Concept Nutrition

SRC International Cooperation

Swiss Red Cross

Swiss Red Cross
Rainmattstrasse 10 / P.O. Box
CH-3001 Bern
Phone 031 387 71 11
www.redcross.ch

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Content

Abbreviations

CMAM	Community management of acute malnutrition
FAO	Food and Agriculture Organization of the United Nations
HIV	Human Immunodeficiency Virus
IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross
IFRC	International Federation of Red Cross and Red Crescent Societies
LRRD	Linking Relief, Rehabilitation and Development
Movement	International Red Cross and Red Crescent Movement
MNCH	Maternal, newborn and child health
National Society	National Red Cross or Red Crescent Society
NCD	Non-communicable diseases
NGO	Non-governmental organisation
RTUF	Ready-to-use food
SRC	Swiss Red Cross
SUN Movement	Scaling Up Nutrition Movement
UNDP	United Nations Development Programme
UNICEF	United Nations Children’s Fund
WASH	Water, sanitation and hygiene
WHO	World Health Organization

1. Introduction

The Swiss Red Cross (SRC) considers nutrition an important determinant of health. Its international cooperation programmes[1] tackle nutrition in various ways within the continuum of humanitarian aid, rehabilitation and long-term development, through either direct action on nutrition or nutrition-sensitive programmes. Despite the importance of the issue, SRC action to date in the areas of nutrition, food security and livelihood support has tended to be diverse and ad hoc. This concept sets the framework and focus for the SRC's engagement in nutrition; it considers direct action on nutrition as well as nutrition-sensitive programming and the different aspects of nutrition in health development and disaster management. The nutrition terminology used is explained in Annex 1.

1.1 Rationale and scope: poor nutrition perpetuates the poverty cycle

Access to good and balanced nutrition is one of the main pillars for a healthy life. Population growth, resource depletion and economic crisis are some of the factors leading to greater food insecurity. Persistent hunger and malnutrition are a day-to-day reality for children, men and women of all age groups, with the most disadvantaged being the most affected by the consequences of poor nutrition. The capacity of households to produce or procure adequate food supplies and equitable distribution of food among household members are essential factors in meeting the nutritional needs of every household member.

Malnutrition has numerous and serious effects on individual health at different stages of the human life cycle. For example, poor nutrition in pregnant women increases the likelihood that they will develop anemia and have low-birth-weight and anemic children. Such children are 20 times more likely than heavier babies to die before their first birthday. Low birth weight itself contributes to poor health outcomes and stunting during childhood and adolescence, with stunted girls having an increased probability of delivering low-birth-weight babies and thus perpetuating the negative nutrition spiral (UNICEF, 2013a). Poor nutrition in children under 2 leads to physical and mental underdevelopment, increased susceptibility to infectious diseases and irreversible stunting. Finally, poor nutrition in adults leads to reduced productivity and a heightened risk of illness in adulthood, including obesity-related non-communicable diseases. Overall, poor nutrition perpetuates the poverty cycle: susceptibility to disease – reduced productivity – expenses for medical care – less money to buy food – low-quality diet – susceptibility to disease.

Besides having a direct impact on health, poor nutrition and food insecurity lower the overall resilience of individuals, households and even communities. Furthermore, under- and over-nutrition add to the burden on already overstretched health systems, compounding the need for diagnostic equipment, medication and supplies for treatment and adequately trained human resources.

Although huge progress has been made towards achieving Millennium Development Goal 1, to eradicate extreme poverty and hunger, 842 million people around the globe continue to suffer from hunger (FAO, 2013). Good nutrition is particularly important during childhood: poor nutrition is an underlying cause of 45 per cent of deaths in children under 5 (WHO, 2013). Worldwide, nearly one in six children under 5 is underweight, and one in four is stunted (UNICEF, 2013a). The 1,000 days from conception until a child's second birthday offer a unique window of opportunity to shape healthier and more prosperous futures for children. The right nutrition during this 1,000-day window can have a profound impact on a child's ability to grow, learn and rise out of poverty. Nutritional deficits in childhood have consequences right into adulthood, resulting in greater susceptibility to disease, lower

[1] In this paper, the terms "programme" and "project" always relate to SRC international cooperation.

educational outcomes and deeper poverty overall, and thus affect a society's long-term health, stability and prosperity (The Lancet, 2013; SUN Movement, 2014).

Moreover, the world increasingly faces a double burden of malnutrition, whereby acute and chronic under-nutrition and micronutrient malnutrition co-exist with over-nutrition and obesity, affecting more than 1.4 billion people worldwide (WHO, 2008). In 2010, 42 million children were obese, with 35 million living in developing countries (WHO, 2012). According to UNICEF (2013a), obesity in children has increased by 54 per cent in the last two decades. Over-nutrition and obesity are important underlying causes of non-communicable diseases, which are responsible for 63 per cent of deaths worldwide (WHO, 2008). Micronutrient deficiencies are common, with one third of the world population suffering from iodine deficiency and more than 40 per cent of women of child-bearing age afflicted with anaemia (United Nations, 2010). Tackling nutrition is therefore not only about food quantity, but also about increasing food quality in terms of diversity, nutrient content and safety.

In recognition of the importance of nutrition to global development for generations to come, discussion of the post-2015 development agenda has included a "hunger, food security and nutrition" component, and the United Nations (2014) Open Working Group on Sustainable Development Goals has proposed that Goal 2 of 17 Sustainable Development Goals be to "end hunger, achieve food security and improved nutrition, and promote sustainable agriculture".

1.2 Strategic and institutional framework: nutrition a future thematic SRC priority

The SRC bases its activities on the seven Fundamental Principles of the International Red Cross and Red Crescent Movement (the Movement) – humanity, impartiality, neutrality, independence, voluntary service, unity and universality.

The SRC's work is guided by the policy frameworks of the International Federation of Red Cross and Red Crescent Societies (IFRC) and the SRC.

IFRC Strategy: The IFRC's *Strategy – 2020 Saving Lives, Changing Minds* renews the commitment to humanitarian aid and calls for more action to prevent and reduce the underlying causes of vulnerability. Access to adequate nutrition and food security are crucial in emergencies and crises to "save lives, protect livelihoods and strengthen recovery from disaster and crisis" (strategic aim 1). In addition, balanced nutrition helps "enable safe and healthy living" (strategic aim 2).

SRC Strategy 2020: The overarching strategy of the SRC defines disaster management and development cooperation as one of its four core business areas, albeit only in relation to SRC engagement at international level.

SRC Strategy 2020 for International Cooperation: The overall goal of SRC international cooperation work is to enable healthy and safe living for vulnerable groups and communities. Health and disasters are the two principal spheres of activity for SRC international cooperation work. Nutrition and water, sanitation and hygiene (WASH) are recognized as important determinants of health and working priorities for international cooperation.

SRC Health Policy: The health policy defines seven thematic priorities: disease prevention, care and health promotion; sexual and reproductive health; WASH; health in emergencies; blood transfusion services; eye care; and nutrition. Nutrition interventions focus on direct nutritional support for children and vulnerable groups, health promotion and contributing to food security.

SRC Disaster Management Concept: The SRC's disaster management activities focus on five thematic priorities: health; WASH; shelter and non-food items; restoring family links; and food security and livelihood support. The distribution of food items, tools, seeds and

equipment to support livelihoods, alongside cash and food-for-work programmes, contribute to improved nutrition among the most vulnerable people.

Other SRC concepts: The concepts on Linking Relief, Rehabilitation and Development (LRRD), partnership and knowledge management provide additional guidance.

The SRC adheres to the following international standards and guidelines:

- the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-governmental Organizations in Disaster Relief;
- the Humanitarian Charter and Minimum Standards in Disaster Response (Sphere);
- the national protocols and guidelines on nutrition of the country concerned, which have in most cases been developed with WHO.

It applies additional standards and guidelines established by WHO, the United Nations, Médecins Sans Frontières, UNICEF and the IFRC (see Annex 2).

1.3 Building on SRC experience in nutrition over the past decade

The SRC is a major player among Swiss humanitarian organisations and enjoys broad public confidence. It is viewed by donor agencies as a professional organisation and known as a competent and reliable partner within the International Red Cross and Red Crescent Movement. As a member of the Movement, the SRC is part of the world's largest humanitarian and development network of volunteers and staff.

In the past, nutrition interventions have been incorporated in SRC programmes in different ways: specific direct nutritional interventions have mainly derived from an emergency context (e.g. drought) or have been included in health care and health promotion programmes.

Examples of **direct nutritional activities** have been:

- the provision of individual food parcels containing locally produced food items in emergencies or targeting the most vulnerable (e.g. HIV-positive people);
- school feeding programmes in emergency situations like droughts;
- assistance by SRC medical emergency response teams for growth monitoring in field hospitals and referral of children with severe acute or moderate acute malnutrition to existing feeding centres run by other organisations;
- nutritional activities (e.g. administration of vitamins and minerals, micronutrients, deworming and growth monitoring), health education and nutrition-related health promotion for pregnant women, nursing mothers and mothers of children under 5 in maternal, newborn and child health (MNCH) programmes;
- referral of severe cases and collaboration with other stakeholders who run feeding centres and refer cases of severe and moderate acute malnutrition;
- promotion of healthy lifestyles in the community, tackling the underlying social and cultural causes of under- and over-nutrition.

Examples of **nutrition-sensitive programmes** have been:

- Nutrition and WASH: improved access to safe drinking water, access to sanitation and improved hygiene and hand-washing practices reduce the incidence of diarrhoea. In addition, having households use waste water in kitchen gardens in order to secure food availability enhances the nutritional status of the beneficiaries.
- Nutrition and cash/food-for-work: the cash- or food-for-work approaches and unconditional cash transfers allow beneficiaries to invest in better nutrition.

- Nutrition and livelihoods: helping people recover the ability to produce their own food by providing them with tools, seeds and livestock.
- Nutrition and disaster risk reduction: preventing soil erosion by planting trees, preferably fruit trees.

No evaluations have been conducted to date of the impact of SRC nutrition activities. As the above examples show, SRC activities have tended to focus more on undernutrition rather than overnutrition (obesity).

In recognition of the importance of nutrition as a determinant of health, the SRC will focus in the coming years on better and more systematically integrating and scaling up successful initiatives in nutrition and household food production in its three cores areas of intervention: emergency relief, rehabilitation/reconstruction and development cooperation.

1.4 SRC definition of nutrition

The SRC has adopted the WHO[2] definition of nutrition as "the intake of food, considered in relation to the body's dietary needs. Good nutrition – an adequate, well-balanced diet combined with regular physical activity – is a cornerstone of good health. Poor nutrition can lead to reduced immunity, increased susceptibility to disease, impaired physical and mental development, and reduced productivity."

The SRC is aware that nutrition is closely related to food security and food sovereignty. However, addressing the entire range of food security and food sovereignty issues lies beyond its scope and is therefore deliberately not considered in this concept paper. SRC programmes will focus on contributing to food production for household consumption in order to increase food availability by addressing food quantity and food quality, without considering questions of economic security, access to markets and value-chain analysis. For this reason, and within the thematic priority of nutrition, the SRC refrains from any kind of food production activities related to economic security, including the provision of animals.

2. Context and challenges for the SRC

2.1 Global context and trends

The SRC considers the following global context and trends particularly relevant for nutrition:

- ***Climate and environmental change.*** Unpredictable and extreme weather strains food production and causes more frequent and severe natural disasters (i.e. droughts, floods, typhoons). The increased occurrence of droughts, erosion or floods affects food production, worsens already precarious food security and causes chronic hunger and malnutrition. Climate change and deforestation bring about scarcity in water resources and desertification of previously arable land. Together with the growing privatization of water, this makes it difficult to obtain water to irrigate food crops.

[2] www.who.int/topics/nutrition/en/.

- ***Increased political instability, fragility of states and protracted crises.*** In recent years, the number of internal and international conflicts has grown and states have become increasingly fragile. During a conflict, access to food can suddenly be diminished or even totally disrupted, resulting in acute hunger and malnutrition in the population concerned. Irregular supplies in a persistently fragile context lead to chronic malnutrition over time. In protracted crisis situations, malnutrition is about three times as high as in other developing contexts – and the longer the crisis, the worse the food security outcomes**.** Since most nutrition investments tend to adopt short-term humanitarian approaches to food and hunger crises, fragile states often get less support for nutrition.
- ***Migration and urbanisation.*** Domestic and international migration, including forced migration due to conflicts (internal displacement and refugees), are on the rise, an outcome of the above (and other) issues. One in three urban residents lives in a slum with no land rights, suffering from poor water, sanitation and hygiene, food shortages, and the absence of basic health services. The slums tend to be in particularly risk-prone areas (flood, earthquake, violence) as urban development often outpaces smart and safe planning.
- ***Global financial crisis and price fluctuations on the market***. Affordability and availability of food in the household depends on market prices. These are influenced by investors, speculation and trading. Price hikes result in fewer households being able to afford sufficient amounts of good-quality food.
- ***Population growth and rising pressure on natural resources.*** Rising life expectancy worldwide puts pressure on the availability of food. Good-quality food items are often replaced by newly engineered and patented seeds that augment quantities only. Large areas of arable land are used to produce biofuel substitutes for scarce fossil resources. Land grabbing and population growth also force individuals and families to migrate. Despite the apparent food scarcity, it is estimated that around one third of food production for human consumption is lost or wasted (Gustavsonn, 2011).
- ***Increased commercialisation of food items with low nutritional value.*** The food industry focuses on the production of cheap, ready-packaged, high-calorie and low-quality food items in all countries of the world. Together with a lack of exercise, these items are the main drivers of obesity, over-nutrition and poor micronutrient intake.
- ***Unequal food distribution within households.*** Social and gender disparities in many cultures of the South and East manifest themselves in food allocation. Despite extensive education campaigns, women and girls still receive less and poorer-quality food than men.

2.2 Challenges for humanitarian players

The SRC takes into account the key challenges facing humanitarian action and its players.[3]

- ***Proliferation of humanitarian players:*** the interest in nutrition and the number of organisations involved in nutrition have risen significantly in recent years. As a result, different stakeholders from all sectors have united in a concerted effort to rise to the United Nations Secretary-General's Zero Hunger Challenge[4]. Positioning the SRC

[3] The challenges are defined in section 2.2 (p. 6) of *Concept – Disaster Management* (SRC, 2012b).

[4] See www.un.org/en/zerohunger/challenge.shtml.

within this complex construct can be a challenge, yet it is also an opportunity to create good linkages, build synergies and increase leverage at county level.

- ***Sustainability of nutrition programmes:*** nutrition programmes linked to a conflict or to the aftermath of a disaster require quick intervention. Supplies of ready-to-use food (RTUF) and micronutrient supplements need to be imported, if not available on domestic markets, and supply chains established. Nutrition needs to be embedded in long-term interventions that attach importance to the availability and use of local food items, ensure food security at household level and promote behavioural change.
- ***Forgotten disasters and "forgotten" countries:*** funds tend to be directed to major natural disasters. Ongoing emergencies, complex, slow-onset disasters (e.g. droughts) and fragile countries afflicted by food scarcity are often neglected and under-funded. Investments in nutrition mostly target the countries with the highest prevalence of stunting and wasting (≥ 40%), while nutritional investments in countries with lower prevalence and different micronutrient deficiencies are neglected.
- ***Lack of reliable nutritional country data:*** obtaining reliable country data is difficult and requires sophisticated research methods and good monitoring of the nutritional status of the target population. Since stunting, underweight and micronutrient deficiencies are often imperceptible and people are not aware of the existence of the nutritional deficits in their community, nutrition may not be high on the development agenda of the relevant government.

2.3 Global conceptual frameworks and stakeholder approach

The SRC bases its work on the conceptual framework of causes and actions on malnutrition developed by UNICEF and subsequently modified by Black et al. (2013) (see Annexes 3 and 4).

While some of the underlying and immediate causes of malnutrition can be addressed by single-stakeholder action, the social, economic and political context plays such an important role that a global multi-stakeholder and multi-sector rather than merely national approach is required. It was thus that the Scaling Up Nutrition (SUN) Movement was launched in 2010. A global undertaking to meet the Zero Hunger Challenge, the SUN Movement unites governments, civil society, businesses and citizens in a worldwide effort to end under-nutrition. Fifty-four countries and more 110 country partners, among them the IFRC, have endorsed the SUN Framework for Action[5], the aim of which is to collectively meet the six global targets agreed at the 2012 World Health Assembly by introducing and scaling up a package of highly cost-effective direct nutrition interventions focused on the 1,000-day window (see Annex 6).

3. Guiding principles

SRC programmes follow the guiding principles set out in its *Strategy 2020 for International Cooperation*, *Concept – Disaster Management* and *Health Policy for International Cooperation 2012–2017*.

Focusing on marginalized and most vulnerable people: SRC programmes strive to meet the health and nutrition needs of marginalised and highly vulnerable people. The SRC

[5] See http://scalingupnutrition.org/wp-content/uploads/2013/05/SUN_Framework.pdf.

makes sure that nutrition is given greater prominence in health policy. Initial assessments cover the nutritional situation and household food security in a target community in order to design appropriate direct nutrition interventions or nutrition-sensitive programming. Nutrition interventions are integrated into SRC health programmes and usually focus on the most vulnerable, such as pregnant and nursing women, children under 5, with particular emphasis on the first 1,000 days, and elderly people living on their own. Depending on the context and circumstances, nutrition interventions for obesity-prone adolescents and adults are included. All activities are set up to promote regular exercise and to meet the special dietary needs of each group.

Promotion of local resources and self-help potentials: The SRC strives to integrate and scale up nutrition in existing programmes. In nutrition programming, the promotion of, and support for, the production of local food items using local resources and know-how are important elements. Strengthening the capacity of beneficiaries to not only sustainably produce a variety of high-quality food items, but also to distinguish between high- and low-value foods and change consumption patterns, is part of the SRC approach to reinforcing the beneficiaries' self-help potential and resilience. Local National Society volunteers or other community volunteers can play an important part in promoting better nutrition for all age groups at community level. They can also help identify under-nourished children and support growth monitoring.

Empowering people for health: Empowering individuals and communities to be capable of managing their health and to claim their right to health is at the core of the SRC's work. Accordingly, SRC projects aim to capacitate and empower women to diversify household food production, improve family dietary patterns and allocate food more equitably between male and female household members.

Working in partnerships, fostering alliances and multi-stakeholder approach: The SRC works with local partners, in particular the local National Society and the Ministry of Health. Wherever it operates, the SRC follows national health and nutrition policies or guidelines. It fosters the establishment and strengthening of working partnerships and alliances in the countries in which it works. As a member of the IFRC, the SRC and its local partners participate in and follow the principles and aims of the SUN Movement and Framework for Action. The SRC is aware that nutrition cannot be tackled by the health sector alone. An interdisciplinary approach involving the agricultural, water and production sectors, from the initial assessment right up to and including implementation, is needed to address the multiple causes of malnutrition. Annex 5 depicts direct SRC actions and possible alliances and partnerships within the strategy on the double burden of malnutrition.

Conflict-sensitivity and do no harm: Food assistance or food production supplies (such as seeds and tools) are handed out during or after a disaster only after the needs and the context have been assessed. The SRC always considers the unintended negative effects of its work (do no harm). Conflict-sensitive project management is therefore a fundamental component of project management in all areas. The SRC carefully assesses the connectors and dividers in a community and provides services equally to all segments of the population, with a special focus on the most vulnerable. Together with the other stakeholders, it carefully selects areas of activity to ensure the best possible service coverage. That being said, the quantity and quality of food support needs to be standardized among stakeholders in order to avoid conflict.

4. Objectives

4.1 General objective

The SRC aims to ensure healthy and safe living for vulnerable groups and communities.

Adequate nutrition contributes to improved health status, saves lives, reduces vulnerability and increases resilience. Nutrition interventions are implemented in rural and urban settings with a view to preventing and combating under- and over-nutrition and to enabling households and communities to sustain their food production for their own consumption.

4.2 Specific objectives

The SRC carries out nutrition-specific interventions and nutrition-sensitive programmes as part of its emergency relief, early recovery, rehabilitation and long-term development programmes using key proven practices (see Annex 5).

Following its approach to link relief, rehabilitation and development (LRRD), the SRC will strengthen nutrition interventions at all stages and promote interventions addressing both immediate needs as well as longer-term development goals.

SRC nutrition support may be complemented by and overlap with other thematic programme components, such as WASH, disease prevention, care and health promotion, eye care and health in emergencies, as outlined in the respective SRC thematic concepts, which describe their relationship to nutrition.

SRC programmes pursue the five nutrition objectives described below.

1. To secure access to and availability of food

The SRC distributes **food baskets** to vulnerable populations, for example to save lives during disasters, for refugees and displaced people, people affected by infectious diseases to boost their immune systems, or for vulnerable elderly people to overcome winter food shortages. To the extent possible, the food baskets contain food items that are available on the local market. They are specifically adapted to the local context and in general contain oil, sugar, salt, pulses and staple crops, to ensure a balanced selection of carbohydrates, proteins and fats. Where possible, fortified food products are provided. Even though the food baskets vary according to country and national policy, the principle of equal distribution in quantity and quality is of utmost importance. Pregnant and nursing mothers, and families with children under 5, are targeted as a priority. An alternative to individual food baskets are **soup kitchens**, which are usually established in poor urban areas of eastern Europe during times of food scarcity and serve to feed a larger segment of the population.
In areas where the local market is intact and has sufficient supplies of food, **food vouchers** or **cash-for-food** projects give beneficiaries access to markets and a choice of products. This approach fosters household responsibility, as the household has to decide how to allocate funds so as to meet its food and nutritional preferences. In locations where the market is not intact, the benefits of **food-for-work** programmes are twofold: physical infrastructure is rehabilitated and workers are paid in food items.

Food distributions in rural areas are often accompanied by the distribution of **seeds and tools.** While distributions bridge the lean time until the first harvest, seeds and tools help families start producing food for personal consumption. Depending on the local context and the availability of water, **kitchen gardens** or **greenhouses** can help increase food availability at household level. However, kitchen gardens in schools and

food preservation measures have not proven to be effective, and are therefore no longer promoted by the SRC.

2. To change health behaviour in terms of nutrition

Health promotion and **health education** focus on all age groups. For children, they include promoting good nutritional practices such as exclusive breastfeeding, complementary feeding after 6 months and improved hygiene practices with hand-washing (see Annex 6). For adolescents and adults, the focus is on healthy eating and a healthy diet, to shape future nutritional behaviour, and on exercising to prevent and counteract over-nutrition and obesity. For vulnerable elderly, nutritional support is an important component of home-based care projects. The national food policy and the nutrition pyramid are important considerations when promoting nutrition. Factors related to substance abuse (e.g. alcohol and tobacco), which has a negative effect on nutrition, are important determinants not to be neglected during health and nutrition education. Innovative interventions, such as diversifying the diet, introducing new recipes or re-introducing traditional recipes, can help induce behaviour change.
Volunteers play a crucial role as nutrition promoters and good role models in their communities, since they have good access to the different categories of beneficiary and age groups

3. To ensure access to health and nutrition services

SRC projects will emphasise the **detection, treatment[6] and referral of malnourished children and adults.** The SRC will strengthen the capacity of local health professionals as well as Swiss-based professional health staff from the pool of disaster management delegates to identify, treat, counsel and refer under- and over-nourished children and adults. SRC projects support the primary health care system, but the SRC does not construct and run therapeutic feeding centres. For cases of severe malnourishment requiring in-patient therapeutic feeding in specialised nutrition centres, the SRC will establish functional referral links. The aim is to establish good collaboration and a network of partners to ensure smooth referral in both directions: severely malnourished children are referred to the feeding centre or hospital. After their discharge, they are supervised and monitored by the relevant community volunteer or primary health care staff.

SRC projects will promote and foster alliances with governments and multilateral partners, such as UNICEF, to advocate for and facilitate the availability of micronutrients and RTUFs for severely and moderately malnourished children and nursing mothers in the area of operation. Depending on the context and availability, the SRC may fund RTUFs and micronutrients to be distributed through the primary health care system on a temporary basis, with a view to promoting local production and an independent social marketing network.

Together with the IFRC, the SRC plans to expand its engagement in the community management of acute malnutrition (CMAM). Volunteers play an important part in rolling out CMAM by promoting the RTUFs and micronutrients and monitoring their intake. Furthermore, the SRC will engage in social mobilisation, including growth monitoring, promoting nutrition services and monitoring the intake of food products as per national standards and guidelines. The volunteer network is an excellent resource

[6]Treatment relates only to provision of RTUFs and micronutrients, and excludes hospital/in-patient treatment of severe acute malnutrition.

for working in and with local communities using approaches that are appropriate in the context and adapted to the volunteers' capacity.

4. To improve the quality of nutrition in health services

SRC projects will advocate the availability of nutrients listed in the national health policy and on the essential drug list (such as local iron, folate acid, zinc and vitamin supplements) in primary health care centres and for health-in-emergency operations and ensure they are given to women during antenatal check-ups. They will comply with national policies and guidelines for the integrated management of childhood illnesses, routine vaccination, nutrition surveillance, exclusive breastfeeding, appropriate weaning and possible micronutrient and Vitamin A supplements for children. All MNCH programmes will include interventions that target the 1,000-day window.

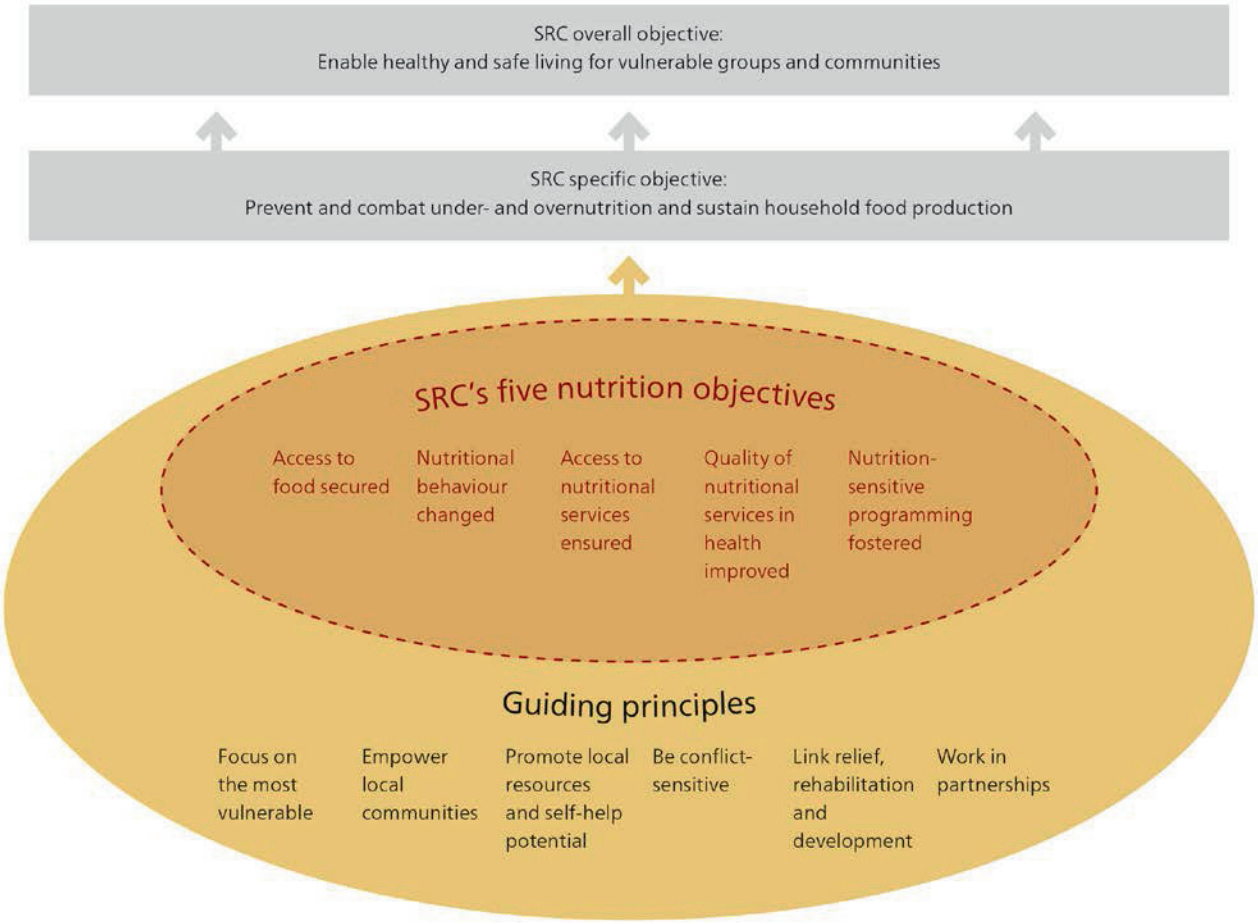
Again, volunteers play an important role in social mobilisation and administration regarding vaccinations, Vitamin A distribution and deworming campaigns.

5. To foster nutrition-sensitive programming within the SRC

The other six thematic priorities of the SRC *Health Policy for International Cooperation 2012–2017* either have an impact on the nutritional status of the beneficiaries or are nutrition-sensitive. WASH interventions prevent diarrhoea and other intestinal diseases and are a major contributor to better nutrition. In particular, hand-washing with soap at critical times has an enormous effect. Nutrition is an important part of eye care (Vitamin A distribution) and of sexual and reproductive health (MNCH services, treatment and care of persons living with HIV/AIDS); it is part and parcel of the fight against non-communicable diseases. SRC projects in these thematic areas need to encompass nutrition-sensitive programming and build competences to more systematically plan, describe and monitor effects in terms of and on nutrition. By training project personnel to use indicators and making them aware of nutrition concerns, the SRC will be better able to measure the effect of these programmes on nutrition. Other activities related to quality management and capacity-building are discussed in sections 6 and 7 below.

Even though women are usually in charge of food and nutrition in the family, SRC projects endeavour to train and empower both women and men in food production, preparation and allocation. Once men are equally aware of the importance of healthy and balanced nutrition, they are more likely to become engaged in food production and to distribute food equitably to all household members. The SRC strives to involve male and female volunteers on an equal footing in nutrition programmes.

Figure 1: Summary of the SRC framework for nutrition interventions



5. Implementation

In its work to implement the above-mentioned objectives, the SRC can call on a variety of instruments and cooperation mechanisms.

5.1 Cooperation within the Movement

In major disasters, the SRC generally acts as part of a Movement operation to provide emergency relief. Such operations are usually led by either the IFRC or the International Committee of the Red Cross (ICRC), depending on the type of disaster, and carried out together with the local National Society. Movement cooperation includes information gathering, crisis management, decision-making and coordination of operations. The SRC uses its rapid response tools to bolster nutrition, seconding SRC health experts in emergencies to the field hospitals or basic health care emergency response units of other National Societies or conducting assessments. The SRC may also contribute funds – earmarked for nutrition (e.g. food baskets) – to IFRC or ICRC emergency appeals and

operations, or purchase and supply seeds and tools for household food production to Movement operations.

In rehabilitation and long-term development programmes, nutrition interventions are usually carried out via bilateral cooperation with the partner organization (the local National Society or an NGO). This allows both the SRC and the local National Society to build up their own structure as far as necessary, but in close coordination with the ICRC, the IFRC and other, non-Movement partners.

5.2 Partnerships and alliances

Partnerships and linkages between the relevant stakeholders are essential to deliver efficient and effective nutrition and household food security activities. Working in partnership also means anchoring the activity in the local context over the long term.

The SRC involves and maintains alliances with different stakeholders at various levels.

- ***National authorities and Ministry of Health*****:** the SRC seeks cooperation with the Ministry of Health and other national authorities relevant to nutrition. Its interventions adhere to and support national policies, rules and regulations along with the SUN framework of intervention for the host country.
- ***IFRC***: the SRC is part of the IFRC CMAM working group, which is headed by the Health in Emergency Department. The SRC commits to help build competences and to give greater prominence to CMAM and nutrition within the IFRC and the Movement.

  As part of the IFRC, the SRC is committed to upholding the SUN Movement Framework for Action and standards.
- ***National Societies:*** this comprises strategic and operational partnerships with host National Societies, alliances of like-minded National Societies, participating National Society cooperation either for joint operations or co-funding of SRC operations. In countries where a nutrition cluster exists and which are members of the SUN Movement, the SRC will encourage the respective National Society to become an active member and be engaged at national level.
- ***Multilateral organisations*****:** the SRC will engage in partnerships with UNICEF and others for the distribution and/or procurement of nutritional products (e.g. RTUFs and micronutrients), depending on the country context, regulations and availability. It will advocate the availability of nutritional products through the primary health care system in its areas of intervention, a pivotal requirement. Alliances with the World Food Programme and the FAO will allow it to work with food-for-work or cash-for work programmes in other sectors. Likewise, membership of and alliances with United Nations clusters and the existing national nutrition cluster will allow it to leverage the impact of its projects.
- ***International and local NGOs****:* the SRC liaises with different international and local NGOs to establish a functional referral and treatment system for severely malnourished children who require therapeutic feeding, and a treatment system and self-help groups for persons suffering from substance abuse.
- ***Alliances with Swiss NGOs and Swiss humanitarian players:*** strengthening partnerships and complementing efforts in the fields of nutrition and food security, in particular with Médecins sans frontières for therapeutic feeding and with Helvetas, Swiss Aid and other NGOs working in the agriculture and livelihood sector on economic security and market access issues. A partnership should be established

with the Swiss Humanitarian Aid department of the Swiss Agency for Development and Cooperation on a joint pool of health experts.

- ***Institutionalized partnerships with the private sector:*** for sponsorship, training and technical support in terms of nutritional products, seeds and tools (e.g. Sight and Life, DSM Nutritional Products).

6. Quality management

6.1 Relevance and impact

SRC nutrition interventions are designed in such a way that they contribute to local, national and global nutrition policies. They are based on a thorough assessment of the beneficiaries' nutritional and health needs and on an understanding of the local reasons for nutritional deficits. SRC nutrition programmes help improve the population's nutrition and thus its health status. They target in particular pregnant and nursing mothers and children under 5 (with special emphasis on the first 1,000 days), in order to foster the mental and physical development of future generations, as well as special groups like people affected by infectious diseases and vulnerable elderly people.

The relevant standards for quality management are specified for all SRC activities in the SRC *Strategy 2020 for International Cooperation*. At the operational level, these are reflected in the quality management manuals for the field and for SRC headquarters.

SRC interventions emphasise good-quality products and services. Food baskets are composed in the light of the nutritional food pyramid of the country concerned and ensure a healthy balance of nutrients. When procuring food and when procuring or distributing nutritional products (e.g. RTUFs, micronutrients) good quality, acceptance, popularity and a certain shelf-life are key considerations.

6.2 Monitoring, evaluation and operational research

The impact chain of nutrition programmes is depicted in the SRC impact model (see Annex 8), which reflects the outputs and outcomes on which the monitoring framework is based. All SRC projects establish a monitoring framework against which progress is analysed. Projects are monitored by applying internal standards for monitoring in line with the standardised project management cycle. Suggested indicators can be found in the specific indicator toolbox for nutrition (see Annex 9). The indicators are in line with the global targets to be achieved.

WASH or other nutrition-sensitive programmes can use appropriate indicators to measure the nutritional impact. A selection of indicators is depicted in the indicator toolbox of the respective thematic priority and in the nutrition indicator toolbox in the worksheet entitled "cross-cutting themes".

Since SRC nutritional interventions have yet to be thoroughly documented and evaluated, operational research and the use of innovative but easy-to-use methods of nutrition assessment, monitoring and surveillance will be encouraged (see Annex 9).

6.3 Capacity development and knowledge management

The SRC is committed to developing and improving its capacity regarding nutrition in emergency relief, rehabilitation and long-term development operations at SRC headquarters and in the field. The scope of the SRC disaster management pool will be expanded to include nutrition. When training Swiss-based staff and local health professionals and volunteers, the SRC adheres to internationally accepted standards and guidelines (see page 6 and Annex 2) and the principles outlined in this nutrition concept. Training is provided by experienced trainers from the IFRC and other National Societies. A selection of e-learning tools is listed in Annex 10.

The SRC is actively engaged in the knowledge management process for Movement nutrition operations and activities, and tends to be more on the learning end in this particular field. Together with the IFRC and other National Societies, it has embarked on a regular exchange of experiences and lessons learnt and a process to develop or adapt guidelines for future operations (in particular CMAM and the use of monitoring tools). Institutionalized briefings and debriefings of delegates and regular exchanges of information between interested delegates in the field and the Department for International Cooperation ensure that knowledge and practice in the fields of nutrition and household food security are built up and disseminated.

7. Resources

7.1 Human resources

The SRC commits to invest resources in building up knowledge and expertise in nutrition at SRC headquarters (among disaster management pool members) and in the field (to strengthen nutrition-related assessments, planning, monitoring and evaluation, and technical support for treatment, care and referral). To support this endeavour, the number of health advisers at headquarters will be scaled up.

7.2 Financial and material resources

Nutrition interventions are generally financed through the sources listed below:

- contributions from the Swiss Government, in particular the Swiss Agency for Development and Cooperation;
- contributions from Swiss Solidarity;
- earmarked contributions from companies, public authorities, foundations and other institutions;
- earmarked private contributions (in cash and in kind);
- the SRC Disaster Relief Emergency Fund.

Annex 1: Classification and definitions of under-nutrition and over-nutrition and Body Mass Index

Classification and definitions of under-nutrition and over-nutrition

Under-nutrition

Low birth-weight**:** defined as a weight of less than 2,500 grams at birth.

Underweight**:** is a composite form of under-nutrition that includes elements of stunting and wasting. It is defined as the percentage of children aged 0-9 months whose weight for age is below minus two standard deviations (moderate and severe underweight) ad minus three standard deviations (severe underweight) from the median of the WHO Child Growth Standards (see Annex 2).

For adults, underweight is measured using the Body Mass Index (BMI) tables. A BMI below 18.5 signifies underweight.

Stunting**:** reflects chronic under-nutrition during the most critical periods of growth and development in early life. It is defined as the percentage of children aged 0 to 59 months whose height for age is below two standard deviations (moderate and severe stunting) and minus three standard deviations (severe stunting) from the median of the WHO Child Growth Standards. Stunting is irreversible after the age of 2 years.

Wasting: reflects acute under-nutrition. It is defined as the percentage of children aged 0 to 59 months whose weight for height is below minus two standard deviations (moderate and severe wasting) and minus three standard deviations (severe wasting) from the median of the WHO Child Growth Standards.

Severe acute malnutrition (SAM): the percentage of children aged 6 to 59 months whose weight for height is below minus three standard deviations from the median of the WHO Child Growth Standards, or by a mid-upper-arm circumference less than 115 mm, or bilateral pitting oedema or marasmic kwashiokor (wasting with oedema).

Moderate acute malnutrition (MAM): defined by WHO/UNICEF as weight-for-height Z-score <-2 but >-3.

Global acute malnutrition: the sum of the prevalence of SAM plus MAM in a population.

Micronutrient deficiencies

Micronutrient deficiencies are a major global health problem. More than 2 billion people in the world today are estimated to be deficient in key vitamins and minerals, particularly vitamin A, iodine, iron and zinc. Most of these people live in low-income countries and are typically deficient in more than one micronutrient. Deficiencies occur when people do not have access to micronutrient-rich foods such as fruit, vegetables, animal products and fortified foods, usually because they are too expensive to buy or are locally unavailable. Micronutrient deficiencies increase the general risk of infectious illness and of dying from diarrhoea, measles, malaria and pneumonia. These conditions are among the 10 leading causes of disease in the world today.

The groups most vulnerable to micronutrient deficiencies are pregnant women, nursing women and young children, mainly because they have a relatively greater need for vitamins and minerals and are more susceptible to the harmful consequences of deficiencies. For a pregnant woman these include a greater risk of dying during childbirth, or of giving birth to an underweight or mentally impaired baby. For a nursing mother, her micronutrient status determines the health and development of her breast-fed infant, especially during the first 6

months of life. For a young child, micronutrient deficiencies increase the risk of blindness and death due to child illnesses such as diarrhoea and measles.

Over-nutrition

Overweight in children under 5 years of age: defined as the percentage of children aged 0 to 59 months whose weight for height is above two standard deviations (overweight and obese) or above three standard deviations (obese) from the median of the WHO Child Growth Standards.

Source: UNICEF, Improving child nutrition. The achievable imperative for global progress*. UNICEF, New York, 2013 (WHO and UNICEF joint definitions).*

Body Mass Index

The Body Mass Index (BMI) is calculated as follows:

$$BMI = \frac{m}{l^2}$$

m = body mass (in kilograms); l= body length in meters

BMI interpretation for adults:

Grading	**BMI**
Severe underweight	≤ 16,0
Moderate underweight	16,0–17,0
Underweight	17,0–18,5
Normal weight	18,5–25,0
Overweight	25,0–30,0
Obesity Grade I	30,0–35,0
Obesity Grade II	35,0–40,0
Obesity Grade III	≥ 40,0

BMI calculation and interpretation for children between 2 to 19 years of age:

http://apps.nccd.cdc.gov/dnpabmi/

Annex 2: Additional standards and guidelines

- The Fanta Project. Training Guide for Community-Based Management of Acute Malnutrition (CMAM) (2008). Available at: www.fantaproject.org/focus-areas/nutrition-emergencies-mam/cmam-training.
- IASC (2008). *A Toolkit for Addressing Nutrition in Emergency Situations*, Nutrition Cluster, IASC. Available at: http://motherchildnutrition.org/resources/pdf/mcn-iasc-toolkit-nutrition-in-emergency-situations.pdf.
- Gender markers in nutrition (see: https://www.humanitarianresponse.info/system/files/documents/files/NUTRITION%202012%20Tip%20Sheet.pdf).
- Food security (Food assistance) (see: https://www.humanitarianresponse.info/system/files/documents/files/FOOD%20SECURITY%201%20FOOD%20ASSISTANCE%202012%20Tip%20Sheet.pdf)
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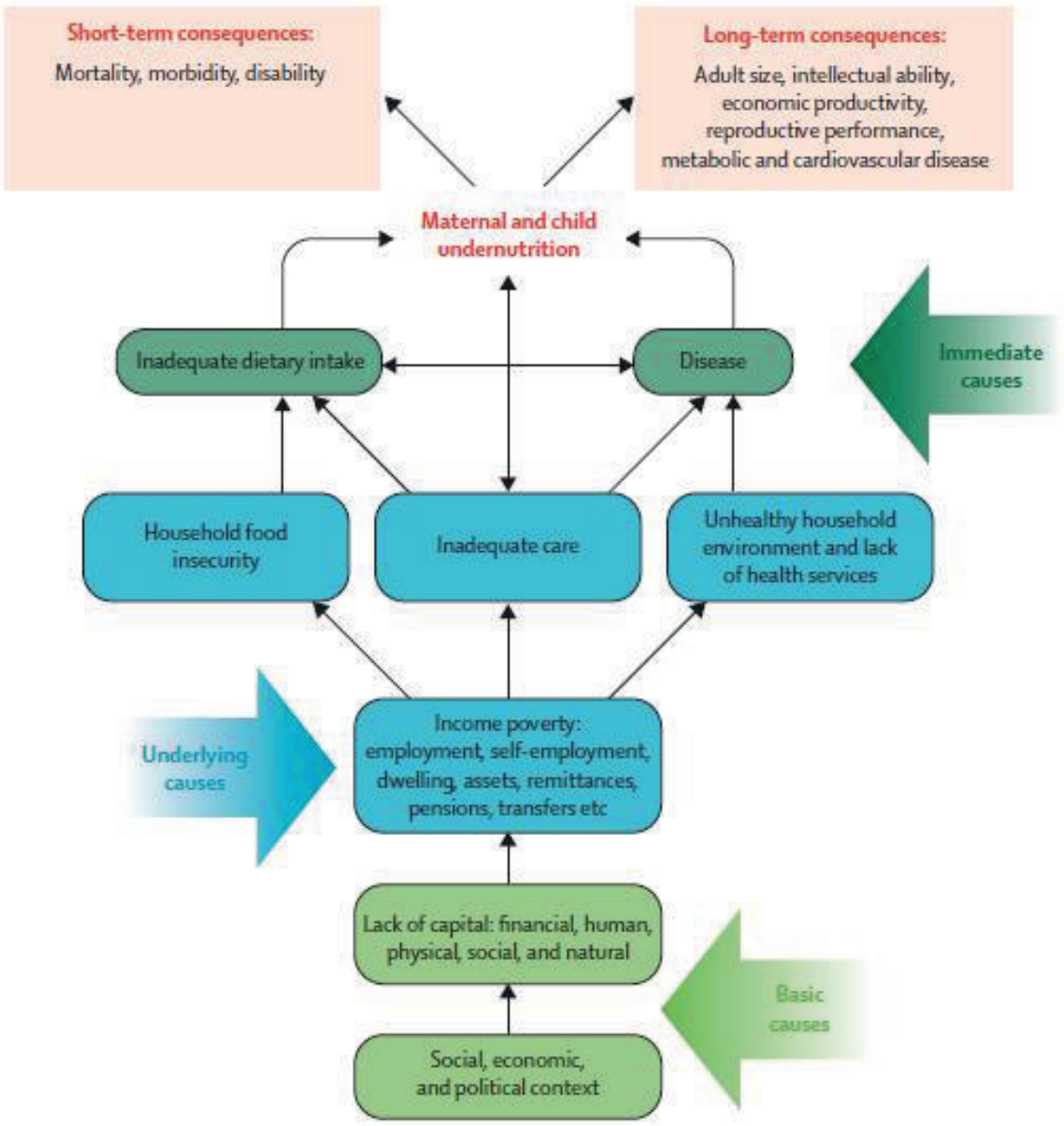
Annex 3: Conceptual framework on under-nutrition



Source: UNICEF (1990) and Black et al. (2008). Framework of the relations between poverty, food insecurity, and other underlying and immediate causes of maternal and child under-nutrition and their short-term and long-term consequences

Annex 4: Framework for actions to achieve optimum fetal and child nutrition and development

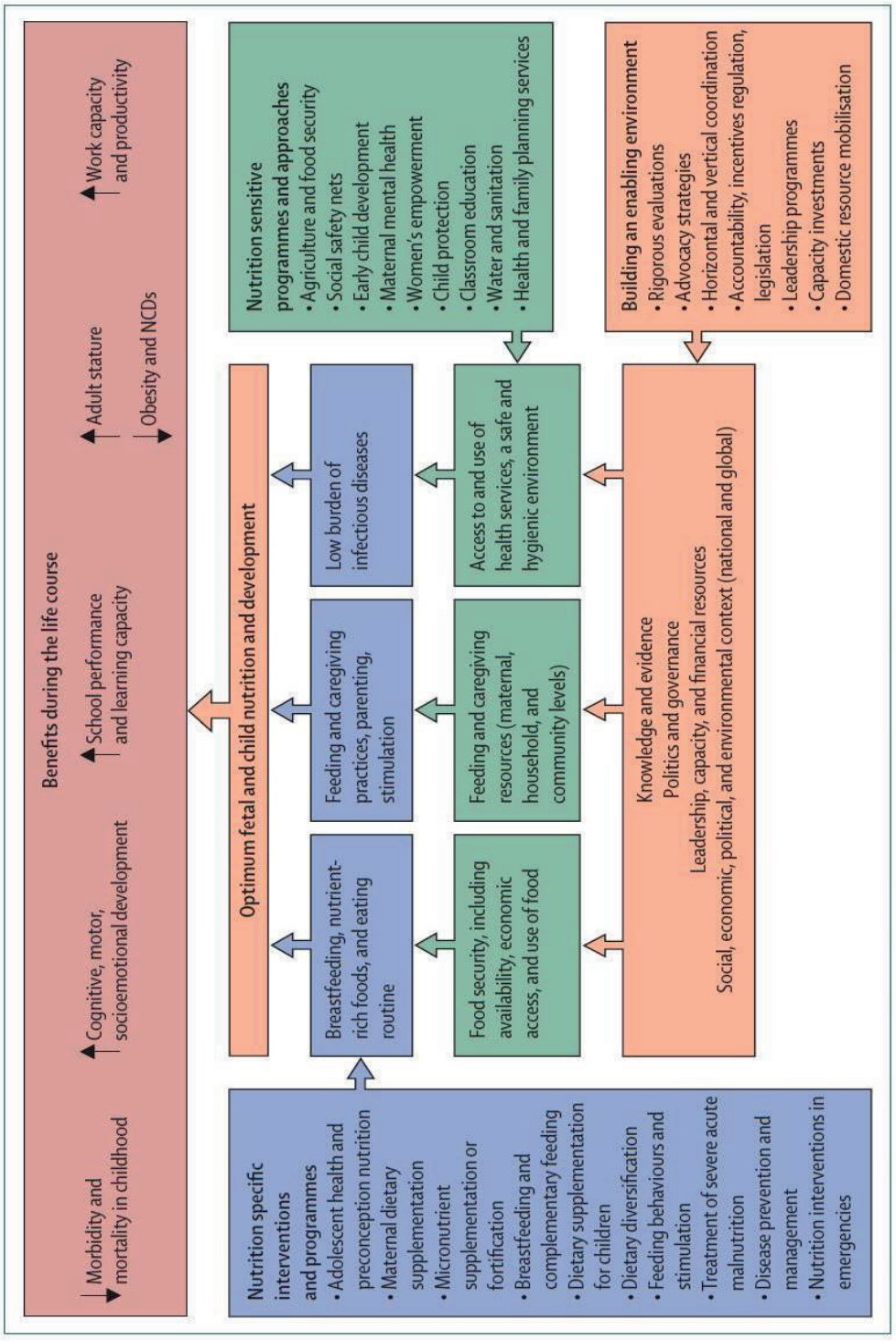


Figure 1: Framework for actions to achieve optimum fetal and child nutrition and development

Source: Black et al. 2013; Lancet 2013

Annex 5: Possible SRC interventions within the strategy on the double burden of malnutrition

Possible SRC interventions are highlighted as grey cells within a comprehensive strategy on the double burden of malnutrition

	Nutrition	**Policy**	**Pillars**	
	Food security	**Food safety**	**Healthy lifestyles**	**Nutrition**
Health		Food safety and hygiene regulations	Promoting healthydiets	Micronutrient supplementation (multiple micronutrients in pregnancy; childhood Vitamin A; preventive zinc)
		Food inspections	Limit availability of inappropriate foods	Management of severe acute malnutrition
		Food standards	Promotion of exercise	Dietary guidelines
			Family planning	Baby-friendly hospitals
				Breast- and complementary feeding promotion
Public works / urban develop-ment	Rural roads	Water and sanitation improvements	Urban bike lanes	Smoke-free home environments
	Irrigation		Pedestrian walkways	
			Road safety	
Agriculture	Sustainable intensification of production	Regulations to improve food safety in processing, transport and storage		Biofortification to improve nutrient density
	Promotion of home gardens			Nutrition-oriented agriculture research
	Food and agriculture policies to promote avail-ability, afford-ability,diversity and quality			Nutrient-preserving processing, transport and storage

				Nutrition-promoting farming systems, agronomic practices and crops
Education	Promotion of school gardens	Hygiene education	Physical exercise	Nutrition education
	School meals		Life skills and sex education	Anemia control
			Gender equity	
Industry / Trade / Commerce	Food availability (manufacture and marketing)	Food standards		Food fortification, especially with folic acid
		Food safety regulations		Locally available fruits and vegetables
				Product reformulation to reduce saturated and transfat sodium, and sugar content
Public in-formation			Marketing of food to children	Marketing code for breast milk substitutes
				Nutrition information campaigns
				Nutrition labeling
Finances / Economy	Food subsidies			Food taxes

Source: R. Shrimpton and C. Rokx, The Double Burden of Malnutrition in Indonesia*, World Bank Jakarta, Report 76192-ID.*

Annex 6: Global targets and cost-effective interventions to improve maternal, infant and young child nutrition

GLOBAL TARGETS TO IMPROVE MATERNAL, INFANT AND YOUNG CHILD NUTRITION
POLICY BRIEF

1,000 DAYS

Malnutrition remains a serious impediment to the progress toward achieving the Millennium Development Goals. **Yet many of the nutrition challenges that have persisted for decades can be resolved within our generation.**

Recognizing that accelerated global action is needed to address the pervasive and corrosive problem of malnutrition, the World Health Organization (WHO) recently identified a set of global targets designed to reduce the unacceptably high burdens of disease and death caused by poor nutrition, particularly during the critical 1,000 days between a woman's pregnancy and a child's 2nd birthday.* By aligning the global community behind six targets aimed at improving the nutritional status of mothers, infants and young children and committing to a decade of investment to expand nutrition interventions, we can prevent the deaths of one million children per year and help build the foundations for healthier and more prosperous societies.

GLOBAL TARGET 1: BY 2025, REDUCE BY 40% THE NUMBER OF CHILDREN UNDER AGE 5 WHO ARE STUNTED.

- *Problem*: Stunting is the irreversible result of chronic nutritional deprivation during the most critical phase of child development—the 1,000 days between a woman's pregnancy and her child's 2nd birthday. Stunted children have weaker immune systems making them more likely to die from common illnesses and disease, and suffer from impaired brain development making them less able to learn in school and earn a good living as an adult.
- *Results*: A reduction in the number of stunted children from 171 million in 2010 to approximately 100 million.

GLOBAL TARGET 2: BY 2025, ACHIEVE A 50% REDUCTION IN ANEMIA IN WOMEN OF REPRODUCTIVE AGE.

- *Problem*: Anemia in women increases the risk of dying during childbirth and increases the risk of babies being born with low birth weight. Iron deficiency anemia affects 1/3 of all women of reproductive age throughout the world.
- *Results*: A reduction in the number of anemic, non-pregnant women from 468 million to approximately 230 million.

GLOBAL TARGET 3: BY 2025, ACHIEVE A 30% REDUCTION OF THE NUMBER OF INFANTS BORN LOW BIRTH WEIGHT.

- *Problem*: An infant's weight at birth is a strong indicator of his or her chances for survival, growth, and long-term health and development. In the developing world, low birth weight stems primarily from poor maternal nutritional status before conception, maternal short stature due mostly to undernutrition and infections during childhood and poor nutrition during pregnancy.
- *Results*: 3.9% relative reduction in the number of infants born with low birth weight per year.

GLOBAL TARGET 4: BY 2025, ENSURE THAT THERE IS NO INCREASE IN THE NUMBER OF CHILDREN WHO ARE OVERWEIGHT.

- *Problem*: Obese children are likely to grow into obese adults, have an increased risk of diabetes and liver disease, and have poorer economic prospects later in life.
- *Results*: The number of overweight children under age 5 would not increase from current levels of 43 million to forecasted levels of approximately 70 million.

GLOBAL TARGET 5: BY 2025, INCREASE TO AT LEAST 50% THE RATE OF EXCLUSIVE BREASTFEEDING IN THE FIRST SIX MONTHS.

- *Problem*: A non-breastfed child is 14 times more likely to die in their first six months of life than a child who is exclusively breastfed. Though breastfeeding is the single most effective nutrition intervention for saving lives, global breastfeeding rates have stagnated or dropped in most regions of the world to an estimated 37%.
- *Results*: 2.3% relative increase per year would lead to approximately 10 million more children per year being exclusively breastfed until six months of age.

GLOBAL TARGET 6: BY 2025, REDUCE AND MAINTAIN CHILDHOOD WASTING TO LESS THAN 5%.

- *Problem*: Commonly used to indicate the severity of a famine or food crisis, wasting is the result of grave disease and/or deprivation of nutritious food at a specific point in time and is seen as an early warning for future increases in chronic undernutrition. The proportion of childhood wasting rose in the second half of the last decade, likely as a consequence of the dramatic spikes in food prices.
- *Results*: Current global prevalence of wasting of 8.6% should be reduced to less than 5% by 2025 and maintained below such levels.

*These targets were endorsed by the 65th World Health Assembly in May 2012 as part of WHO's comprehensive plan on maternal, infant and young child nutrition. Sources: Black, R. et al "Maternal and Child Undernutrition" *The Lancet*, January 2008; Save the Children "The Child Development Index 2012"; UNICEF, "Committing to Child Survival: A Promise Renewed" Progress Report 2012.

www.thousanddays.org

Cost-effective interventions:

TABLE 1 Evidence Based Direct Interventions to Prevent and Treat Undernutrition

Promoting good nutritional practices ($2.9 billion):
- ❑ breastfeeding
- ❑ complementary feeding for infants after the age of six months
- ❑ improved hygiene practices including handwashing

Increasing intake of vitamins and minerals ($1.5 billion)
Provision of micronutrients for young children and their mothers:
- ❑ periodic Vitamin A supplements
- ❑ therapeutic zinc supplements for diarrhoea management
- ❑ multiple micronutrient powders
- ❑ de-worming drugs for children (to reduce losses of nutrients)
- ❑ iron-folic acid supplements for pregnant women to prevent and treat anaemia
- ❑ iodized oil capsules where iodized salt is unavailable

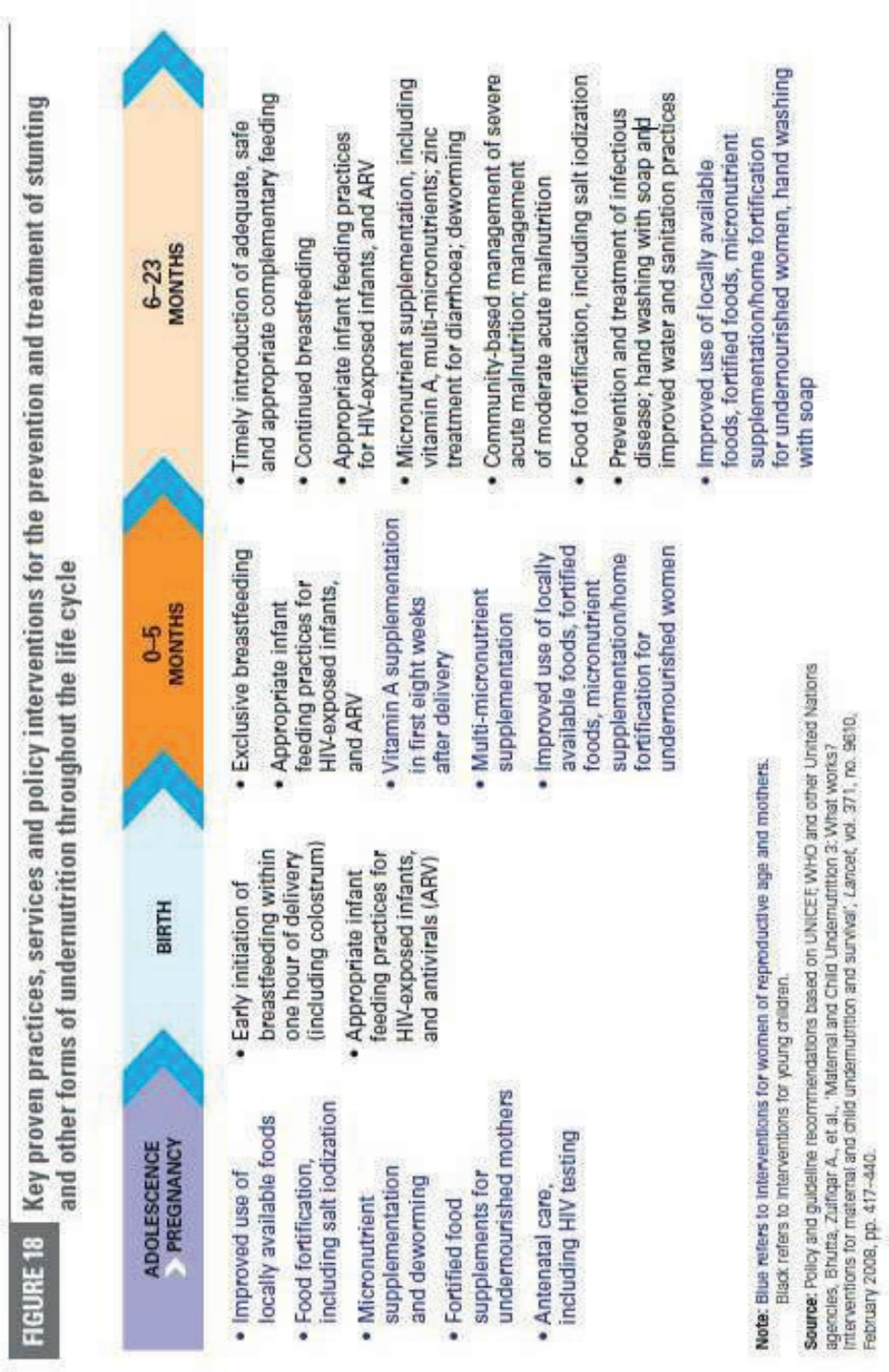
Provision of micronutrients through food fortification for all:
- ❑ salt iodization
- ❑ iron fortification of staple foods

Therapeutic feeding for malnourished children with special foods ($6.2 billion):
- ❑ prevention or treatment for moderate undernutrition
- ❑ treatment of severe undernutrition ("severe acute malnutrition") with ready-to-use therapeutic foods (RUTF).

Reference: Scaling Up Nutrition: What Will it Cost? Horton, et.al. 2009

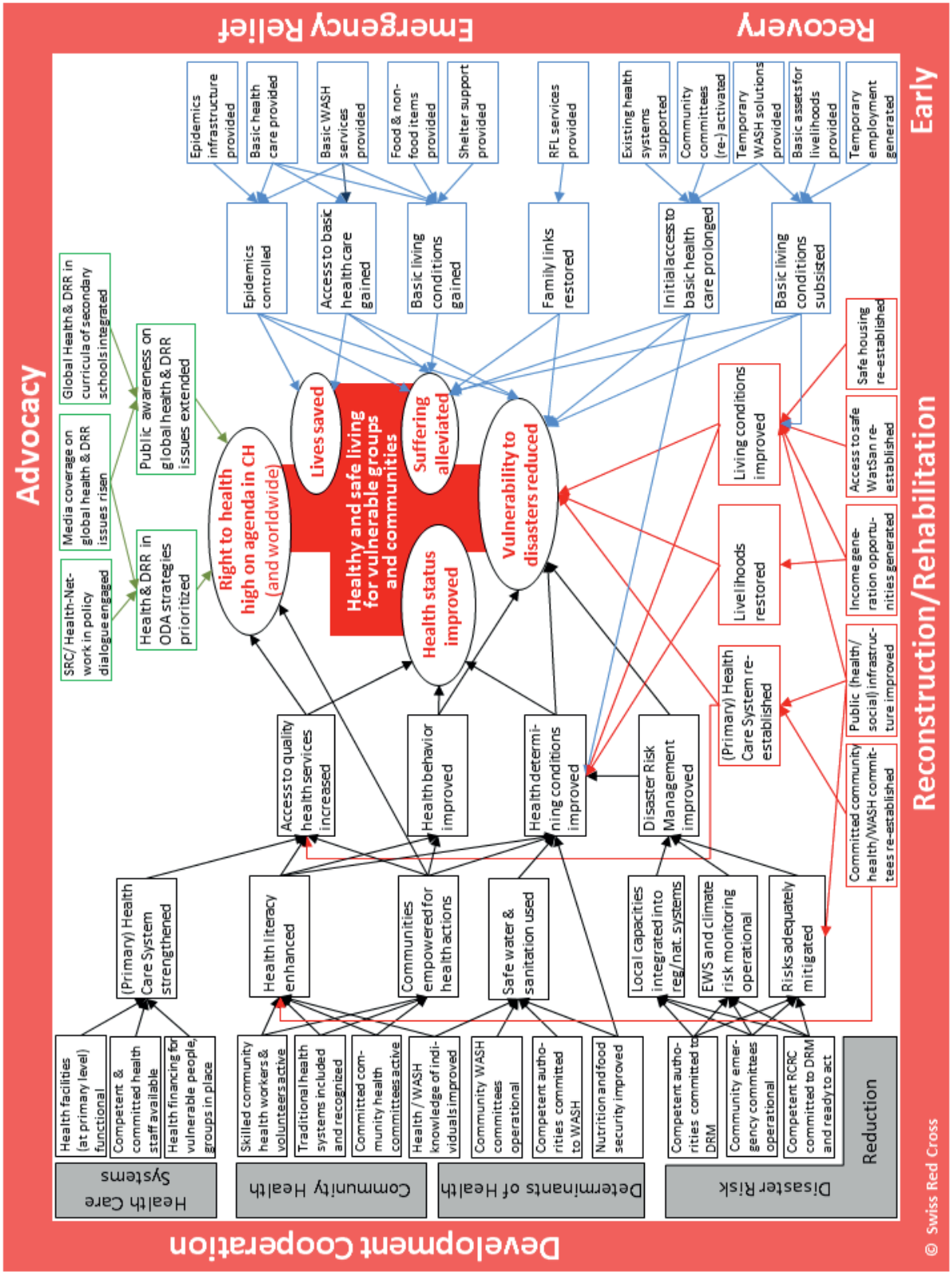
Source: SUN Movement Framework for Action, 2011.

Annex 7: Key proven practices, services and policy interventions by age group



Source: UNICEF, Improving child nutrition. The achievable imperative for global progress. *UNICEF, New York, 2013.*

Annex 8: SRC impact model



Annex 9: Assessment and monitoring instruments

SRC internal DMS link to nutrition indicator toolbox

Nutrition indicator toolbox

Web links to assessments and questionnaires

SMART Methodology for Measuring Mortality, Nutritional Status and Food Security in Crisis Situations

FAO guidelines for assessing nutrition-related knowledge, attitudes and practices

Web links for nutrition mobile phone apps nutrition

Mobile phones with special nutrition apps are useful for documenting child growth and for the timely detection of cases of malnutrition for immediate referral.

unicef severe acute malnutrition report app

IDS mobile nutrition surveillance

Annex 10: A selection of nutrition e-learning tools

Nutritional status assessment and analysis. This course covers the basic concepts of malnutrition, describes how nutritional status is assessed, and identifies the most commonly used nutrition indicators, as well as the criteria to be used when selecting the indicators in specific contexts and situations. Duration: 2 hours. This course is part of the FAO e-learning courses on food security, and is now available on the IFRC learning platform (as part of its memorandum of understanding with FAO): https://ifrc.csod.com/LMS/LoDetails/DetailsLo.aspx?loId=0222d146-aeb3-4fc5-9777-0bd3a0804752&back=%2fLMS%2fBrowseTraining%2fBrowseTraining.aspx%3ftab_page_id%3d-6#t=1

Programme for infant and young child feeding – training course. Jointly developed by UNICEF and Cornell University. This training course aims to enhance the competencies and build capacity of UNICEF staff and counterparts who are involved in Infant and Young Child Feeding (IYCF) programmes in developing countries. This includes programme development, programme implementation, programme evaluation, and other related activities for improving nutrition and health outcomes of infant and young children. This is a certificate course http://www.nutritionworks.cornell.edu/security/index.cfm?Action=Login&Course=unicef&Error=nohome

Nutrition in Emergencies, UNICEF. This course covers basic concepts around the humanitarian system and reform, undernutrition and response in emergencies, individual assessment and micronutrients. The package aims to increase the accessibility of information within key modules of the Harmonized Training Package: Resource Material for Training on Nutrition in Emergencies (the HTP) to strengthen the technical knowledge of individuals working in or aspiring to work in emergency nutrition. This course offers a certificate. http://www.unicef.org/nutrition/training/

Harmonised training package (HTP) – UNSCN (United Nations System Standing Committee on Nutrition). The HTP is primarily a resource for trainers in the Nutrition in Emergencies sector and it can be used by individuals to increase their technical knowledge of the sector. It is designed to provide trainers from any implementing agency or academic institution with information from which to design and implement a training course according to the specific needs of the target audience, the length of time available for training and the training objectives. It can be used as stand-alone modules or as combined modules depending on the training needs. http://www.unscn.org/en/gnc_htp/howto-htp.php#howtousehtp

Emergency Nutrition Network Lessons. Infant feeding in emergencies. The e-learning lessons were produced as part of a package of resources to help in orientation on infant and young child feeding in emergencies developed by Emergency Nutrition Network, IFE Core Group members and collaborators. These resources are targeted at emergency relief staff, program managers, and technical staff involved in planning and responding to emergencies, at national and international level. The e-learning lessons are designed to the IYCF in emergencies orientation package and to support Module 17 of the HTP. They can be used in self learning, in preparation for a face-to-face training, or as a group exercise .http://lessons.ennonline.net/

Annex 11: References

(all websites accessed between February and August 2014)

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Swiss Red Cross