complement those included in a general

Community health: Refers to the health status of a defined group of people and the actions and condition, both private and public (governmental) promote, protect, and preserve their health. (McKenzie et al., 2005)

Community Health Promoter (CHP): A community health promoter is a member of a community who is chosen by community members or organization to provide basic health and medical care within their community. They focus on providing preventative health care and health education often in line with Ministry of Health policies and procedures. In some contexts, the term can be used interchange with CHW such as in the OP-MNP.

Community Health Worker (CHW): A community health worker is a member of a community who is chosen by community members or organization to provide basic health and medical care within their community. They focus on providing preventative health care and simple treatments often in line with Ministry of Health policies and procedures. In some contexts, the term can be used interchange with CHP such as in the OP-MNP.

Conflict of interest: A situation where there is the risk that a secondary interest of an organization or individual unduly influences, or is perceived to unduly influence, the independence or objectify of professional judgement or actions regarding a primary interest (ensuring the best interests of the child in MNP programming) or undermine public trust in those operations.

Continued breastfeeding: The continuation of providing breast milk to children 6 months and older.

Education: In the context of MNP programming, education encompasses activities designed to enhance the ability and motivation of caregivers to voluntary adopt nutrition-based MNP programming strategies to improve childhood health and wellbeing.

Exclusive breastfeeding: The provision of only mother's breast milkn without any other liquids or solids, not even water, except for oral rehydration solution or drops or syrups of vitamins, minerals, or medicines (WHO, 2016).

Food security: A situation when all people, at all times, have physical, social and economic access to sufficient, safe, and nutritious food that meets recommended dietary needs and food preferences for an active and healthy lifestyle (FAO, 2000).

Individual-level assessment: A process to evaluate the caregiver-young child pairs, establish feeding practice and needs, and decide what type of support may be necessary. There are two levels of assessment: a simple rapid assessment and full assessment.

Infant: A child aged 0-11 completed months (may be referred to as 0-<12m or 0-<1 year). An older infant means a child from the age of 6 months up to 11 completed months of age.

Micronutrient supplement: A product which provides specific micronutrients that are not available as part of the regular diet.

Micronutrient powders: A single dose packet containing dry powder that contains specific micronutrients that can be added to any semi-solid or solid food that is ready for consumption.

Newborn (neonate): A child under 28 days of age.

Nutrient gap: The difference between nutritional requirements and nutritional intake, considering both energy and nutrient adequacy.

Optimal (recommended) infant and young child feeding: Early initiation (within one hour) of exclusive breastfeeding, exclusive breastfeeding for the first six months of life, followed by nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years or age or beyond. *Recommended* rather than optimal feeding practices are referred to in the OG-MNP.

Qualified health or nutrition worker: In the context of MNP programming, a health or nutrition worker or a community health worker (CHW) or community health promoter (CHP) who has undergone training on relevant, contextually appropriate health and/or nutrition matters.

Recommended infant and young child feeding: *See Optional (recommended) IYCF*.

Targeted MNP programming: Programs that provide nutritional support for caregivers to use MNP with children aged 6-23 months.

Targeted supplementary feeding: Programs that provide nutritional support to individuals with moderate acute malnutrition.

Young child: A child from the age of 12 months up to the age of 23 completed months (may also be referred to as 12-<24m or 1-<2 years).

WHO MNP Point-of Use-Guideline: Refers to the document produced by the WHO that outlines guidelines for use of micronutrient powders for point-of-use fortification of foods consumed by infants and young children aged 6-23 months and children aged 2-12 years (WHO, 2016).

Definition sources

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Annex A

Sector/Speciality	*Sections*
All sectors (general)	3.6, 4.2
Agriculture	5.3
Early Childhood Development	2.6, 3.6
Food Security and Livelihoods	4.5, 4.6
Health:	
Reproductive, maternal, newborn and child health	4.6
Infant and young child feeding practices	1.1, 2.2-2.6, 3.1, 3.5, 3.7, 4.2, 4.3, 4.4, 4.6, 5.1, 5.5, 6.3, 6.9, 7.2
WASH	3.5, 4.2, 4.6,

Annex B

Example SBCC Guide on MNP.