Technical Consultation on Measuring Nutrition in Population-Based Household Surveys and Associated Facility Assessments

19 & 20 September 2018
Washington D.C.

Acknowledgement:

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Executive Summary

On September 19-20, 2018, the Bill and Melinda Gates Foundation (BMGF) and the United States Agency for International Development (USAID) convened a two-day technical consultation on 'Measuring Nutrition in Population-Based Household Surveys and Associated Facility Assessments'. The meeting was hosted in collaboration with United Nations Children's Fund (UNICEF), and the World Health Organization (WHO), with technical support provided by Data for Decisions to Expand Nutrition Transformation (DataDENT), an initiative led by the Johns Hopkins Bloomberg School of Public Health that aims to address gaps in nutrition measurement and advocate for stronger nutrition data systems. This consultation is one of several collaborative efforts between BMGF, USAID, UNICEF and WHO intended to improve the quality, availability, and use of actionable nutrition data.

The two-day gathering brought together 67 nutrition experts from a wide variety of backgrounds and perspectives. Participants include representatives from the donor community, academic institutions, United Nations (UN) agencies, non-governmental organizations (NGOs) and a variety of government agencies, including those from Bangladesh, Ethiopia, India, Malawi and Nigeria.

For most lower and middle income countries (LMICs), population-based household surveys (PBHS) are the primary source of nutrition data for policy and program decision-making. Facility-based surveys, which involve the assessment of service delivery facilities, are also implemented extensively, though generally seen as an underutilized source of data within the maternal, newborn and child health (MNCH) and nutrition communities. The primary goal of this consultation was to produce a set of recommendations for how to *strengthen* the nutrition-related content in large-scale household and facility surveys. The objectives were as follows:

1. To review how nutrition data, including indicators and data sources, are currently being used by different stakeholders at global and country levels and identify the gaps that remain in their information needs that could be filled through household or facility surveys.
2. To review recommendations from recent technical consultations for improving collection of anthropometric and micronutrient status data in large-scale household surveys.
3. To identify ways to augment, improve and/or harmonize questions about nutrition intervention coverage, infant and young child feeding (IYCF) and other diet quality measures using the core questionnaires of the major household and facility surveys as a starting point.

The consultation was designed as a combination of expert presentations, panel discussions, and intensive working group (WG) sessions, with WG participants divided into the following categories of interventions: 1) Child Growth, 2) IYCF, Diet Quality, and Food Security; 3) Maternal, Infant, and Young Child Nutrition (MYCIN) Counseling and Support; and 4) Micronutrients (MN). After four rounds of deliberations, the WGs presented their final outputs in terms of 1) PBHS recommendations, 2) facility survey recommendations, and 3) prioritization of recommendations (in Tiers), including a research and development (R&D) agenda.

As a key input to the WG sessions, preliminary results were compiled from a recently administered stakeholder survey on data use and needs. Other inputs to the WG sessions included presentations by each of the major survey platforms, including Demographic and Health Survey (DHS), Multiple Indicator Cluster Surveys (MICS), Standardized Monitoring and Assessment of Relief and Transitions (SMART), Living Standards Measurement Study (LSMS) and Service Provision Assessments (SPA), along with an update on harmonization efforts between the DHS and MICS. Representatives from Ethiopia, India and Nigeria discussed their most pressing data needs and challenges associated with collection and use of nutrition data in their countries. And updates were provided from recent technical consultations on anthropometry data quality and MN status measurement. Finally, presentations and panel discussion took place with representatives from countries, data platform representatives and donors.

Some key points articulated by **country representatives** included:

- Technical capacity to implement accurate, reliable surveys remains a challenge, with the number of nutrition graduates growing but still insufficient. *(Ethiopia)* The education level of respondents must also be considered when devising potentially complex questions. *(India)*

- Due to capacity constraints (listed above), the inclusion of any new indicators (from upcoming DHS/MICS revisions) would ultimately depend upon the 'feasibility' of adding additional questions to already over-burdened questionnaires. *(India)*
- Utilization of data remains a notable challenge, with efforts constantly needed to bridge the gap between researcher/technical staff and the policy makers within governments. *(Ethiopia)*
- Improved harmonization of indicators, data collection timing, and sampling modalities is critical for countries to be able to compare nutrition status between rounds of different surveys (e.g. DHS to MICS), and to utilize results for performance budget reviews. *(Nigeria)*

Key considerations articulated by **donors and survey representatives** included:

- There is intense competition among stakeholders from different domains, each wanting their individual interests represented in the DHS and other surveys. Given this, any new submissions (of a new or modified question) should be strongly justified, well-validated, feasible to collect, and comprehensively thought through, including possible responses and a tabulation plan *(DHS)*
- Survey revision is a delicate balancing act, considering key data needs and how they can best be met without overburdening and potentially undermining a given survey. There is always an opportunity cost to adding data. Each time the survey size is increased, the quality of *all* of the data collected is undermined. *(MICS)*

A wide range of valuable ideas and suggestions were generated, including potential modifications for the upcoming DHS questionnaire design, the need for further discussion on nutrition indicators, and the possible creation of a monitoring and evaluation reference group (MERG) for nutrition. This group came together around its shared commitment to quality nutrition data, and to using that data to improve people's lives. It is hoped that the outputs from this gathering will continue to advance progress towards our shared global nutrition goals.

September 19, 2018 – Day One Proceedings

Welcome and opening remarks

Ellen Piwoz, BMGF

This consultation gathers together nutrition experts from a wide variety of roles, responsibilities and perspectives, who share the goal of improving the quality, validity and availability of nutrition-related data. The meeting will address both multi-purpose and nutrition-specific surveys, both at the household and facility levels, and ultimately aims to enhance our individual and collective abilities to make improved programmatic and policy-oriented decisions. This two-day consultation is a collaborative initiative, with support from the BMGF and USAID, along with technical support from WHO and UNICEF.

Omar Dary, USAID

Apologies were extended on behalf of Anne Peniston, Chief of the Nutrition and Environmental Health Division at USAID, who was not able to attend this meeting. The speaker noted that under her leadership, nutrition has regained a prominent position within USAID, particularly in the context of multi-sectoral programming.

Nearly 28 years ago, UNICEF published its seminal 1990 document summarizing good nutrition as dependent upon three key elements: food, health, and care. Later, an emphasis on early childhood development similarly demonstrated the need to look beyond food and nutrients when examining nutritional outcomes. UNICEF also promulgated the formula for Assessment, Analysis and Action, but over the past 20 years, our tendency has been to jump into Action without sufficient time spent on the understanding the conditions (Assessment and Analysis), thus causing us to either address needs that don't exist; or alternatively, giving insufficient attention to the most concerning of issues.

Today we know that data is power, since having accurate data allows us to determine which interventions are performing well, and which are not. This meeting is an opportunity to discuss how to measure the effects and outcomes of interventions in a simple, low cost, timely and reliable manner. The DHS, MICS, SMART, and various

nutrition-specific surveys have played an incredibly important role in nutrition. This group is here to help improve and complement these platforms.

Introductions and review of agenda

Rebecca Heidkamp, Johns Hopkins

In recent years, there has been a call for a 'global nutrition data revolution'. For that to happen, there are many areas across the data value chain that need to be strengthened, from prioritizing *which* data is collected, to identifying data gaps, and deciding how it will be collected, compiled, presented and translated. We know that PBHS are the primary source of nutrition data for policy and program decisions in most LMICs. We also know that facility based surveys are an underutilized source of data within the MNCH and nutrition communities. This consultation aims to ensure that population- and facility-based surveys are as strong as they can be so that they contribute to effective decision making and improved global nutrition outcomes. This group is here to make some practical recommendations concerning nutrition measurement.

The three major objectives of this consultation are:

1. To review how nutrition data, including indicators and data sources, are currently being used by different stakeholders at global and country levels, and identify the gaps that remain in their information needs that could be filled through household or facility surveys.

2. To review recommendations from recent technical consultations for improving collection of anthropometric and micronutrient status data in large-scale household surveys.

3. To identify ways to augment, improve and/or harmonize questions about nutrition intervention coverage, IYCF and other diet quality measures using the core questionnaires of the major household and facility surveys as a starting point.

There are a wide range of actors present at this technical consultation, including technical experts, country representatives (from public sector, UNICEF and USAID), representatives from the major survey programs, and various development partners (donors and global leaders). Refer to the Agenda for details of planned proceedings, speakers, and panelists.

This consultation was hosted by the BMGF and USAID, in collaboration with UNICEF and WHO. Technical support was provided by DataDENT, a four-year initiative funded by BMGF to do technically-rooted advocacy to strengthen the nutrition value chain. DataDENT collaborators include JHU, the International Food Policy Research Institute (IFPRI) and Results for Development.

Plenary 1: Results from a Nutrition Stakeholder Survey of Data Use and Data Needs

Andrew Thorne-Lyman, Johns Hopkins

To better understand the nutrition community's uses and needs for data, an online survey was conducted in the months leading up to this consultation. The results of that survey were analyzed, and the preliminary findings were compiled for use during the WG sessions. There were 235 completed responses to the survey.

The survey objectives were to:

- Understand what type of data the nutrition community is using
- Learn how that varies by types of users
- Find out what nutrition data needs are not being met, and why
- Explore variation by different types of users

- Bring the perspectives of the general nutrition community, particularly people who couldn't be at this consultation

The survey found that 74% of respondents access the DHS, making it the most common in-country data source. Accessing data from the DHS was more common among people with a multi-country focus than a single country focus (85% vs 60%). The MICS was also heavily accessed (42% of respondents), followed by other national nutrition surveys. 'Breastfeeding counseling' and 'complementary feeding counseling' were the top two types of data utilized, according to respondents, although it was noted that respondents were likely referring to the IYCF practice indicators given that counseling data is not often collected through population based surveys.

How frequently do respondents want breastfeeding counselling data to be available?

Is data available as frequently as you'd like it to be?	Single country focus (N=67)	Multi-country focus (N=60)
Yes	41.8	28.3
No	58.2	71.7

Preferred frequency of data availability	Single country focus (N=39)	Multi-country focus (N=43)	Overall (N=82)
Every 6-10 years	0.0	0.0	0.0
Every 2-5 years	12.8	14.0	13.4
Annual	48.7	51.2	50.0
Quarterly	12.8	23.3	18.3
Monthly	23.1	7.0	14.6
Other	2.6	4.7	3.7

In interpreting survey results, participants were encouraged not only to examine the most *prevalent* uses of information, but also, which indicators are *less* utilized, and why. For example, data on coverage of calcium (Ca) supplementation of pregnant women was only accessed by 8% of respondents in the past year, perhaps due to the lack of programs. Follow-up questions were asked on certain data, e.g. breastfeeding counseling (see slide at top right) to illuminate issues such as how frequently different users would ideally like such data to be available.

Excel sheet "Open ended responses"

"Micronutrient status other than iron, vitamin A- particularly nutrients that may relate to anemia"

"Exclusive breastfeeding during the period since birth, not just on a single day"

The survey also investigated challenges experienced with nutrition data, with nearly half (49%) citing 'data not available at geographic level needed', 39% citing data being 'out of date', and 34% citing a lack of 'trend' data, among others. At the end of the survey, respondents were asked if there are specific indicators they wanted to access, but were not available, see slide at bottom right. Detailed results from the survey were made available by WG topic.

Q&A and Discussion link

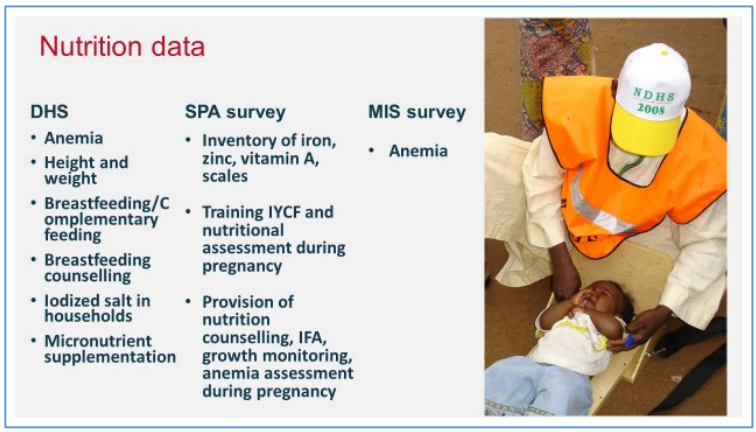
Plenary 2: Overview of Major Nutrition-Related Household Survey Platforms DHS, MICS, SMART and LSMS

Erin Milner, USAID

This panel session aims to provide an overview and shared understanding of the four major nutrition-related, household (HH) survey platforms: DHS, MICS, SMART and LSMS. In particular, it will cover the objectives, design, sampling, and nutrition content and revision process for the four platforms. It also includes a session on the DHS/MICS harmonization process that is currently underway.

Sorrel Namaste, DHS Program

Many people do not realize is that DHS surveys are country-owned, and the DHS program is a technical assistance organization that provides technical support to improve the collection of data and facilitate its use. The DHS is just beginning Phase 8, so the timing of this meeting is opportune. Another lesser-known point is that the DHS is actually a 'program' and under that program are different types of surveys: the DHS, the Malaria Indicator Survey (MIS) and SPA survey.



In addition to the four, standard core questionnaires (HH, women's, men's and biomarker), there is now a fieldworker's core questionnaire, and an option to add DHS modules, which provides further flexibility to countries. The DHS does not have a nutrition 'module'; however, significant nutrition data comes from all three surveys, as demonstrated in the slide at right. Interestingly, the most published topic of all of the DHS information collected is nutrition.

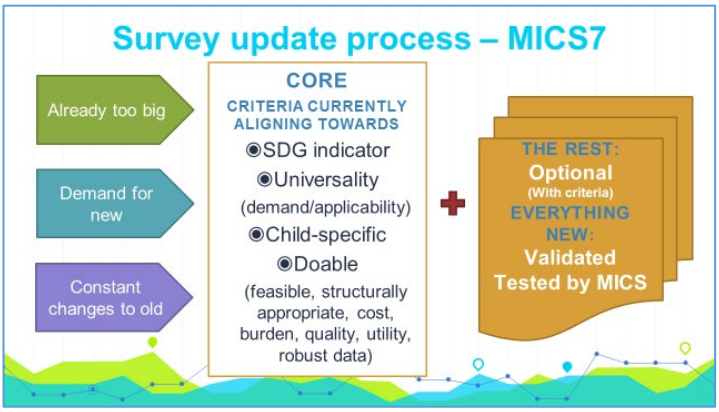
Revisions to the core questionnaire take place every five years, at the beginning of the Program phase. A nutrition review group will be established soon to solicit and incorporate input from the various nutrition-related stakeholders. The types of criteria that are used to determine revisions include: global and country indicator demand, USAID priorities, feasibility, question validity, appropriateness of DHS as the data platform, and alignment with other surveys. More information can be found at dhsprogram.com/

Bo Robert Beshanski-Pedersen, UNICEF (MICS)

MICS started out as a project intervention to capture very specific data, and began transitioning to a 'program' in 2005. MICS and DHS have been collaborating since the start of MICS, and collaboration continues to increase, both formally and informally, each year. The MICS is currently in its 6th round, with 60 confirmed surveys in this round. The interest and pressure to do more surveys, and with a greater volume of content, is enormous.

The survey structure of MICS is composed of a HH questionnaire, with four additional questionnaires for women, men, under-5s and 5-17 year olds. More specialized content is dealt with through the use of modules that countries can add in as desired. In terms of sampling, MICS has the ability to conduct oversampling of certain ethnic groups or sub-national populations, and has increasingly done so. A classic example is the oversampling done for the Roma populations in the Balkans.

All content in MICS relates to well-defined, internationally-agreed indicators. Therefore, there is *no* content that is not part of a numerator, a denominator or background characteristics. All *new* content or *revisions* to content must therefore meet this basic criteria. MICS follows a revision timeline of approximately every four years (officially its three, but it always takes longer). New content requires validation and then field testing before getting incorporated into the MICS.



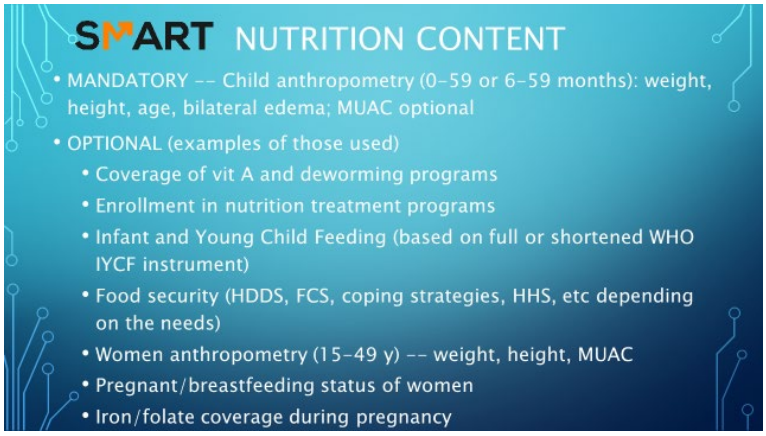
From rounds five to six, there was an approximately 50% increase in content to an already very large survey. The MICS team is definitely struggling under the weight of this enormous content. One option being considered is to refocus the MICS entirely around the Sustainable Development Goals (SDG) indicators and those indicators that are universally demanded/applied, child-specific and doable (see slide at right). In this vein, all of the IYCF indicators would be removed from the core content and made optional.

More information can be found at mics.unicef.org/

Oleg Bilukha, Center for Disease Control (CDC) (SMART)

SMART is very different than DHS and MICS. SMART emerged in 2005 as a simplified methodology for field surveys, particularly ones that take place in emergencies. It is designed for a simple, two-stage cluster survey; a simple random survey; or an exhaustive survey that NGO practitioners can easily implement in the field with good quality results. It emerged from a concern that NGO-implemented field surveys were not complying with minimum standards.

SMART is composed of a manual and user-friendly software for planning, cluster selection, data entry, automated analysis, quality checks and other related tasks. It was historically used for small-scale surveys, i.e. the level of districts, sub-districts, refugee/IDP camps or settlements. Action Against Hunger (ACF) Canada is the global project convener; they keep the manual and software up-to-date and provide training on their use. Almost 100% of all emergency and post emergency refugee setting surveys are done using the SMART methodology, and it is used by all of the major NGOs and UN agencies.



About eight years ago, many countries who had implemented the DHS or MICS every 4-5 years called for a lighter survey to track anthropometry every 1-2 years. SMART responded with what are now called SMART national survey. Although they are nationally-representative like DHS and MICS, SMART does not use over-sampling and has a significantly streamlined questionnaire.

SMART does not dictate which, if any, additional variables should be added to a questionnaire, but it is recommended that they are kept to a minimum. There is, in fact, research to show that the shorter the questionnaire, the higher the quality of the data, and the higher the completion rate. It is also recommended that 'standardized' indicators are used (e.g. for Water, Sanitation and Hygiene (WASH)) instead of inventing new questions. The nutrition-related data that has been collected using SMART are listed in the slide above. SMART guidance is updated regularly, and can be found at smartmethodology.org

Mimi Siwatu, World Bank (LSMS)

LSMS is different than the other survey platforms presented at this consultation in that it covers a very wide range of topics, mostly national and subnational, in order to have a comprehensive understanding of poverty. The three key areas of work include: 1) technical assistance in data production; 2) methodological and policy research; and 3) training and dissemination of lessons learned from previous LSMS experiences.

Typically, the LSMS is implemented every 2-3 years to depict the changing dynamics in the welfare situation over time. In many of the countries where LSMS works, these are the only nationally representative, multi-topic surveys that take place. To protect confidentiality of HHs, the LSMS uses scrambled de-identified data, which is particularly helpful for agricultural data.

The LSMS is primarily focused on welfare (monetary and non-monetary), multipurpose (beyond indicators to include behavior and phenomena), and are multi-level (HH, individual, community and plot), and disaggregated by gender. Nutrition content is actually a very small portion of the LSMS survey content, though it's a very important aspect since food consumption data is critical to analyzing overall welfare.

Anthropometrics are included, using panels of children (in some countries) allowing measurement of linear growth and growth velocity. Food security using various models, though not yet standardized, is also included. LSMS is

not globally updated the way that DHS and MICS are. Instead, individual countries are assisted to utilize the most up-to-date information available. More information can be found at surveys.worldbank.org/lsms

Chika Hayashi, UNICEF (DHS - MICS Harmonization)

There is a long history of harmonization between DHS and MICS, and the majority of survey content is already harmonized. Indicators in DHS 7 and MICS 6 have recently been reviewed in the areas of anthropometry, IYCF, low birth weight and HH consumption of iodized salt.

The review did find some minor differences in terms of who is asked the questions regarding children under five, and also in terms of how 'missing' and 'don't know' responses are handled. These differences were not deemed significant. Anthropometric methods are aligned and neither collects 'growth monitoring and promotion' data. There are slight differences in how HH consumption of iodized salt is presented, and while methodologies for data collection on IYCF counseling are aligned, there is a difference in the way that data is collected regarding food consumed by the child (i.e. open recall (MICS) versus a list approach (DHS)).

This presentation contains a summary of the differences between the DHS and MICS that were found in this review, and also notes that these differences do not have significant implications. An internal summary document has been created, and discussions concerning these differences will continue over the coming months.

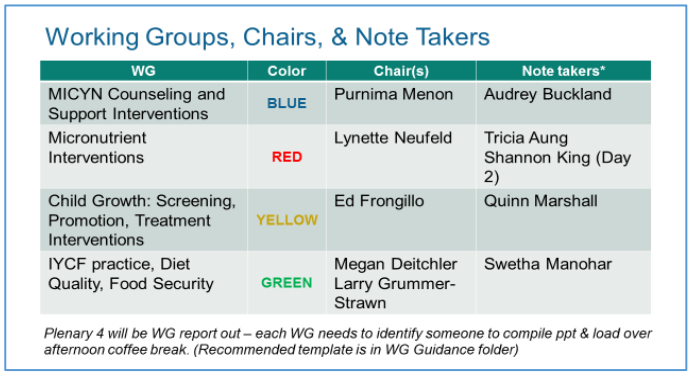
Q&A and Discussion link

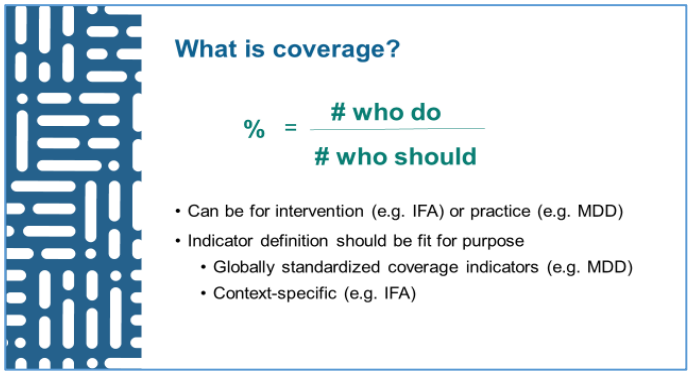
Introduction to Working Group Sessions 1 & 2

Rebecca Heidkamp, Johns Hopkins

There are four WGs that have been identified for this consultation (see slide at top right), and the participants in each group are listed here.

This presentation contains the goals and aims of the WG sessions, as well as other detailed guidance and resources available to the WGs for each session. For the purposes of this consultation, coverage is defined in the slide at bottom right.





The goal of WG sessions 1 and 2 is to develop and prioritize recommendations to improve the nutrition content of PBHS questionnaires.

The WGs will aim to:

1) Identify gaps in nutrition coverage data that are appropriate for measurement in PBHS and prioritized by stakeholders; and,

2) For priority gaps, review and recommend changes to the most commonly used questionnaires, including the DHS and MICS, and other PBHS platforms.

Detailed guidance under each of these topics is provided in this Power Point Presentation (PPP).

The following WG Resources were provided in four main folders:

- WG guidance, which includes a template for reporting out to plenary.
- Results from data stakeholder survey, which was presented by Andrew Thorne-Lyman this morning, and is organized by WG.
- Question library, which includes source documents and WG-specific documents to assist in analysis.
- Other resources, including journal articles and presentations on coverage, food security and child diet (2-5 years of age).

Plenary 3: Working Group Day 1 Report Out

Note: This session was moved from the originally-planned time listed in the agenda.

MYCIN WG Day 1 Presentation (from WG Sessions 1&2)

The MYCIN Counseling WG reviewed the following list of interventions and surveys, along with relevant question examples.

Overview: surveys with relevant question examples

Intervention	Population	Slide #	DHS*	MICS	PMA2020	NI Surveys	IFPRI	Other
MIYCN counseling during pregnancy	PW	3			Yes		Yes	DHS Nepal
Support for early initiation of breastfeeding	PW	13			Yes			
Breastfeeding counseling during PNC	2 days post delivery	15	Yes	Yes	Yes		Yes	
Counseling / support for exclusive and continued breastfeeding (1m+ post partum)	Child<24m	23			Yes	Yes	Yes	DHS Nepal
Counseling for complementary feeding	Child<24m	25			Yes	Yes	Yes	DHS Nepal
Cross-cutting IYCF promotion via FLW, community platform and/or mass media	Child<24m	28				Yes	Yes	DHS Nepal
Other maternal support interventions (BFHI, maternity protection, etc)	TBD	36			Yes			

*DHS Core Questionnaires. New DHS questions are listed in "Other."

The following initial commentary emerged from this WG session:

MIYCN counseling during pregnancy actually includes several additional components: diet, physical activity, consumption of supplements (iron folic acid (IFA), Ca, etc.), and breastfeeding. Counseling is central to other interventions as well, including MN programming and growth monitoring.

As evidenced in the table above, there is a huge data gap with regards to MYCIN counseling during pregnancy, **though nearly all of the MICYN counseling indicators are amenable to inclusion in PBHS**, and some could be verified/examined in facility assessments, (e.g. content of Antenatal (ANC) counseling).

The following section reflects the WG's initial discussions on modifications to the questionnaires:

Tier 1 – maternal dietary counselling during pregnancy

6xx	During this pregnancy, did a health care provider or community worker talk with you about what foods to eat?	YES NO DON'T KNOW	NO… 2 (SKIP TO 6xx)
6xx	What topics did he or she talk to you about?	1) TOPIC LIST FOCUSED ON DIETARY ADVICE	

The WG proposed additions to DHS and MICS core questionnaires with respect to IYCF counseling. These questions related to whether a health care provider worker spoke to the woman about breastfeeding during pregnancy, and what topics were discussed, see questions 4xx, 6xx and 457 in slide #6 of the PPP.

Similarly, the WG proposed additions with regards to maternal nutrition counseling; i.e. adding questions on maternal diet, physical activity, supplements, and breastfeeding. **See proposed question in slide at right**.

The Baby Friendly Hospital Initiative (BFHI) can be measured in a PBHS and two indicators (from the BHFI Global Guidance) were identified that could potentially be incorporated into the core DHS and MICS questionnaires. One such question has already been tested in Performance Monitoring and Accountability (PMA2020) and is feasible to include: "*When you delivered [name], did a health worker help you put the baby to your breast?"*

Modifications in the area of community platforms and mass media were recommended to address the enabling environment of breastfeeding /IYCF. The question could be worded: *"In the last six months, did a health care provider or community worker talk with you about how to feed your child?"*

Finally, the WG noted that there was a meeting on September 17 where suggested changes to questionnaires were made. Many of the participants at the current consultation also attended that meeting and generally concur with those recommendations.

See the final recommendations for questionnaire modifications in the MYCIN WG Day 2 Presentation.

Q&A and Discussion link

Detailed Notes from the MYCIN WG

IYCF, Diet Quality and Food Security WG Day 1 Presentation (from WG Sessions 1&2)

There was no power point for this presentation. This WG, renamed the "Dietary Practices WG", covered IYCF practice; dietary practice for children (2-5 years of age) and women of reproductive age; and food security. The WG reviewed the list of interventions and surveys, along with relevant question examples listed in the slide at right.

Overview: surveys with relevant question examples

Intervention	Population	Slide #	DHS*	MICS	PMA2020	NI Surveys	FTF	FACT	FFP	IFPRI	GroundWork	Other
WHO IYCF Indicators (see list in slide set)	Child<24m	3	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	TZ SMART NNS
Diet assessment in children 2-5y	Child 24-59m	47									Yes	
MDD-W	WRA; PLW	50			Yes		Yes	Yes*	Yes	Yes		DHS Nepal
New indicators – "unhealthy" foods, diet quality	WRA; Child<5y	61			Yes					Yes	Yes	DHS South Africa
Food Security	HH	69			Yes		Yes	Yes	Yes	Yes		Nepal DHS

*DHS Core Questionnaires. If unique to DHS country survey listed in "Other."

The WG decided to expand its parameters to include healthy *and unhealthy* eating. Most of the data collected to date has been in the under-2 population and women of reproductive age, so the group also decided to

expand the demographic parameters (of its examination) to include: ages 5-9, 10-14, boys matching women of reproductive age, and men.

The following section reflects the WG's initial discussions on modifications to the questionnaires:

At a consultation this past summer, the WHO-UNICEF IYCF indicators were reviewed/revised and a set of 17 indicators were proposed. Five existing indicators were proposed for deletion. This WG agreed to support WHO/UNICEF agenda in carrying these proposals forward into household survey design. They also agreed to suggest to WHO/UNICEF that 'median duration of breastfeeding' indicator *not* be deleted from the questionnaire. The WG agreed that continued documentation and research is necessary regarding the best method for collecting the data, e.g. list or open recall of foods child consumed.

For women of reproductive age, the WG focused on indicators that are already well established, e.g. Minimum Dietary Diversity for Women (MDDW), which is experiencing growing uptake, and has an abundance of evidence to support its use.

See final recommendations for questionnaire modifications in the IYCF, Diet Quality and Food Security Day 2 Presentation.

Q&A and Discussion link

Detailed Notes from the IYCF, Diet Quality and Food Security WG

Child Growth WG Day 1 Presentation (from WG Sessions 1&2)

There was no power point for this presentation. The Child Growth WG reviewed the following list of interventions and surveys, along with relevant question examples.

Overview: surveys with relevant question examples

Intervention	Population	Slide #	DHS*	MICS	PMA2020	NI Surveys	IFPRI	Other
Monitoring of Weight Gain during pregnancy	PW	3			Yes			
Food supplementation during pregnancy	PLW	5			Yes		Yes	DHS India
Growth Assessment - GMP	Child<5y	11			Yes	Yes	Yes	DHS Nepal & India
Screening for Acute Malnutrition (MUAC)	Child<5y	18			Yes	Yes		
Food supplementation for complementary feeding	Child<24m	21	Yes*		Yes		Yes	DHS India
Management of severe acute malnutrition (SAM)	Child<5y	26	Yes					
Management of moderate acute malnutrition (MAM)	Child<5y	29	Yes					
Other food support programs	HH; WRA; Child<5y	32			Yes			DHS India
Cash Transfer programs	HH; PLW; Child<5y	35		Yes	Yes		Yes	

*DHS Core Questionnaires. DHS country-specific questions are listed in "Other."

The following initial commentary emerged from this WG session:

- The way that low birth weight is currently handled in the survey exercises # of children who have weight recorded in cards, recall of birthweight, recall of birth size) should be revisited, and discussed further by the nutrition community.
- While focus of nutrition policy and programming in LMIC has been on stunting, wasting, LBW and anemia, this needs to shift to ensure that overweight/obesity, unhealthy diets, and non-communicable diseases are addressed as well.
- While collecting data on the growth of children, attention should also be paid to collecting data on the nutrition status of the mother.

The following section reflects the WG's initial discussions on modifications to the questionnaires:

- For monitoring of weight gain during pregnancy, the WG endorsed the wording that appears in PMA2020 and considered it a Tier 1 question. They also recommended asking the PLW if she was weighed, and whether the health provider talked to her about weight gain.
- For supplementation during pregnancy, the WG endorsed the question in PMA2020, and recommended adding it as a Tier 2 question. A question about receiving any form of assistance could also be asked, along with whether that support was food, and if so, what type of food.
- For growth assessment, there was a rigorous debate, which ended with assigning it a Tier 1 categorization. The WG felt it was critical to better understand growth assessment because: 1) If it is being done, it may not be being done well; and, 2) it may be utilizing more resources than necessary. The question from PMA2020 should be modified to suit the country-specific period of time, and height, weight and/or arm circumference, can be verified if all were assessed. It was also recommended that the question from PMA2020 be modified to simply ask whether the provider had talked to the woman about her child's weight.
- In the DHS core questionnaire, there are questions on food supplementation related to complementary feeding, but there is no equivalent in the MICS. The DHS questions ask about use of Micronutrient Powders, ready to use therapeutic foods, and ready to use supplementary foods in the past seven days. The WG decided that to understand these issues, it would be better to ask if the child been enrolled in a program that would provide food or a food supplement; how often that happened; and what kind of food.
- For other kinds of programmatic support, there is a question in the MICS asking about other social transfers. The WG did not endorse this question, and decided it was best to conduct research on the existing MICS surveys and explore exactly what is being learned from this question.

More generally, the WG would ideally like to know who received something *relative to who needed it.* Unfortunately, arriving at that denominator is very challenging. There is still value, however, in knowing who received it *relative to the entire demographic group*, e.g. out of all PLW, how many received food supplementation. This data is much easier to collect, though less valuable in terms of understanding whether current need is being met.

See final recommendations for questionnaire modifications in the Child Growth WG Day 2 Presentation.

Q&A and Discussion link

Detailed Notes from *Child Growth WG*

Micronutrient WG Day 1 Presentation (from WG Sessions 1&2)

The MN WG reviewed the following list of interventions and surveys, along with relevant question examples. Given the length of the intervention list, this group was subdivided into three groups: 1) Women, 2) Food Fortification, and 3) MN for Children Under Five.

Intervention	Population	Slide #	DHS	MICS	PMA2020	NI Surveys	IFPRI	Groundwork	Other
Iron or IFA supplements	WRA; AD; PW; LW	5	Yes		Yes	Yes	Yes	Yes	Tanzania SMART; UCDavis (general)
Folic acid supplementation	WRA; AD; PW	5						Yes	
Multiple micronutrient supplementation	WRA; AD; PW	16			See iron supp.			Yes	
Calcium supplementation	PW	19			Yes	Yes	Yes	Yes	
Vitamin D	PW	25						Yes	
Postpartum Vitamin A supplementation (low-dose for high deficiency pop)	PLW	27			Yes			Yes	UCDavis
Deworming	PW	31	Yes		Yes		Yes		
Pediatric iron supplements	Child<5y	35	Yes				Yes	Yes	
MMS - MNP or tablets	Child<5y	39	Yes		Yes	Yes (multiple)			
SQ-LNS	Child<5y	47							UCDavis
Vitamin A supplementation (high-dose)	Child<5y	50	Yes		Yes	Yes	Yes	Yes	UCDavis; Senegal SMART; Tanzania SMART
Zinc supplementation with ORS for children with diarrhea	Child<5y	62	Yes	Yes	Yes	Yes (multiple)			Senegal SMART; Food for Peace
Salt (iodine; DFS)	HH; WRA; Child<5y	72	Yes	Yes	Yes				SMART Niger; SMART Tanzania
Food fortification: wheat; maize; sugar; oil; bouillon; rice	HH; WRA; Child<5y	79	Yes	Yes	Yes	Yes		Yes	UCDavis; FACT
Fortified Complementary Foods	Child<24m	97	Yes	Yes	Yes				FACT

The following general observations were made:

- Coverage data on MN interventions would be more meaningful for program decision making if linked with MN status data.
- Ideally, countries would generate a comprehensive overview of supplement/fortification nutrient sources for each of their priority demographic groups.
- Age groups in surveys are not always aligned with WHO guideline age groups making it challenging to make conclusions about coverage on WHO recommendations by WHO age group.
- With regard to MNs, there is an additional challenge in terms of understanding and clearly defining what we want to know, e.g. do we want to know coverage of *any* product regardless of origin? Or do we want to know coverage of public health programs that distribute those products?
- Adolescents are becoming a priority among donors. This is certainly true for girls, but increasingly for boys as well.
- There is a data gap on the status of, and programs for, the elderly.

The following section reflects the WG's initial discussions on modifications to the questionnaires:

Recommendations from Sub-WG on Women: For PLW, the group decided to combine IFA, Iron (Fe), and Multiple Micronutrient (MMN) supplementation, for now, at this survey level. The current question in the DHS for 'contact coverage' should be modified slightly; they should ideally be linked to a facility survey (to know what products are being distributed, etc.); and should ideally identify the 'source' of the supplement (i.e. "did you buy it, was it given to you, etc."). Finally, while it's important to include a proxy for 'effective coverage', it was acknowledged that the proxy relies on 'dirty data', (i.e. the question asking how much was consumed will probably not be answered reliably). It was agreed that this 'rough estimate' of the number consumed is probably the best we can do for the moment. See slide #2 in PPP for details. Similar recommendations were also made for Ca for PLW (i.e. contact coverage, source and effective coverage), though it was seen as a Tier 3 question. See slide #3 in PPP.

The WG did not recommend inclusion of postpartum Vitamin A Supplementation, Vitamin D, and deworming questions as they are not recommended by WHO and are not frequently implemented. For women of reproductive age, the group recommended adding the same questions as above (contact coverage, source, and a rough estimate of effective coverage) for folic acid (FA) and Fe containing foods. See slide #6 in PPP.

Recommendations from Sub-WG on Food Fortification: For foods that are fortified as part of a national program, the WG recommended adding questions to ascertain whether anyone in the HH had eaten key fortified foods (dependent on country priorities) in the past week, and if 'yes', asking about the source (e.g. purchased, made at home, or given as part of a program), which will permit the assessment of contact coverage of fortifiable foods. These were seen as being ready for inclusion into DHS and MICS. It was additionally recommended that the indicators could potentially be aligned with the existing LSMS questions. The WG recommended adding a follow-up question to DHS HQ 145, which asks to examine salt in the HH to see ascertain if it is iodized. The follow-up question would ask those respondents who did *not* have salt in the HH to state whether they had used salt in the past week, and where they had obtained it. Finally, a more detailed module including standardized questions to assess contact and effective coverage should be developed an optional DHS module, and should include foods that are not often fortified such as bouillon cubes, as this is increasingly a source of iodized salt. See slide #9 in PPP for details.

Recommendations from Sub-WG on MN for Children Under 5: The WG's general recommendation was that if a particular MN supplement is part of a national program being implemented at large scale, then a question should be asked about that MN; but if not, then a question is not necessary. If questions are included, as with MN interventions for women, the focus should be on receipt as well as place obtained and estimate of quantity consumed (for rough estimate of effective coverage). The Vitamin A question should be retained in MICS. For iron syrup, micronutrient powder (MNP), and deworming; the WG recommended aligning the recall period with international guidance, changing it from seven days to six months. Ideally, questions would also be added about how much was received; whether the child actually consumed it; and whether it was being administered for treatment or prevention purposes. See more detail on slide #11 of the PPP.

See final recommendations for questionnaire modifications in the Micronutrient WG Day 2 Presentation.

Q&A and Discussion link

Detailed Notes from Micronutrient WG

Plenary 4: Panel Discussion: Meeting Country Data Needs

Moderator: Ellen Piwoz, BMGF

Note: This session originally appeared as Plenary 3, but was moved to the end of Day 1 (i.e. Plenary 4).

The panelists were asked to describe some of the most pressing nutrition-related data needs from their country-specific perspectives, as well as their greatest challenges with data collection and use.

Anamika Singh, National Institute for Transforming India (NITI) Aayog, India

The current thinking is that there is *too much* data, and it's coming from too many sources, which has become quite overwhelming. The National Nutrition Mission aims to improve collaboration between the various ministries, making the situation more manageable. The Comprehensive National Nutrition Survey (CNNS) captures anthropometry, biochemical details, MN deficiencies, non-communicable disease (NCD) risk factors among children, Vitamin E, etc., as well as all of the issues that were either not covered (or not adequately covered) under the NFHS. The CNNS also targets children 0-19 years, so adolescents *are* included.

Another challenge is that the current survey design and data utilization processes are extremely centralized, disempowering field- and district-level staff who collect the data, since they are not involved in data selection or use. The Mission is grappling with how to increase/change their involvement to help them understand the data's value and the need for accuracy and reliability.

Ibrahim Kana, Federal Ministry of Health, Nigeria

In recent years, Nigeria has begun to shift to performance-based budgeting, and the implications of this have prompted heated debate. The shift required comparing SMART data to MICS data, which state-level staff

ultimately challenged on technical merits, claiming that there were too many differences between the surveys' data collection approaches to use them as a basis for comparison between years. As countries move to performance-based budgeting, it's critical that data collected using these data collection platforms is comparable, and therefore that the nutrition community work to harmonize indicators and questions across the surveys.

Masresha Anegago, Ethiopian Public Health Institute, Ethiopia

A major challenge has been to raise awareness regarding the importance of nutrition among the highest ranks of the government. The advocacy work over the past 10 years is finally paying off, and policy makers are beginning to see that nutrition problem as an economic and development problem. Funding, however, remains a challenge. The first MN survey (2005) was intended to take place every five years, but due to lack of funding, the timeline was extended to every 10 years. Technical capacity also remains a challenge, though the number of nutrition graduates is gradually increasing. Finally, utilization of data is a significant challenge, with efforts constantly being made to narrow the gap between the researcher/technical staff and the policy maker.

More Detailed Notes from Each Presenter

Q&A and Discussion with each Country Representative

End of Day 1

September 20, 2018 – Day Two Proceedings

Plenary 5: Report Out from Anthropometry Data Quality & Micronutrient Status Measurement Meetings

Moderator: Omar Dary, USAID

Data quality was one of the many important topics raised during the country presentations yesterday. Many experts believe that *bad* data is actually worse than *no* data because it creates the risk of poor decisions. The harmonization of data platforms also emerged as an important theme. Issues of data quality and data comparability were the themes of a workshop convened by Food and Nutrition Technical Assistance (FANTA) in 2015, and following that workshop a Technical Expert Advisory group on Nutrition Monitoring (TEAM) was formed under the umbrella of WHO and UNICEF. Rafael Flores-Ayala will report out from that group's recent progress.

Rafael Flores-Ayala, CDC

Rafael presented on behalf of the WG on Anthropometry Data Quality (ADQ), which is part of the TEAM noted above. The TEAM was formed in 2015, with the goal of advising WHO and UNICEF on global nutrition monitoring. The task of coordinating the various TEAM WGs and achieving consensus between the DHS, MICS and SMART has been enormously challenging; though progress was evident at the recent meeting in Atlanta (June 2018).

The FANTA meeting report (from the 2015 workshop noted above) examines the significant differences observed between the DHS, MICS and SMART, (when applied in similar locations and time frames), which have led to confusion at many levels. Cognizant of these challenges, the TEAM included in its work plan the production of a report on improving anthropometric data quality. The report will contain recommendations on Organization and Survey Design (Chapter 1), Fieldwork Procedures (Chapter 2), and Data Processing, Analysis, Reporting and Assessment of Data Quality (Chapter 3). A long list of topics for further research have also been identified by the ADQ WG.

Moderator: Omar Dary, USAID

Various nutrition-oriented departments of the USG have combined forces to form the Micronutrient Delivery Platforms WG and the Nutrition Information Systems WG. These WGs are working on MN biomarkers and bio-indicators, and presented the following commentaries and recommendations:

- WHO has produced several guidelines for reducing MN deficiencies, including anemia due to a deficiency in iron.
- WHO also has guidelines for iron supplements for children 6-23 months of age, and 24-59 months, and for the use of MNP for the prevention and treatment of anemia.
- To claim that these interventions are truly 'evidence based', MNP as an iron source must be measured separately from MNP as a source of other nutrients (i.e. separate indicators). Before doing this; however, a government needs to understand the need (i.e. the magnitude, the severity and the prevalence) of the MN deficiencies, and to establish a mechanism for measuring the attributable changes due to a given intervention.
- The lack of assessment of biomarkers and bioindicators has been identified as a weaknesses of current monitoring systems.

Maria Elena Jefferds is an expert on these topics, and has been with the CDC since 2001.

Maria Elena Jefferds, CDC

This presentation provides an overview of the Technical Meeting on Assessments of Micronutrient Biomarkers in Population-Based Surveys, which took place last Tuesday (September 18, 2018). The meeting aimed to discuss the rationale and lessons learned from assessments of MN biomarkers in LMICs through PBHS.

Omar Dary (USAID) presented justifications for MN assessments and the importance of the sample quality. He stressed that MN intervention impact depends upon MN intake and many other environmental factors. He also noted that pooled capillary samples open opportunities for assessing other key MN indicators. ***Daniel Raiten, US Department of Health and Human Services / National Institutes of Health (HHS/NIH)*** reminded the group that food does not equal nutrition; context matters; and measuring micronutrient status can be enormously complex. ***Ken Brown (BMGF)*** reviewed the plethora of new initiatives and tools (for measuring MN status) that will soon be available. And finally, ***Lisa Rogers (WHO)*** discussed the importance of biomarkers at the global level, and within the context of reporting on the global nutrition targets and burden of disease. She noted that PB micronutrient status surveys are a critical need, particularly for demographic groups that are emerging as priorities e.g. adolescents.

Representatives from surveys in Uganda, Malawi and the Gambia delivered lessons learned from 'linking' MN surveys with PBHSs like MICS and DHS in LMICs. There are various models for collaboration with varying modalities and intensity of co-collection (e.g. integration, light linking, piggy-backing, etc.). It's important to acknowledge that collaboration does require greater resources and can be a burden to the survey organization. Developing a MN module is a possibility for the large PBHSs; the indicators and methods already exist, what is missing is a set of standards.

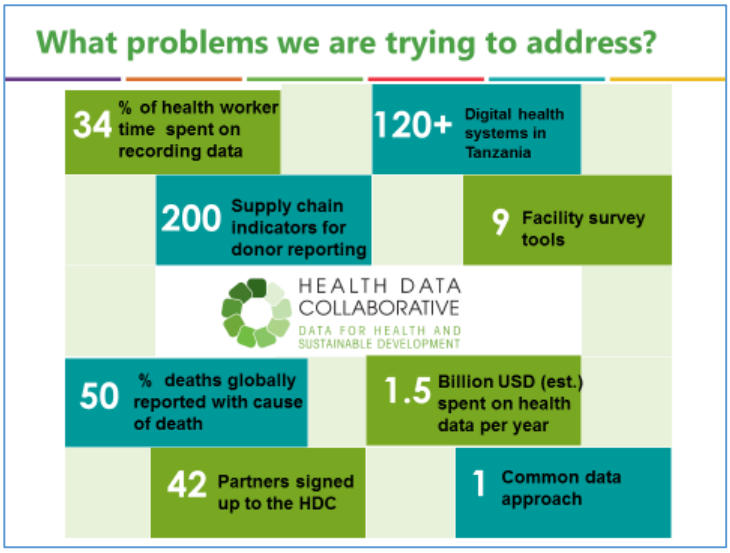
Q&A and Discussion link

Plenary 6: Overview of Nutrition Content in Facility Surveys

Moderator: Chika Hayashi, UNICEF

This session is dedicated to reviewing and discussing health facility-based surveys. The participants of this consultation are generally less familiar with this topic, in comparison to PBHSs, so there are likely to be more questions. Amani Siyam (WHO) begins the discussion with an overview of facility-based surveys, followed by a presentation on the SPA, by Rukundo Benedict (ICF).

Amani Siyam, WHO



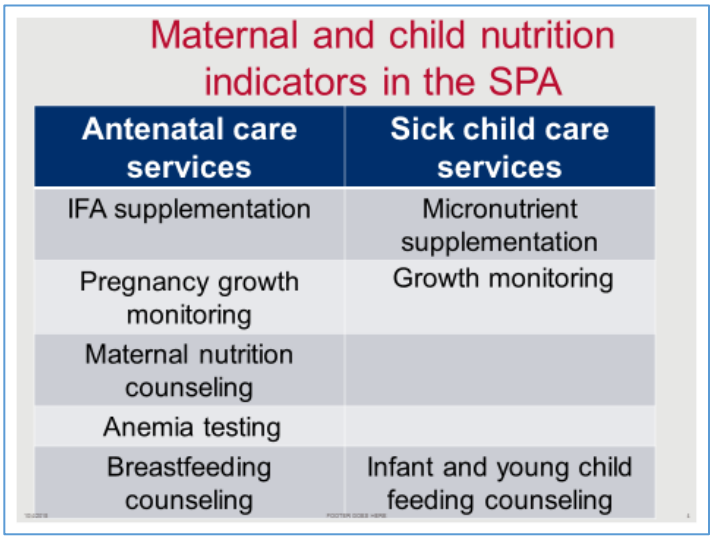
Many of the same conundrums that were discussed in relation to PBHSs, also exists for facility-based surveys. The only issue that is more challenging for facility surveys is that they need to cater to 101 service areas. They are a 'must have' assessment, because governments depend on them for knowing what is happening in their health facilities in terms of providing quality service.

The Health Data Collaborative (HDC) is a massive initiative that came about after the transition from the Millennium Development Goals (MDGs) to the SDGs. All of the global health partners came together and acknowledged that they were not collaborating as efficiently as they could be. As noted in the slide at right, an enormous amount of time and resources are invested in reporting, e.g. 34% of health worker time is spent on recording data. The stated goal of the HDC is, therefore, to improve country data systems and capacity to track progress toward the health-related SDGs and Universal Health Coverage (UHC).

There is a fierce competition between all of the service areas to capture as much attention (and share of health-related investments) as possible in a given country. HDC Objective 2, therefore, aims to improve efficiency, and *align* investments and support to countries. This will ideally allow governments to reallocate support to those areas that are performing and/or are underfunded, and away from those that are not performing and/or are overfunded.

Finally, the HDC's Objective 3 aims to increase the impact of global public goods by 1) harmonizing survey modules (including indicators, methodologies, etc.); and, 2) catalyzing support for ONE country system of facility surveys, using a modular approach. The goal is to be able to compare oranges to oranges, and avoid the challenge that the Nigerian presenter described on day 1 of this consultation. Examples were provided from the 2017 Sierra Leone Service Availability and Readiness Assessment (SARA)-Plus facility survey and the 2014 Tanzania Service Delivery Indicators (SDI) facility survey. See the PPP for details.

Rukundo Benedict, ICF


Maternal and child nutrition indicators in the SPA

Antenatal care services	Sick child care services
IFA supplementation	Micronutrient supplementation
Pregnancy growth monitoring	Growth monitoring
Maternal nutrition counseling	
Anemia testing	
Breastfeeding counseling	Infant and young child feeding counseling

The SPA is a nationally representative *sample* survey or a *census* of health facilities. It covers service availability, service readiness and service delivery. In the context of nutrition, the SPA contains indicators under antenatal care and sick child care, see slide at right. A typical SPA survey uses a sample size between 500 and 1000 health facilities.

This presentation contains graphs comparing SPA data between five different countries, examining the percentage of facilities providing IFA supplements, percentage of providers with training on nutritional assessments during pregnancy, counseling on IFA supplements, among others, see PPP for slides.

Linking DHS and SPA surveys (to examine relationships between the service environment and nutrition outcomes) has been done in some countries, and requires creativity. The linking is done geographically, where household survey data in a region are linked to facility data aggregated at the same region level. There are, however, some important considerations including: utilizing a sample versus census methodology, timing of the surveys, indicator reference periods, among others.

Q&A and Discussion link

Introduction to Working Group Sessions 3 & 4

Andrew Thorne-Lyman, Johns Hopkins

WG Session 3: The goal of WG Session 3 is to develop recommendations to improve the nutrition content of health facility assessments. The aims of this session are to:

1) Identify information gaps in nutrition service availability and quality that are amenable to facility surveys; and,
2) For priority gaps, identify whether they can be addressed in the SPA.

Detailed guidance under each of these topics is provided in the PPP. As with WG sessions 1 & 2, resources for sessions 3 & 4 were provided in the a WG Resources folder.

As the IYCF, Diet Quality and Food Security indicators were deemed largely inappropriate for SPA surveys, that WG continued working on PBHS recommendations during WG Session 3.

WG Session 4: The goal of WG Session 4 is to review prioritization of household survey recommendations (begun in WG Sessions 1&2), and specify R&D needs. The aims of this session are:

1) Revisit prioritization of proposed changes for both HH surveys to confirm their relative importance. (Make a list of all new questions proposed to DHS core (for Plenary 8 exercise).
2) For Tier 3 priorities, specify what sort of R&D is needed and at what scale.

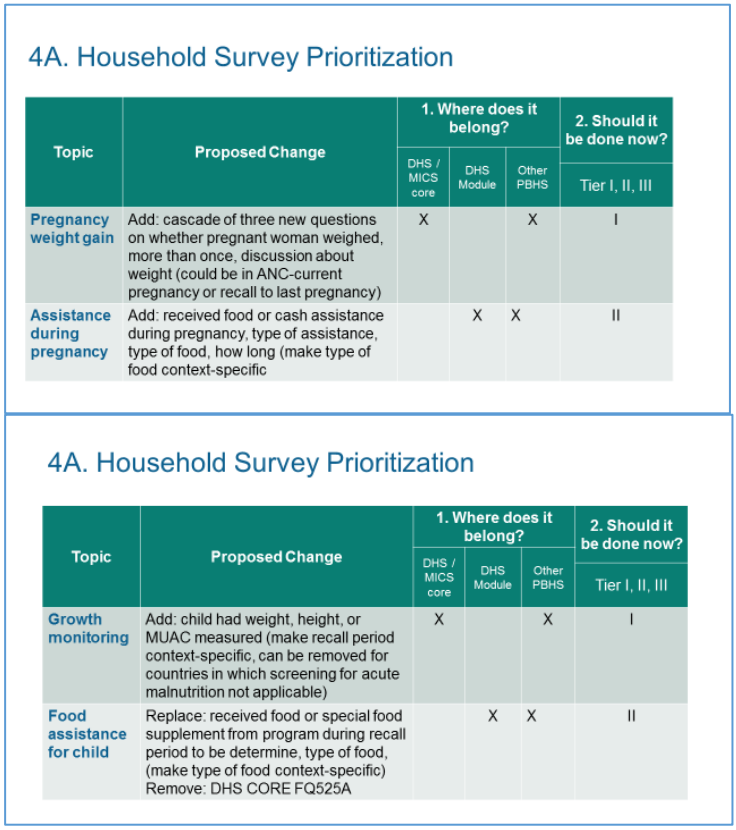
Plenary 7: Working Group Day 2 Report Out

Child Growth WG Day 2 Presentation (from WG Sessions 3 & 4)

Session 3: Recommendations for Facility Surveys:

Growth monitoring during pregnancy and childhood are covered under the MICYN WG; however, there is a data gap around acute malnutrition. The WG made three recommended modifications to the SPA questionnaire:

1) Increase specificity in SPA question 1202.01, adding 'assess and treat or refer child acute malnutrition'.
2) In SPA question 304.08, specify training related to country Community-Based Management of Acute Malnutrition (CMAM) protocols and related follow-up.
3) In the facility inventory question 2331, add a review of Ready-to-Use Therapeutic Foods/Ready-to-Use Supplementary Foods (RUTF/RUSF) supplies, guidance, & job aids.



4A. Household Survey Prioritization

Topic	Proposed Change	1. Where does it belong?			2. Should it be done now?
		DHS / MICS core	DHS Module	Other PBHS	Tier I, II, III
Pregnancy weight gain	Add: cascade of three new questions on whether pregnant woman weighed, more than once, discussion about weight (could be in ANC-current pregnancy or recall to last pregnancy)	X		X	I
Assistance during pregnancy	Add: received food or cash assistance during pregnancy, type of assistance, type of food, how long (make type of food context-specific		X	X	II

4A. Household Survey Prioritization

Topic	Proposed Change	1. Where does it belong?			2. Should it be done now?
		DHS / MICS core	DHS Module	Other PBHS	Tier I, II, III
Growth monitoring	Add: child had weight, height, or MUAC measured (make recall period context-specific, can be removed for countries in which screening for acute malnutrition not applicable)	X		X	I
Food assistance for child	Replace: received food or special food supplement from program during recall period to be determine, type of food, (make type of food context-specific) Remove: DHS CORE FQ525A		X	X	II

Session 4: Prioritization of PBHS Recommendations and R&D:

The WG recommended modifications to topics related to pregnancy weight gain, assistance during pregnancy, growth monitoring, and food assistance for the child. See slides on previous page for details.

Research items include:

1) Examine cash transfers across multiple MICS country contexts to see how the current questions are being used.
2) Develop population-based coverage indicators along the CMAM cascade.

Q&A and Discussion link

Detailed Notes from Child Growth WG

MYCIN WG Day 2 Presentation (from WG Sessions 3&4)

Session 3: Recommendations for Facility Surveys:

The MYCIN WG identified data gaps in the areas of maternal nutrition, BFHI and IYCF; and they recommended modifications (see slide at right) to the SPA facility audit, service provider interview, service observation and client exit interviews.

It was noted was that none of the SPA service provider interviews contain any 'knowledge' questions, though there were training / exposure questions. The SPA does not have exit interviews when women are discharged after delivery. If that were added in the future, there are other useful questions that could be included.

Session 4: Prioritization of PBHS Recommendations and R&D:

The WG prioritized the modifications under maternal nutritional counseling, BFHI, code monitoring, breastfeeding counseling, IYCF counseling and mass media listed in the slide at top right.

The Tier 1 questions to be modified are listed in the slide bottom right.

Facility survey questions for MICYN

Behavior/life stage	Facility audit	Service provider interview	Service observation	Client exit interviews
Maternal nutrition (diet, activity, micronutrient supplements, BF)	Job aids for BCC/counselling	Training Ideally knowledge	Already there. Include key messages/content for diet and activity/rest	Only IFA there. Include one question on diet/physical activity
BFHI	- Observations for inclusion/display of the policy & displays of products covered under the code	- Training on the Code - Knowledge related to the Code		Check for prescription/promotion of formula in sick child care? [context specific?] *Possible to include exit interviews after delivery (several topics to be covered, including early initiation support)*
IYCF	IMCI chartbook (already included) Job aids for BCC/counseling	*Included* *-Consider inclusion of knowledge*	*Included*	- Check on prescriptions or recommendations on formula during sick child exit interview

Household Survey Prioritization

Topic	Question	Core DHS/MICS	Nutrition module	Other surveys
Maternal nutrition counseling	During this pregnancy did a provider talk with you about foods to eat…	Yes	Expand questions to address physical activity and counseling for supplement use/side effects	
BFHI	Did anyone help with breastfeeding after delivery		Yes	
	Rooming in		Test and include	
	Referral to or information on community support		Test and include	

Topic	Question	Core DHS/MICS	Nutrition module	Other surveys
Code monitoring	Past 6 mo, promotion of BMS at health facility		Y	Y
	Past 6 mo, promotion of BMS in media		Y	Y
	Free samples when pregnant or after birth		Y	Y
	Prescription of BMS when sick		Y	Y

Topic	Question	Core DHS/MICS	Nutrition module	Other surveys
BF counseling	BF counseling during ANC	Y	Y	Y
	In first one month after birth, anyone talk with you about BF?		Test and consider	Test and consider
IYCF counseling	In last 6 mo, anyone talk about feeding your child	Y (female)	Y	Y
IYCF community support and mass media	In last 6 mo, anyone talk about feeding your child	Y (male)		
	Mass media exposure		Test and include 1 question	Expanded set for country specific?

Core Tier 1 questions on MIYCN counseling

Maternal nutrition During this pregnancy did a health care provider talk with you about what foods to eat when you are pregnant? If yes, which topics	WHO ANC guidance on including dietary counseling/messages in ANC
Breastfeeding counselling [in ANC module] When you were pregnant with NAME, did a health care provider/CW talk with you about breastfeeding?	Because PNC already includes something (needs slight modification) Addresses need to capture BF counseling during ANC (in upcoming WHO guidance on BF and existing ANC guidance)
IYCF counselling [BF and CF] – in male and female questionnaires In last 6 months did HW/CW talk with you about how to feed your child? If yes, what topics?	Addresses BF and CF counseling. When asked for younger infants, can capture early BF support as well

The question around maternal nutrition counseling overlaps somewhat with the previous presentation (e.g. pregnancy weight gain), therefore there is potential to link these questions.

Q&A and Discussion link

Detailed Notes from MYCIN WG

IYCF, Diet Quality and Food Security WG Day 2 Presentation (from WG Sessions 3&4)

This WG did not address the facility surveys (WG Session 3) since indicators for their interventions were not amenable to facility-based surveys. This provided further time for the WG to finalize their decisions, prioritize their recommended modifications for PBHS, and develop a research agenda.

The WG identified data gaps in the following areas:

1) Unhealthy food consumption for children under two years of age.
2) No information on food consumption for women of reproductive age.
3) Limited data on food insecurity, which is a SDG indicator.

The WHO/UNICEF consultation that took place this past summer (mentioned in WG Day 1 report out) continues discussion on the topic of children under 2, and this WG will continue to contribute to those discussions.

On food security, the Food Insecurity Experience Scale (FIES), developed by FAO, is considered state of the art for collecting food insecurity data, and is, therefore, recommended by this WG.

Research items include:

1) Explore ways to gain efficiency using Computer Assisted Personal Interviewing (CAPI) to analyze where time is being spent.
2) Test FIES using the first three questions as a screener for other questions.
3) Develop/identify software for in-country analysis of FIES.
4) Test to see if probing on solid/semi-solid foods could be shortened for infants less than six months of age.
5) Develop indicators on diet among adolescents based on new WHO guidance.

Collaborate with, and derive learning from, the following ongoing research:

1) The Gallup World Poll, developing indicators related to diet quality and unhealthy eating in individuals 15 years and older, including men.
2) INTAKE, an FHI-360 initiative, examining indicators of diet quality for non-pregnant, non-lactating women.

Topic	Proposed Change	1. Where does it belong?			2. Should it be done now?
		DHS / MICS core	DHS Module	Other PBHS	Tier I, II, III
Children <2	Sub-divide child food list to capture unhealthy foods (differentiate by source) • No F&V • SSBs • Junk food	X			I
WRA	New question on MDD-W (includes unhealthy foods)	X			I
Food insecurit	New question on Food Insecurity Experience Scale (8 items)	X			I

Topic	Proposed Change	1. Where does it belong?			2. Should it be done now?
		DHS / MICS core	DHS Module	Other PBHS	Tier I, II, III
Children <2	Delete bottle-feeding for children other than the youngest (DHS)	X			I
Children <2	Delete count of solid/semi-solid foods for <6 mos (DHS)	X			I
Children <2	Delete probing on medicines/vitamins (MICS)	X			I

Topic	Proposed Action	1. Where does it belong?			2. Should it be done now?
		DHS / MICS core	DHS Module/ Expanded MICS	Other PBHS	Tier I, II, III
Children 2-<5 y	Consider application of dietary assessment question to all children < 5 a. MDD/healthy diet b. Unhealthy diet		X		III
Quantitat ive dietary assessm	Explore opportunities for piggybacking nutrition survey onto other platforms			X	II

Finally, in relation to the construction of food group listings, the WG emphasized the importance of capturing biofortified crops.

Q&A and Discussion link

Detailed Notes from the *IYCF, Diet Quality and Food Security WG*

Micronutrient WG Day 2 Presentation (from WG Sessions 3&4)

Session 3: Recommendations for Facility Surveys:

On the facility inventory of the SPA core questionnaire, the WG recommended:

1) Questions should clarify whether the products mentioned are intended for children or for women (e.g. iron from women versus iron syrup for children).
2) Where there is a list of products aligned with national policies, questions need to be included on those products, (e.g. IFA pills for women may need to include multiple micronutrient supplements if that's the national policy).
3) Similarly, under 'observations' in the SPA core questionnaire, there should be questions that relate to the national policies, e.g. if there's a calcium policy in a given country, there should be a question asking the woman if she received calcium.
4) The group did not go through the counseling questions in the SPA core questionnaire, but they acknowledged that this would be important to review in detail at a later date.

Session 4: Prioritization of PBHS Recommendations and R&D

The prioritization of recommendations is listed at right. Under 'All Fortification Vehicles', the WG recommended adopting the questions that have already been developed and tested for the PMA2020, aligned with whatever fortification is mandatory in a given country.

Topic	Proposed Change	1. Where does it belong? DHS /MICS core	DHS Module	Other PBHS	2. Should it be done now? Tier / Priority
FORTIFICATION					
All fortification vehicles	Add question to permit separation of fortifiable food	yes			I
All fortification vehicles	Develop detailed module of coverage and utilization		X	X	III
Salt iodization	Developing a new spot test that provides a yes/no result	[eventually]			III
Salt iodization	Explore potential for sample shipping of YES samples (for quantitative testing)	[possible]	[If not possible in core]		II
Salt iodization	Where did you get the salt? (for those who did not get salt)	X			
CHILD MICRONUTRIENTS					
	Reword recall question about iron-containing supplements to be last 6 months (consume or get needs to be resolved)	X			
Iron containing supplements	When yes response: Add type of supplement; where received				III
SQ-LNS	Remove from core DHS		X	X	
Child nutrients	525a drop question	X			III
PREGNANT WOMEN					
Calcium supplementation	Develop standardized indicators (similar to Iron)		X	X	III
	Ask first about any iron containing supplement	X			I
	Modify to report for pregnancy in past 2 (or 5 years - review)	X			I
	Add question to ask where received purchased	X			I
Iron supplements/ IFA/ MMN	Keep current question on quantity consumed	X			no change
WOMEN OF REPRODUCTIVE AGE					
	Any FA supplement in past 6 months	X			I
	Any Fe containing supplement in past 6 months	X			I
Iron supplements/ IFA/ FA/ MMN	Add question to ask where received purchased	x			
All groups/ all programs	Comprehensive compendium of recommended coverage and utilization indicators (and associated questions)		x	X	III

Two indicators were mistakenly omitted from the slide at right:

1. The food list in PMA2020 could be used in LSMS.
2. Several members of the group advocated that fortification coverage should be included, particularly given that it's been tested and validated in large-scale PBHSs.

Q&A and Discussion link

Detailed Notes from Micronutrient WG

Plenary 8: Group Exercise on Overall Prioritization of Recommendations for Core Surveys

A group exercise was conducted to get an informal and non-binding sense of how participants were individually prioritizing the recommended modifications to the core DHS survey at this stage in discussions. The survey was conducted 'live', using survey monkey, and 39 people responded. The two highest ranked indicators in the exercise were 'coverage of breastfeeding counseling' and 'unhealthy foods for children'.

Group	Topic	Addition
Growth	Pregnancy weight gain	• Add: cascade of three new questions on whether pregnant woman weight, more than once, discussion about weight *(could be in ANC-current pregnancy or recall to last pregnancy)*
	Growth monitoring	• Ask whether child had weight, height, MUAC measured in specifed period (make recall period context-specific, can be removed for countries in which screening for acute malnutrition not applicable)
MIYCN Counseling	Maternal nutrition	• During this pregnancy did a health care provider talk with you about what foods to eat when you are pregnant? IF yes, which topics
	Breastfeeding counselling [in ANC module]	• When you were pregnant with NAME, did a health care provider/CW talk with you about breastfeeding?
	IYCF counseling in male and female questionnaires	• In last 6 months did HW/CW talk with you about how to feed your child? If yes, what topics?
IYCF practices, diet quality & food security	Unhealthy Foods for children	• sub-divide current food list to capture unhealthy foods (No F&V, SSBs, Junk Food)
	MDD-W	• add questions on women food group consumption in previous 24 hours
	Food Insecurity Experience Scale	• Add FIES series of questions (8 items)
Micronutrients	Child iron	• Any iron-containing supplements in the last 6 months? If yes, specify which
	IFA in pregnancy	• Add question about whether purchased or received.
	Iron in women of reproductive age	• Do you take? If so, where did you access?

Plenary 9: Response from country, survey program & development partners representatives

Moderator: Ellen Piwoz, BMGF

S.K. Singh, International Institute for Population Sciences, India

India has completed four rounds of the DHS to date; it is considered a very trusted source of health and nutrition information. India has added many new dimensions of child health and nutrition within the larger, national-level survey. The most recent challenge is that the survey now provides district-level representation, thus the sample size has increased five-fold. Furthermore, the number of questions in the National Family Heath Survey 5 (NFHS-5) has increased dramatically since NFHS-4, (see slide at right), and most of the additions are due to efforts to align with the DHS.

Number of Questions in Different Questionnaires in NFHS-4 and NFHS-5

NFHS-4(2015-16)	NFHS-5 (2019-20)
❖Household - 77	❖Household - 86
❖Man – 202	❖Man - 220
❖Woman – 468	❖Woman – 533
❖ Biomarker- 173	❖ Biomarker - 179

The Indian survey takes all of the changes decided in these international fora, and wherever feasible, incorporates them into the NFHS. The word 'feasible' is used intentionally here because there are many limitations on what can and can't be incorporated. One

important consideration is the level of education of the respondent. 54% of women, for example, are not able to say their month and year of birth. Other techniques have to be used to glean this information.

The Indian NFHS has also had to make other modifications to mitigate the burden of increasing the sample size fivefold. For example, all questions related to sexual behavior are only asked at the state level. All questions related to maternal and child health (including nutrition) are only asked at the district level. Any further additions decided at this meeting will have to be very carefully considered by India's stakeholders, because the burden is already very high.

India has 120,000 health facilities throughout the country, and it utilizes the SPA to generate data facility data. India also administers the Health Management Information System (HMIS) to provide district-level data. Linking the two surveys is a strong possibility which is being discussed. The NFHS-5 has already been designed and is ready for implementation, so any further modifications would only be incorporated into the next round (NFHS-6).

Gulnara Semenov, DHS

It's been extremely useful to hear the diverse views expressed during this consultation. It's worth noting that perhaps half of the modifications recommended by this group have not been raised as a high priority during DHS staff's discussion with implementing agencies and other in country partners as part of survey design discussion with countries. For example, food diversity-related questions are rarely recommended for inclusion by country-based stakeholders, with the exception of perhaps UNICEF or USAID.

It's very important to carefully formulate the questions that are being proposed. There is likely to be a plethora of questions submitted, many of which will be strongly-formulated, well-validated prospects. Some will be prioritized due to their ties to SDG indicators, or for other reasons. It's also important to consider the feasibility of collecting the data for a given indicator. If, for example, it's not feasible to collect the information in an accurate and reliable manner, then the recommendation is not likely to be accepted.

In recent trips to Tajikistan, Kenya, and Ghana the topic of duplication of data collection was raised. In some countries there are multiple sources of the same data, but the results from these sources are very different. It's important to examine the quality of the survey methodology and ask the question: do we trust the results coming from this survey? It's better not have a survey at all than to have one that is poorly designed and not trustworthy.

The DHS is currently planning the DHS 8 revision and is in the process of developing the criteria for adding indicators. For example, each new indicator needs to be justified, well-validated, comprehensive (in terms of the possible responses); relevant to the survey; and feasible (in terms of collection). Furthermore, the goal is to limit the time taken to interview women. Given these constraints, and the likelihood of some recommendations not being accepted, it will be important for this group to carefully *prioritize* its recommendations.

Finally, it's worth noting that a new maternal health care module has just been tested, and, at some point in the future, a nutrition module may be developed as well.

Bo Robert Beshanski-Pedersen, UNICEF

It's common for newly-launched HH survey platforms to deliver poor quality data in its early days. MICS was no exception. But over time, the quality has improved, but it doesn't necessarily improve evenly across the survey topics/categories; certain topics get more attention, training or funding, and they consequently deliver better quality. Birth history data, for example, was not previously captured in MICS; it was only conducted occasionally. When it was done; however, it was done very well due to the attention it attracted. Now it's done everywhere, and consequently, the quality has declined.

It's important to point out that each time the survey size is increased, the quality of *all* of the data collected is undermined. Though it's difficult to measure the damage, it's definitely there, and this needs to be considered going forward. There is always an opportunity cost to adding data.

Madeleine Short Fabic, USAID

As the USAID management team lead for DHS, Madeline is involved with surveys across the globe, many of which have significant challenges. She, therefore, takes a cautious approach, and is concerned about overloading surveys and the consequent effects of this on data quality.

Everyone at this consultation, as well as colleagues within USAID, have data needs related to their respective areas of interest. The groups with the most success in driving the direction of the DHS (and other surveys) are generally those groups with strong M&E WGs or MERG. Malaria in particular has been extremely successful in that space.

It may be useful for a MERG to be established for the global nutrition community. Ideally, the MERG would create the list of the key indicators, that can then be distilled into the key questions, and then the question of which platforms are best suited to answer those questions can be selected, i.e. via a PBHS, a facility survey, an HMIS system, programmatic data collection, or via research.

For DHS 8, the five-year contract was awarded last week. More specialized sampling approaches, including split sample designs which will allow more modules to be added, will be pursued. Biomarkers will continue to be explored, which is a very challenging space for DHS, so they generally opt for field-friendly biomarkers that don't require a nurse, complex cold chains, etc. to collect, and for which laboratory analyses can be done in country.

Revision is an ongoing balancing act; considering the key data needs and how they can best be met. It's important for this group to think beyond the topic, the question, and the categories of responses. Instead, for modifications to be incorporated, the group needs to think all the way to the tabulation plan, so that the DHS isn't in the position of guessing what's needed.

This is a unique time in history: there is a love of data, there are gaps in data, and, often, there is an over-abundance of data. It's not always better to have more data; it can be dissuasive in terms of advocacy and can paint a picture that science isn't believable, especially when different indicators and survey results paint a varied picture of the same scenario. This can be confusing and potentially undermining to our common goals, so it's important to be cognizant of these issues as this revision proceeds.

Abigail Perry, UK DFID

In reviewing the final draft of the 2018 Global Nutrition Report, it's clear that that we're still facing a disaster in terms of progress on malnutrition. An absence of data makes it difficult to know why this is the case. This meeting and the conversations taking place here are incredibly important towards better understanding and documenting what progress *has* been made across the range of interventions that we keep promoting, including breastfeeding, support for women during pregnancy, targets on low birth weights, targets on NCDs, and targets on child survival. Some of these data gaps can be addressed through PBHSs (e.g. DHS and MICS), but we as the nutrition community need to take very seriously the advice coming from the individuals who spend their days working on those surveys, which means seriously considering the complexity and burden of adding and changing content.

The individuals and institutions making recommendations must do their homework, and keep modifications simple and well-formulated to ensure collection of good quality data. As importantly, it's clear that revisions to PBHSs and facility-based surveys are only *part* of the story. The issue of how assessments and data ecosystems come together to influence investments in nutrition and health is critically important as well.

Whether it's through the creation of a MERG or building on BMGF's initiative on data value chains, this group must think through what questions need answering and what are the strategies for answering them, whether operating in fragile contexts with high rates of wasting, or the many settings where obesity and NCDs are prevalent. Finally, forming a plethora of different initiatives is counterproductive. Let's instead work collaboratively to solve these questions.

Q&A and Discussion link

Wrap Up and Closing Comments:

Rebecca Heidkamp, Johns Hopkins

The main objective of this consultation was to identify priority nutrition coverage data gaps that could be filled using PBHS or facility surveys, drawing upon the perspective of a wide variety of nutrition data experts and users. The meeting also had the more ambitious objective of developing and prioritizing recommendations for improving questions across the PBHS and facility surveys, starting with the DHS, MICS and SPA, but also thinking more broadly to other survey instruments. These were extremely ambitious tasks, but progress made on both fronts over these two days has been remarkable.

We generated a wide range of valuable insights, ideas and suggestions related to population-based HH and facility surveys including further discussion on nutrition indicators, potential inputs to upcoming DHS questionnaire development process and the possible birth of a MERG on nutrition data. Finally, a report documenting the contents of this meeting will be finalized in the coming weeks.

Ellen Piwoz, BMGF

Gratitude was extended to all of the participants and to the DataDENT team for the extraordinary resources that were provided to the WGs for formulating their recommendations. Thanks was also extended to USAID, WHO, and UNICEF for partnering with BMGF to make this consultation a reality. Many pearls of wisdom were shared at this the two-day long meeting, and the three objectives were met and exceeded. There is much work ahead, and, fortunately, there is a clear roadmap and timelines for delivering recommendations to DHS and other survey instruments. This group is here because of its shared commitment to quality nutrition data, and to using that data to improve people's lives. This is the overarching commitment that drives this and other upcoming initiatives that will emerge from this gathering.

Summary of Draft Recommendations for DHS 8

Over the course of the two-day meeting, participants identified a number of recommendations and research priorities across the thematic working group areas that can strengthen and streamline the nutrition content of PBHS and facility assessments. A select number of recommendations were more specifically prioritized by working groups for DHS 8 and the next round of SPA questionnaire. Each of these proposed modifications were seen by groups to meet guidelines that may be used to evaluate additions to the DHS including: 1) Specific formulation of validated questions and 2) previous testing at scale. These recommendations are summarized below as they stood at the end of the two-day meeting.

It is acknowledged that revision of the core questionnaires is a process with stringent criteria and that each of these proposed modifications must be fleshed out in greater detail, carefully considering their fit, feasibility, and how this data will be used. In the coming months a sub-group of individuals from the Nutrition Data convening will execute this more detailed work in preparation for submission to the DHS forum expected to open in early 2019. This detailed review will include a review of the list of proposed key indicators, how this will be distilled into key questions, and full justification for modification and inclusion using the DHS Forum requirements. As such the recommendations presented in this report should be considered the preliminary priority topics for inclusion in the DHS that emerged from this meeting, and not the final recommendations with the required level of detail.

In the table below, we distinguish between modifications to the core questionnaire, and additions that are recommended for a new Nutrition Module, that could be requested by countries and adopted to country needs.

Note: *The participants also made a series of recommendations for the Service Provision Assessment questions which are not included below. The same detailed review process will be employed for finalization of these indicators and questions.*

MIYCN Counseling

Sub-Category	Question	Core vs. Module
Maternal Nutrition	ADD question about whether during last pregnancy woman received information or advice about which foods to eat. Follow-up question about specific messages	Core
Maternal Nutrition	ADD question about whether during last pregnancy woman received information or advice on other nutrition-relevant topics including consumption of specific MN (e.g. IFA, Calcium) and physical activity	Module
BFHI	ADD series of questions for all facility-based births about whether: 1) she had skin-to-skin contact with her baby immediately or within 5 minutes after birth, 2) she received support with learning to breastfeed after delivery, 3) her baby was kept with her in same room for entire period from delivery to discharge, and 4) she was informed about where she could access breastfeeding support in the community after discharge from the birth facility"	Core
BF-PNC	KEEP current questions in PNC section counseling in the first 2 days - but MODIFY to "receive information about BF". Keep question about observation of BF	Core
BF-ANC	ADD question to ANC section about receiving information about breastfeeding from health care provider or community worker and a follow-up question about specific messages	Core
BF - Within 1 month of life	ADD questions about: 1) receiving information about breastfeeding; and 2) observation of BF from health care provider or community worker after first 2 days but before the first month of life. Follow-up questions about specific messages	Module
Complementary Feeding	ADD question to child health section for all children 6-36 months about receiving information on how to feed child from health care provider or community worker in the previous 6 months and a follow-up question about specific messages	Core
IYCF Mass Media	ADD question to child health section for all children 6-36 months about exposure to mass media regarding IYCF in the previous 6 months.	Core
MIYCN Counseling (male)	ADD question to male questionnaire about IYCN counseling receipt in the previous 6 months	Module

Child growth interventions

ANC – Weight gain	ADD series of questions about monitoring of weight gain during pregnancy including whether during her last pregnancy a) woman was weighed; b) whether it was once or more than once; and c) whether they health provider or community worker talked to her about her weight	Core
ANC – social program (food or cash)	ADD questions about whether women received food or cash assistance during pregnancy. Follow-up questions about type of assistance, content of food support (if applicable), and duration of support	Module
Child - Growth Assessment	ADD question about whether child had specific dimensions of growth assessed in specified recall period: 1) weight, 2) height/length, and/or 3) MUAC (modify which forms and period based on national policies/programs)	Core
Child - Food Assistance	ADD questions about whether child received food assistance during specified recall period. Follow-up questions about specific type of food support (if applicable) and duration of support	Module

Micronutrient interventions

During pregnancy / ANC	ADD questions about receipt and source, as well as consumption of specific forms of MN including Ca, Vitamin D, etc. (These should be added only if national policies and protocols support)	Module
All women of Reproductive Age	If national policies and protocols support, ADD questions about receipt of iron and folate-containing supplements by non-pregnant women and adolescent girls with follow-up questions about specific type, source, and number consumed	Module
HH - Fortification	ADD questions about household-level consumption in the previous 1 week of any food types that are currently being fortified per national policy or that could be fortified in countries that are considering a fortification policy. Requires 2 questions for most (did your HH consume any in last week? Are they able to specify the brand consumed?)	Core or Module (TBD)
HH Fortification	MODIFY current core question to include a follow-up question for those who respond that they do not have salt available in the home, whether or not they consumed any salt in previous 1 week.	Core

Children under 5	MOVE current question about MNP or IRON (as well as RUTF, RUSF) consumption to MODULE as they should only be included if they are part of a national policy or program. Then MODIFY question by: a) separate questions about MNP vs. other forms of iron supplements; b) change recall period(?) from consumption in the previous 1 week to 3 or 6 months	Module

Diet/food security

Women Diet (WDD)	ADD series of questions to assess minimum dietary diversity in women (MDD-W) and ensure that it is possible to specifically identify consumption of foods of concern including sugar-sweetened beverage (SSB), savory snacks, and sweet snacks.	Core
Child Diet <24m (SSB, Snacks)	MODIFY current food list for dietary recall to identify consumption of sugar-sweetened beverages (SSB), savory snacks, and sweet snacks	Core
Child Diet >24m (SSB, Snacks)	ADD recall questions about consumption of sugar-sweetened beverages (SSB), savory snacks, sweet snacks	Module
FIES (SDG Indicator)	ADD Prevalence of moderate and severe Household Food Insecurity using the Food Insecurity Experience Scale set of 8 standard questions	Core

Acronyms

ACF	Action Against Hunger
ADQ	Anthropometry Data Quality
ANC	Antenatal Care
BFHI	Baby Friendly Hospital Initiative
BMGF	Bill & Melinda Gates Foundation
Ca	Calcium
CAPI	Computer Assisted Personal Interviewing
CDC	Center for Disease Control
CMAM	Community-Based Management of Acute and Moderate Malnutrition
DataDENT	Data for Decisions to Expand Nutrition Transformation
DHS	Demographic and Health Survey
FANTA	Food and Nutrition Technical Assistance
HDC	Health Data Collaborative
HH	Household
HHS/NIH	US Department of Health and Human Services / National Institutes of Health (HHS/NIH)
HMIS	Health Management Information System
IFA	Iron Folic Acid
IFPRI	International Food Policy Research Institute
INTAKE	Center for Dietary Intake, an FHI-360 initiative
IYCF	Infant and Young Child Feeding
JHU	Johns Hopkins University
LMIC	Lower & Middle-Income Countries
LSMS	Living Standards Measurement Study
M&E	Monitoring & Evaluation
MDDW	Minimum Dietary Diversity for Women
MDG	Millennium Development Goals
MERG	Monitoring & Evaluation Reference Group
MICS	Multiple Indicator Cluster Surveys
MMN	Multiple Micronutrient (supplementation)
MN(P)	Micronutrient (Powder)
MNCH	Maternal, Newborn and Child Health
MYCIN	Maternal, Infant, and Young Child Nutrition
NCD	Noncommunicable Diseases
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NITI	National Institute for Transforming India
PMA2020	Performance Monitoring and Accountability 2020
PPP	Power Point Presentation
PBHS	Population-Based Household Survey
R&D	Research and Development
RUTF/RUSF	Ready-to-Use Therapeutic Foods / Ready-to-Use Supplementary Foods
SDG	Sustainable Development Goals
SDI	Service Delivery Indicators
SMART	Standardized Monitoring and Assessment of Relief and Transitions
SPA	Service Provision Assessments
TEAM	Technical Expert Advisory group on nutrition Monitoring
UHC	Universal Health Coverage
UK DFID	United Kingdom Department for International Development
UN	United Nations
USG	United States Government
WG	Working Group
WHO	World Health Organization
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

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Technical Consultation on Measuring Nutrition in Population-Based Household Surveys and Associated Facility Assessments

Convened by the Bill & Melinda Gates Foundation, and the United States Agency for International Development (USAID), in collaboration with the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO)

Technical coordination provided by DataDENT

AGENDA
(v. Sept 16 2018)

Objectives:

1. To review how nutrition data, including indicators and data sources, are currently being used by different stakeholders at global and country levels and identify the gaps that remain in their information needs that could be filled through household or facility surveys.

2. To review recommendations from recent technical consultations for improving collection of anthropometric and micronutrient status data in large-scale household surveys.

3. To identify ways to augment, improve and/or harmonize questions about nutrition intervention coverage, infant and young child feeding (IYCF) and other diet quality measures using the core questionnaires of the major household and facility surveys as a starting point.

Wednesday, 19 September 2018		
Time	**Topic**	**Presenter/ Moderator**
8:00	Breakfast & registration	
8:30	Welcome	Ellen Piwoz/Anne Peniston
8:45	Introductions & review of agenda	Rebecca Heidkamp
9:00	**Plenary 1**: Results from a nutrition stakeholder survey of data use and needs *Presentation followed by large group Q&A*	Andrew Thorne-Lyman
9:40	**5-minute transition**	
9:45	**Plenary 2**: Overview of major nutrition-related household survey platforms *Series of brief presentations followed by large group Q&A*	Chair: Erin Milner DHS: Sorrel Namaste MICS: Bo Pedersen SMART: Oleg Bilukha LSMS: Gbemisola Oseni DHS-MICS Harmonization Work: Chika Hayashi

Time	Topic	Presenter/ Moderator
11:00	Coffee Break	
11:20	Introduction to Day 1 working groups (WG)	Rebecca Heidkamp
11:35	**WG Session 1**: Develop recommendations to improve the nutrition content of household survey questionnaires	WG Chairs
13:00	Lunch	
14:00	**Plenary 3**: Panel Discussion: Meeting country data needs *Moderated panel discussion*	Moderator: Ellen Piwoz Anamika Singh: India Zhenyu Yang: China Ibrahim Kana: Nigeria
14:40	**5-minute transition**	
14:45	**WG Session 2**: (Continued) Develop recommendations to improve the nutrition content of household survey questionnaires	WG Chairs
15:45	Coffee break	
16:00	**Plenary 4**: WG Day 1 report out *15 mins per WG followed by large group discussion*	Moderator: Rahul Rawat WG rapporteurs
17:20	Wrap-up – Day 1	Rebecca Heidkamp
17:30	Meeting adjourned	
18:30	**Group Dinner** Ted & The Bully Bar, 1200 19th St NW, Washington, DC 20036	

Thursday 20 September 2018

Time	Topic	Presenter/ Moderator
8:00	Breakfast	
8:30	**Plenary 5**: Report out from Anthropometry Data Quality & MN Status Measurement Meetings *Two presentations followed by large group Q&A*	Chair: Omar Dary R. Flores (CDC) M. Jefferds (CDC)
9:05	**5-minute transition**	
9:10	**Plenary 6**: Overview of Nutrition Content in Facility Surveys *Two presentations followed by large group Q&A*	Chair: Chika Hayashi Amani Siyam (WHO) R. Benedict (ICF)
9:50	Introduction to Day 2 WG	Andrew Thorne-Lyman
10:05	Coffee Break	
10:20	**WG Session 3**: Recommendations to improve the nutrition content of facility assessments	WG Chairs
11:20	**WG Session 4**: Prioritizing WG recommendations for HH & facility surveys and defining research needs	WG Chairs

Time	Topic	Presenter/ Moderator
12:20	Lunch	
13:20	**Plenary 7**: WG Day 2 report out *10 mins per WG followed by large group discussion*	Moderator: Rahul Rawat WG rapporteurs
14:20	**Plenary 8**: Large group exercise on overall prioritization of recommendations for core surveys	DataDENT Rebecca/Andrew
15:15	Coffee break	
15:30	**Plenary 9:** Response from country, survey program & development partners representatives *Moderated panel discussion*	Moderator: Ellen Piwoz <u>Country Representatives</u> S.K. Singh (India) Mustafiz Rahman (Bangladesh) <u>Data Platform Representatives</u> Gulnara Semenov (DHS) Bo Pedersen (MICS) <u>Donor Representatives</u> Madeline Short (USAID) Abi Perry (DFID)
16:30	Wrap-up, action steps	Rebecca Heidkamp
16:50	Closing	Ellen Piwoz

First Name	Last Name	Organization
Silvia	Alayon	Save the Children/Alive & Thrive
Masresha	Anegago	Ethiopian Public Health Institute (EPHI)
Maaike	Arts	UNICEF
Riley	Auer	Johns Hopkins Bloomberg School of Public Health
Tricia	Aung	Johns Hopkins Bloomberg School of Public Health
Rukundo	Benedict	ICF
Oleg	Bilukha	CDC
Ken	Brown	Bill & Melinda Gates Foundation
Audrey	Buckland	Johns Hopkins Bloomberg School of Public Health
Calogero	Carletto	World Bank
Jennifer	Coates	Tufts University Friedman School of Nutrition Science
Nicki	Connell	Eleanor Crook Foundation
Carla	Da Silva Sorneta	European Commission
Omar	Dary	USAID
Megan	Deitchler	Intake, FHI 360
Reina	Engle-Stone	University of California, Davis
Rafael	Flores-Ayala	Division of Nutrition, Physical Activity and Obesity/CDC
Edward	Frongillo	University of South Carolina
Laurence	Grummer-Strawn	World Health Organization
Shauna	Hargrove	Bill & Melinda Gates Foundation
Chika	Hayashi	UNICEF
Rebecca	Heidkamp	Johns Hopkins Bloomberg School of Public Health
Maria Elena	Jefferds	CDC
Kiersten	Johnson	USAID Bureau for Food Security
Ibrahim	Kana	Federal Ministry Of Health, Nigeria
Eeshani	Kandpal	World Bank
Shannon	King	Johns Hopkins School of Public Health
Monica	Kothari	PATH
Julia	Krasevec	UNICEF
Habtamu	Lashtew	Save the Children
Keith	Lividini	HarvestPlus/IFPRI
Jose	Lopex	USAID Guatemala
Swetha	Manohar	Johns Hopkins Bloomberg School of Public Health
Quinn	Marshall	Johns Hopkins Bloomberg School of Public Health
Pragya	Mathema	UNICEF-Bangladesh
Mduduzi	Mbuya	Global Alliance for Improved Nutrition
Christine	McDonald	CHORI/IZiNCG
Purnima	Menon	International Food Policy Research Institute (IFPRI)
Erin	Milner	USAID
Melinda	Munos	Johns Hopkins Bloomberg School of Public Health
Sorrel	Namaste	ICF
Lynnette	Neufeld	Global Alliance for Improved Nutrition
Violet	Orchardson	USAID/Malawi
Bo	Pedersen	UNICEF
Anne	Peniston	USAID

Abigail	Perry	UK Department for International Development
Ellen	Piwoz	Bill & Melinda Gates Foundation
Alissa	Pries	Helen Keller International
S M Mustafizur	Rahman	Institute of Public Health Nutrition, Government of
Rahul	Rawat	Bill & Melinda Gates Foundation
Dolores	Rio	UNICEF-WCARO
Lisa	Rogers	World Health Organization
Marie	Ruel	International Food Policy Research Institute (IFPRI)
Kuntal	Saha	WHO
Gulnara	Semenov	The DHS Program/ICF
Madeleine	Short Fabic	USAID
Anamika	Singh	NITI Aayog, India
S.K.	Singh	International Institute for Population Sciences, India
Gbemisola	Siwatu	World Bank
Amani	Siyam	World Health Organization
Andrew	Thorne-Lyman	Johns Hopkins Bloomberg School of Public Health
Anne	Walsh	Power of Nutrition
Bill	Weiss	Johns Hopkins Bloomberg School of Public Health
James	Wirth	GroundWorks
Sara	Wuehler	Nutrition International
Zhenyu	Yang	National Institute for Nutrition and Health, China CDC

Technical Consultation on Measuring Nutrition in Population-Based Household Surveys and Associated Facility Assessments

19-20 September 2018 - Washington, DC

BILL & MELINDA GATES foundation

USAID

unicef

World Health Organization

Data DENT

Introductions & review of agenda

Why this consultation?

- To realize a “nutrition data revolution” each link in data value chain needs to be strengthened

- PBHS are the primary source of nutrition data for policy & program decision making in LMIC; Facility surveys are an underutilized data source.
- Need to consolidate technical knowledge, experiences & stakeholder priorities to ensure nutrition community’s data needs are appropriately reflected in PBHS & facility surveys

Consultation objectives

1. To identify priority nutrition coverage data gaps that can be filled through population-based household or facility surveys
    - *Consider what is currently available to & being used/accessed by nutrition community*
2. To develop & prioritize recommendations for improving coverage questions across PBHS & facility surveys
    - *Use most common platforms (DHS/MICS & SPA) as starting point but consider wider array of survey types*
3. To share key takeaways from recent consultations on anthropometry quality and measuring micronutrient status data in PBHS

Agenda Overview

	Day 1: Wednesday 19th	Day 2: Thursday 20th
	Focus: Household Surveys	Focus: facility surveys & overall priorities
Morning	• Plenary 1: Nutrition community data access & demand • Plenary 2: Overview HH survey programs • WG 1: Recommendations for HH surveys	• Plenary 5: Anthro & MN Status meeting report out • Plenary 6: Overview Facility Surveys • WG 3: Recommendations for facility surveys • WG 4: Prioritization & research needs
Afternoon	• Plenary 3: Country stakeholder perspective • WG 2: Recommendations for HH surveys (continued) • Plenary 4: WG report out & discussion	• Plenary 7: WG report out & discussion • Plenary 8: Big picture prioritization • Plenary 9: Donor, survey & country response
Evening	• Group Dinner	

Introductions: What institutions are represented? (1)

Technical Experts

- Alive & Thrive
- US Centers for Disease Control (CDC)
- CHORI
- Global Alliance for Improved Nutrition (GAIN)
- GroundWorks
- HarvestPlus
- Helen Keller International
- International Food Policy Research Institute (IFPRI)
- Intake - FHI 360
- ISiNCG
- Johns Hopkins Bloomberg School of Public Health
- Nutritional International
- PATH
- Save the Children

Introductions: What institutions are represented? (2)

Technical Experts (continued)

- Tufts University Friedman School of Nutrition Science and Policy
- University of California Davis
- University of South Carolina SPH

Country Representatives

- Ethiopian Public Health Institute (EPHI)
- Federal Ministry of Health, Nigeria
- NITI Aayog, India
- UNICEF Bangladesh
- UNICEF WCARO
- USAID Guatemala
- USAID Malawi

Introductions: What institutions are represented? (3)

Survey Programs

- DHS / SPA (ICF)
- MICS (UNICEF)
- LSMS (World Bank)
- SARA / HDC (WHO)
- SMART

Development Partners / UN Agencies

- USAID
- European Commission
- Power of Nutrition
- Eleanor Crook Foundation
- UK Department for International Development
- Bill & Melinda Gates Foundation
- UNICEF
- WHO
- World Bank

Technical coordination by

Data DENT

Data for Decisions to Expand Nutrition Transformation

Johns Hopkins Bloomberg School of Public Health

IFPRI International Food Policy Research Institute

R4D Results for Development

Plenary 1

Results from a nutrition stakeholder survey of data use and needs

Data DENT

Data for Decisions to Expand Nutrition Transformation

Results from a nutrition stakeholder survey of data use and needs

Andrew Thorne-Lyman

Johns Hopkins Bloomberg School of Public Health

Acknowledgements

From DataDENT/JHU

- Rebecca Heidkamp
- Audrey Buckland
- Shannon King
- Tricia Aung

From Bill & Melinda Gates Foundation

- Rahul Rawat
- Ellen Piwoz

Special thank you to all of you who took the survey!

Presentation overview

- Description of the survey sample
- Key high level findings of relevance to this meeting
- Examples of the types of data that are available in dropbox
- Disclaimer: Analysis is still preliminary (ideas welcome)
- Please do not circulate

Survey objectives

- Understand…
  - What types of data are the nutrition community using?
  - How does this vary by user types?
  - What data needs are not being met, and why not?
- Explore variation by different types of stakeholders
- Bring the perspectives of the wider community into this room
- Survey was also part of a bigger effort

Methods

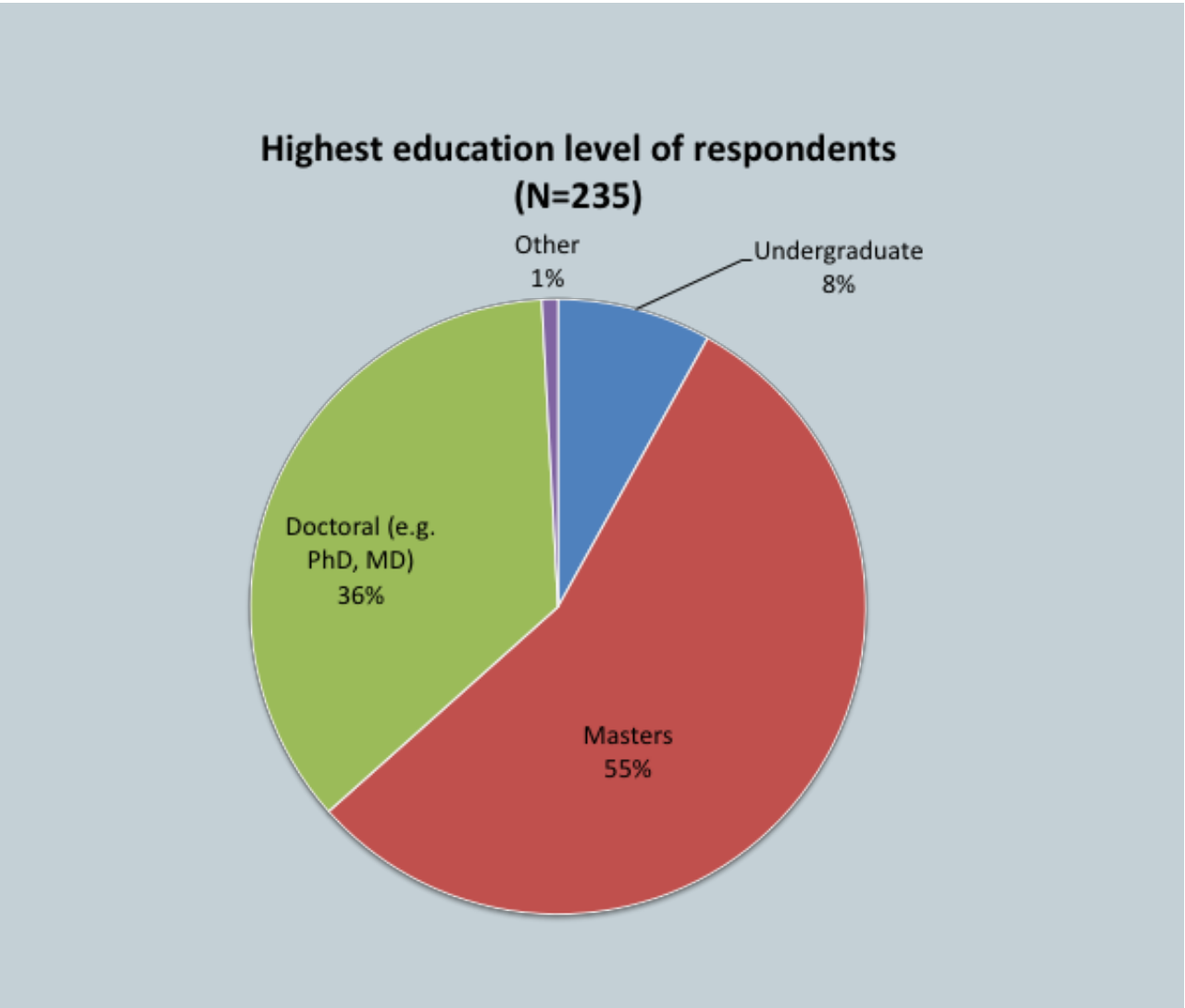
- Survey created using Qualtrics
- Disseminated through:
  - Online nutrition listservs (Ag2Nut etc)
  - Networks (SUN, Unicef, BMGF, JHU)
- Data collected July 16-August 16
- 264 survey responses received, 235 with responses beyond identifiers
- Denominator for questions varied due to non-completions
- Respondents made good use of multiple response options!

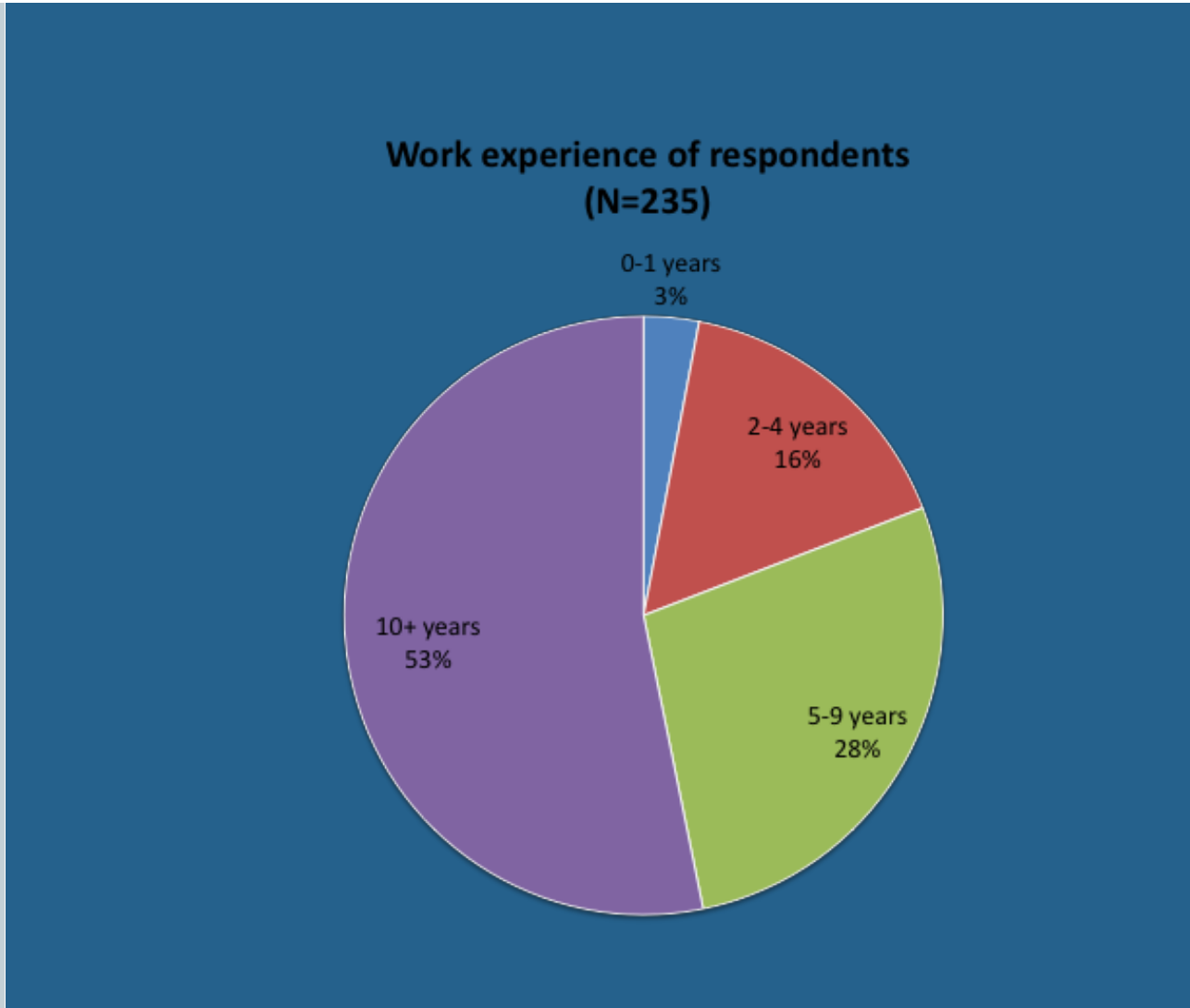
Factors we can disaggregate by:

- Single vs. multi country focus
- Type of organization
- Country or region (not in this presentation)

First a bit about the surveyed population

Respondents were well educated and experienced!

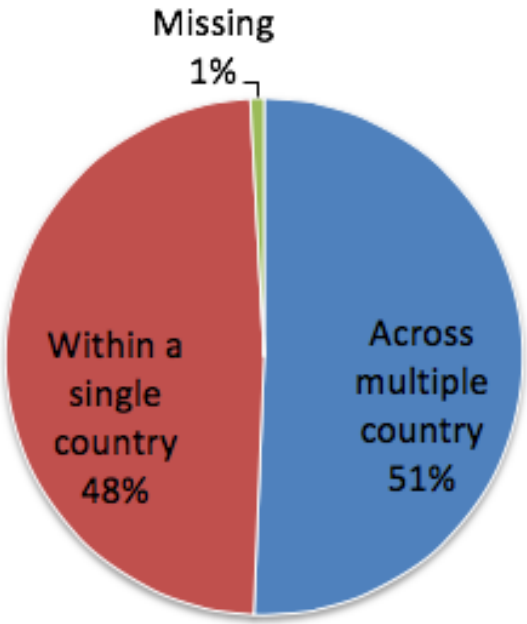




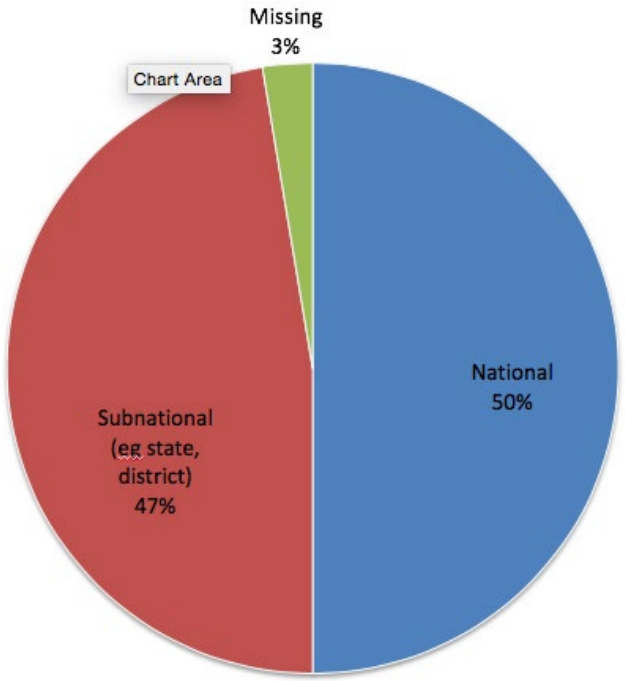
In the past 12 months, which countries has your work related to? (select all)

Country	Responses
Ethiopia	54
India	52
Kenya	42
Bangladesh	42
Nigeria	39

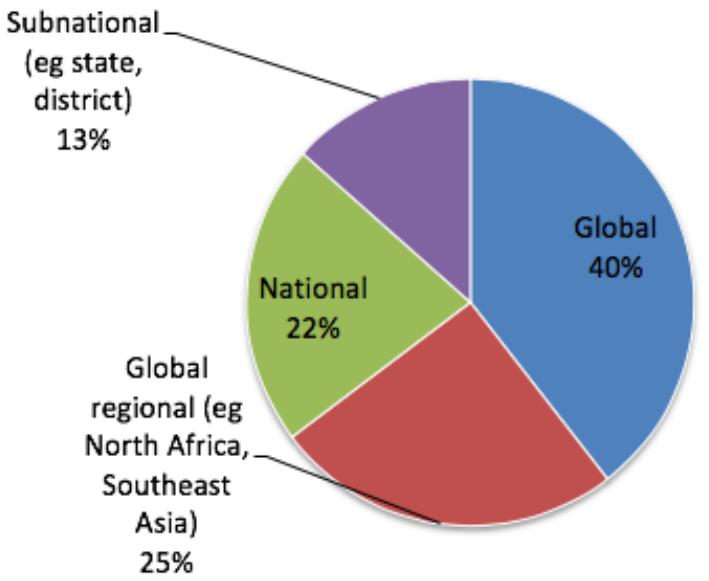
OVERALL SAMPLE
(N=235)



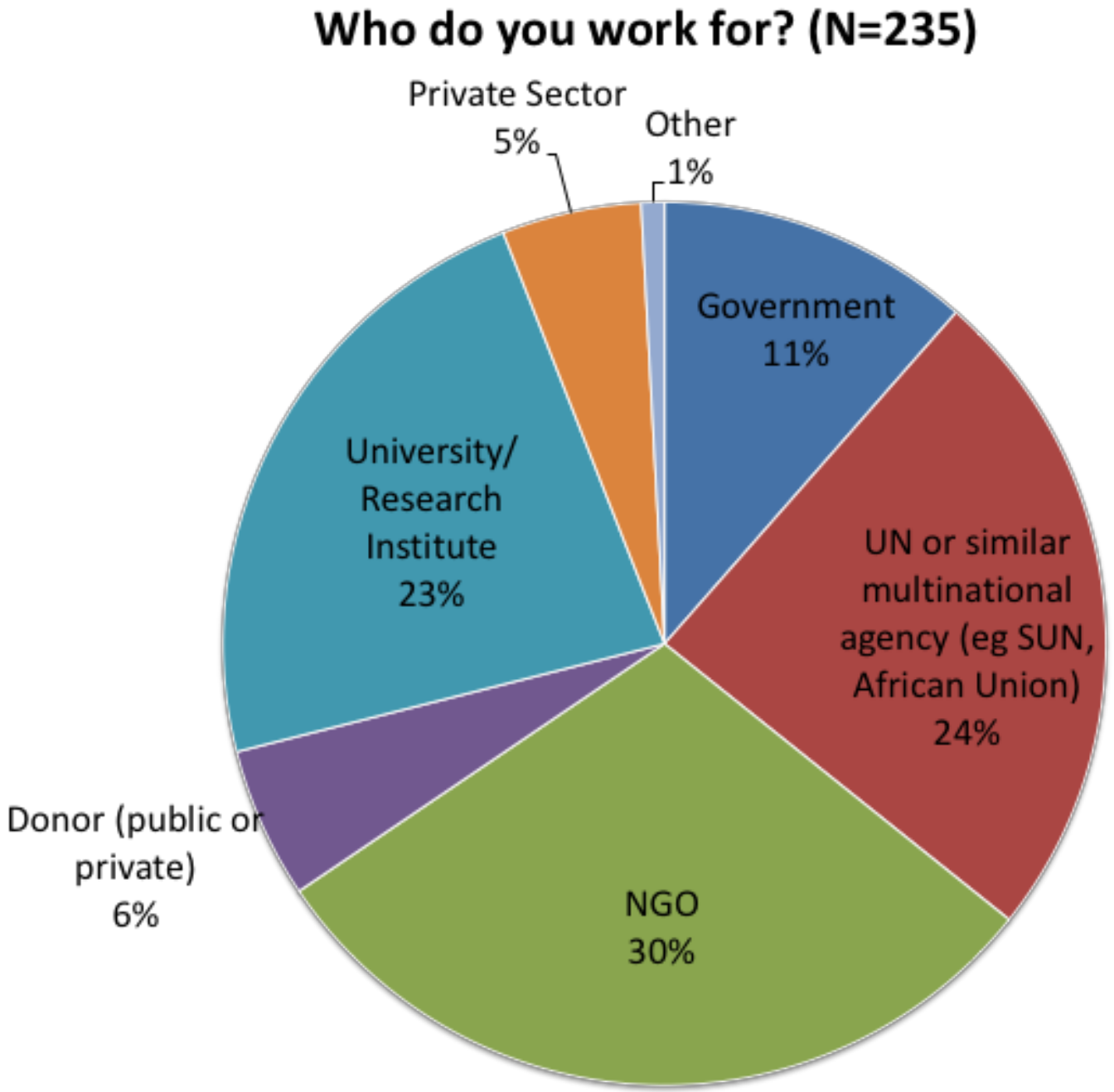
SINGLE COUNTRY FOCUS
(N=114)

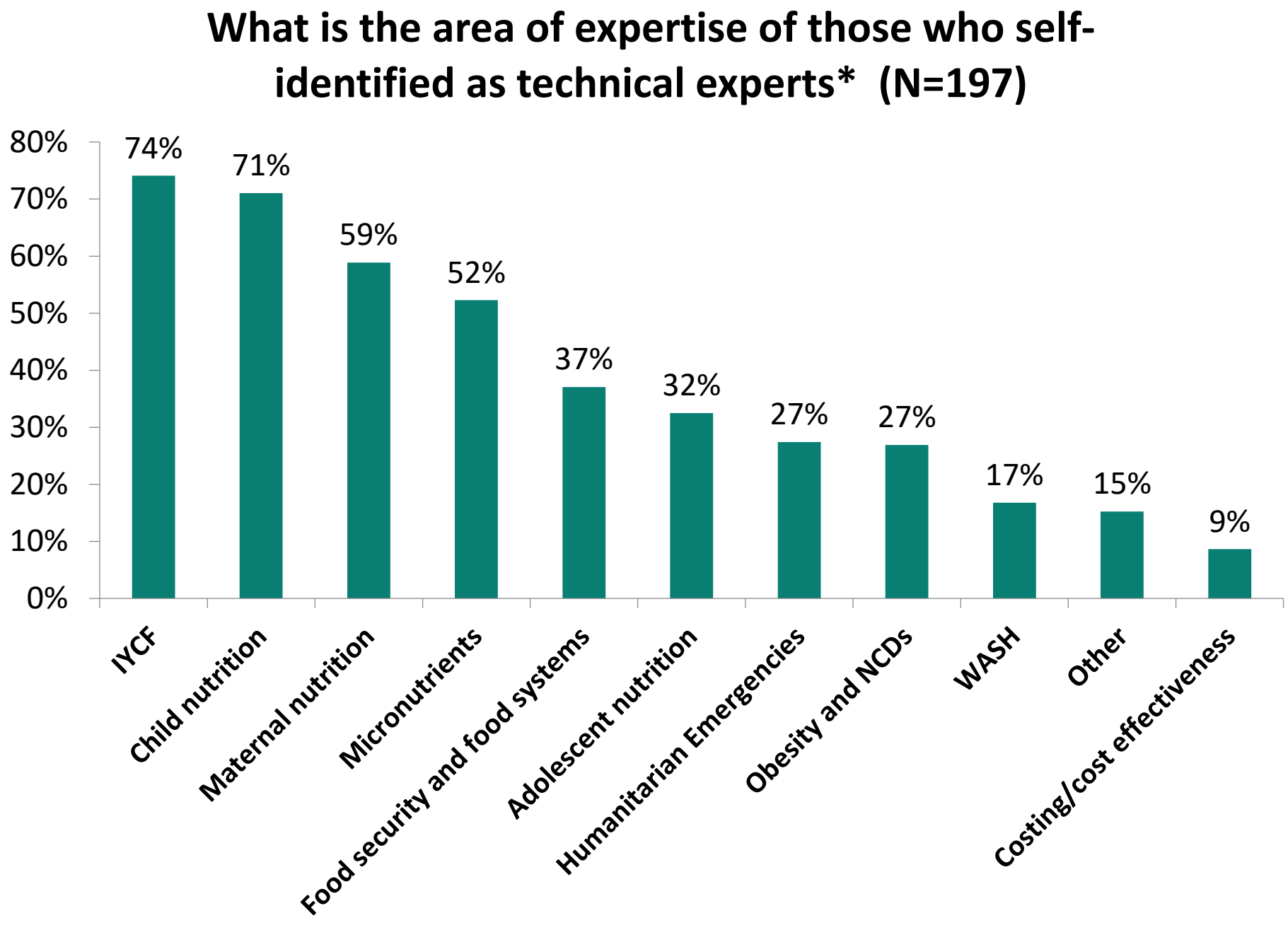


MULTI COUNTRY FOCUS
(N=119)

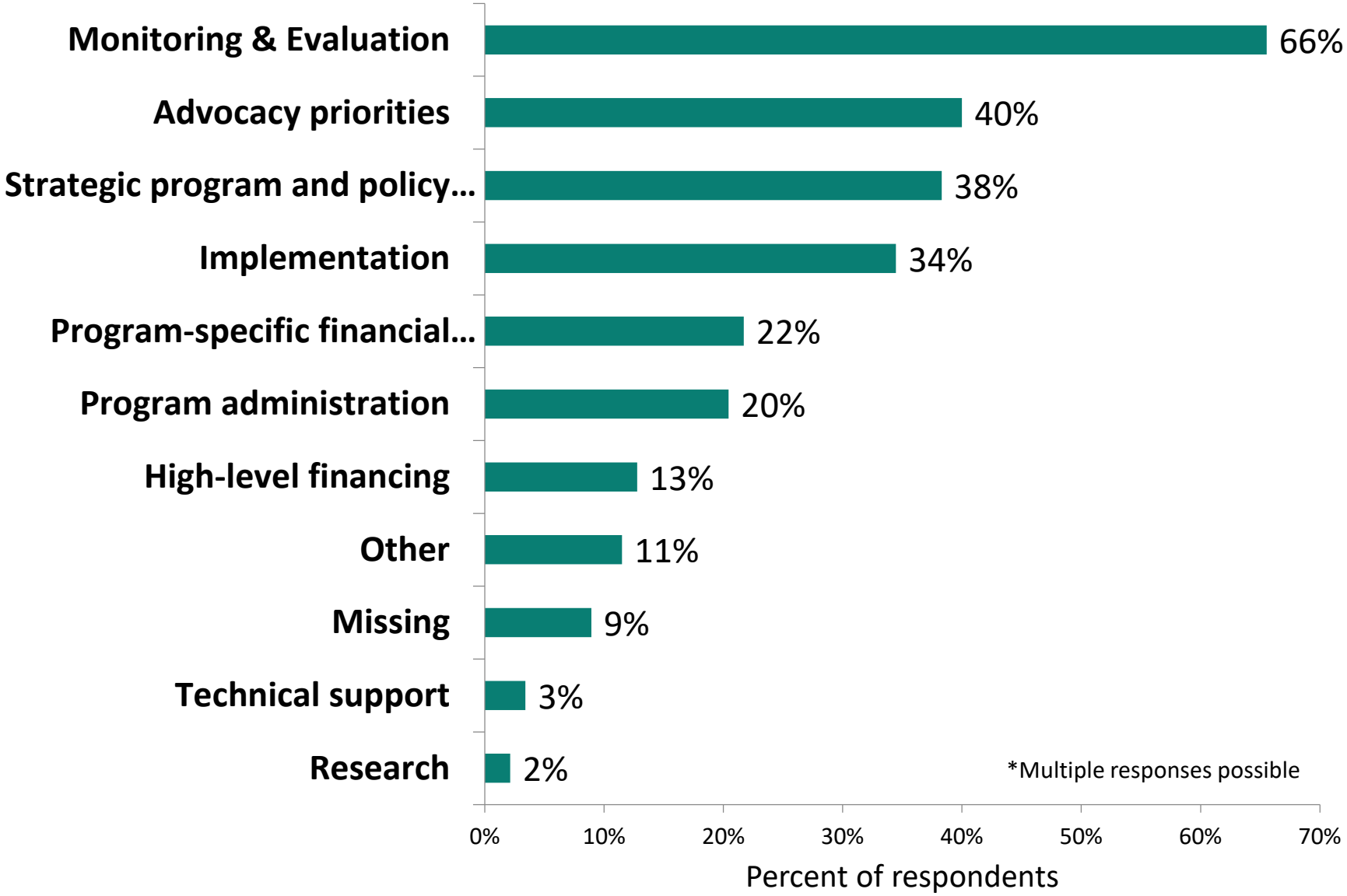


Sample included a good range of geographical focus


Who do you work for? (N=235)
Private Sector 5%
Other 1%
Government 11%
UN or similar multinational agency (eg SUN, African Union) 24%
NGO 30%
Donor (public or private) 6%
University/ Research Institute 23%


What is the area of expertise of those who self-identified as technical experts* (N=197)
80%
70%
60%
50%
40%
30%
20%
10%
0%
74%
71%
59%
52%
37%
32%
27%
27%
17%
15%
9%
IYCF
Child nutrition
Maternal nutrition
Micronutrients
Food security and food systems
Adolescent nutrition
Humanitarian Emergencies
Obesity and NCDs
WASH
Other
Costing/cost effectiveness

What type of decisions do you make in your current professional role?* (N=235)



Where do people access nutrition data?

National data sources accessed in the past year

	Overall	Single country focus	Multi-country focus
Individual (N)	**191**	**88**	**102**
Demographic Health Survey (DHS)	73.8	60.2	**85.3**
Multiple Indicator Cluster Survey (MICS)	41.9	15.9	64.7
Other National Nutrition Survey (e.g. micronutrient survey)	40.8	44.3	38.2
National survey using SMART methodology	39.3	29.5	48.0
National Dietary Intake / Food Consumption Survey	33.5	37.5	30.4
Sub-national survey using SMART methodology	33.0	26.1	38.2
DHIS-2 / similar online HMIS portal	32.5	33.0	31.4
Health Management Information System (HMIS) (not web-based portal)	28.3	26.1	29.4
Household, Income, Consumption & Expenditure survey	18.3	19.3	17.6
National food security “hot spot” monitoring system / FEWS-NET	18.3	15.9	19.6
World Bank Living Standard Measurement Studies(LSMS)	15.2	4.5	24.5
WFP Food Security Monitoring System (FSMS) (eg. mVAM monitoring/Food Security Bulletins)	13.6	6.8	19.6
Other survey specific to program or policy-(please specify all others used)	13.1	12.5	12.7
WFP Comprehensive Food Security and Vulnerability Assessments (CFSVA)	12.0	6.8	16.7
Other national household surveys with nutrition data (specify all name(s))	11.0	12.5	9.8
Service Provision Assessment (SPA)	11.0	6.8	14.7
WFP Emergency Food Security Assessment (EFSA)	9.9	6.8	12.7
Demographic surveillance sites (DSS)	9.9	13.6	6.9

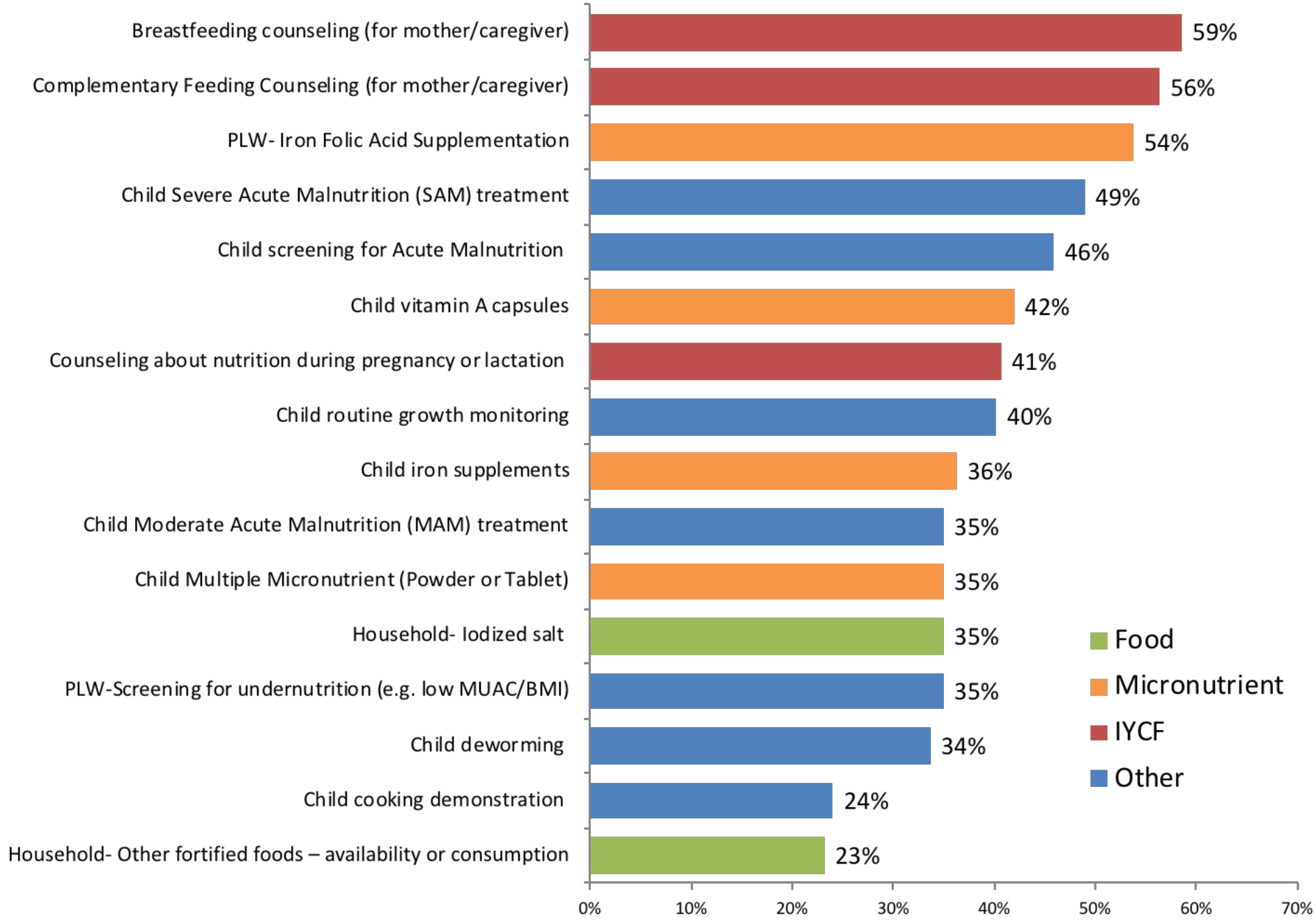
Global/Aggregated data sources accessed in the past year

	Overall	Single country focus	Multi-country focus
Individual (N)	**177**	**76**	**100**
Global Nutrition Report	**75.1**	65.8	82.0
UNICEF State of the World's Children Report	56.5	42.1	**68.0**
UNICEF, WHO and the World Bank Joint Malnutrition Estimates	39.0	28.9	**47.0**
UNICEF Nutrition datasets*	38.4	27.6	**46.0**
FAO The State of Food security and Nutrition in the World	36.2	30.3	40.0
World Bank Nutrition Country Profiles	35.6	30.3	39.0
Scaling up Nutrition Monitoring, Evaluation, Accountability and Learning (MEAL)	32.2	32.9	32.0
WHO Global Targets Tracking Tool	29.4	23.7	33.0
Countdown to 2030	28.8	21.1	35.0
WHO Global Health Observatory	24.3	21.1	27.0
FAO Country Indicators	19.8	14.5	24.0
WHO Vitamin & Mineral Nutrition Information Systems	18.6	13.2	22.0
WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene	14.1	3.9	22.0
IHME Global Burden of Disease	13.6	5.3	20.0
Hunger and Nutrition Commitment Index Global: Country profiles	11.3	7.9	14.0
FAO/WHO Global Individual Food Consumption Data Tool (GIFT)	11.3	6.6	14.0
IHME Child Growth Failure	6.2	1.3	10.0
Other global sources	2.8	1.3	4.0

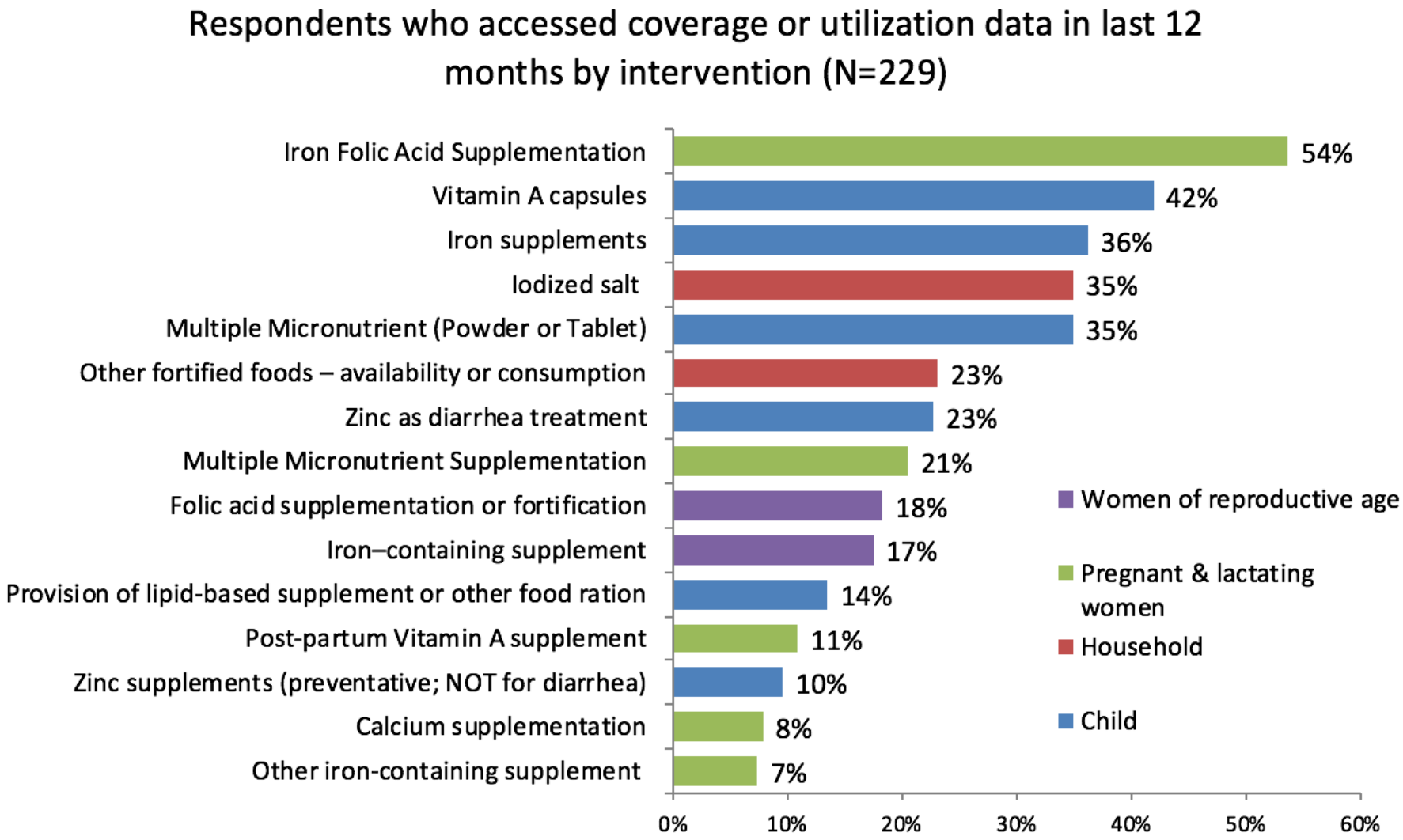
*Vitamin A indicators highlighted in VCE

What coverage data do people access?

Coverage or utilization data accessed in the past year (N=229) [1]



IFA supplementation of women was the indicator with greatest access, although child data on various micronutrients was also accessed frequently



How frequently do respondents want breastfeeding counselling data to be available?

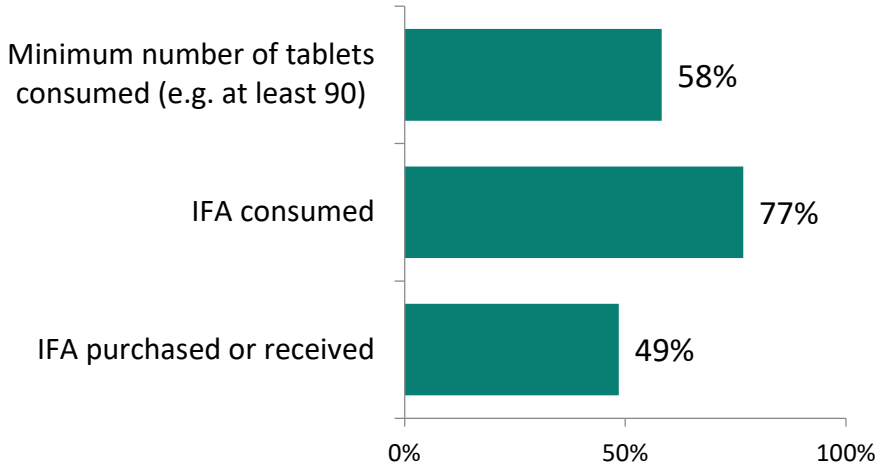
Is data available as frequently as you'd like it to be?		
	Single country focus (N=67)	Multi-country focus (N=60)
Yes	41.8	28.3
No	58.2	71.7

Preferred frequency of data availability			
	Single country focus (N=39)	Multi-country focus (N=43)	Overall (N=82)
Every 6-10 years	0.0	0.0	0.0
Every 2-5 years	12.8	14.0	13.4
Annual	48.7	51.2	50.0
Quarterly	12.8	23.3	18.3
Monthly	23.1	7.0	14.6
Other	2.6	4.7	3.7

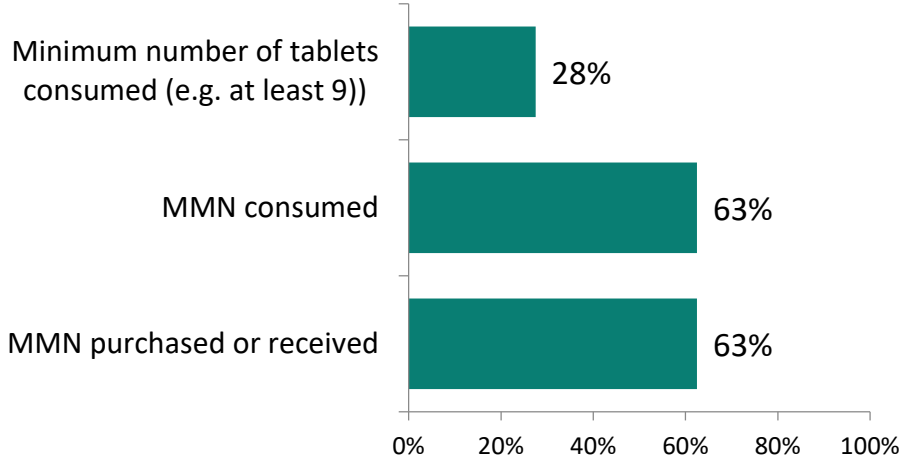
Iron Folic Acid & Multiple Micronutrients

Which indicators were used by those who reported accessing coverage or utilization data in the previous year:

Iron folic acid)
(N=103)



Multiple Micronutrient Supplementation (MMN) *
(N=40)



*Multiple responses possible

Challenges

Of those reporting data access and utilization challenges, what are the challenges you frequently experience with nutrition data?

	Overall	Single country focus	Multi-country focus
Individual (N)	**196**	**89**	**106**
Data is not available at the geographical level I need (i.e., subnational)	49.0	43.8	52.8
Data is often out-of-date so I cannot use data to make decisions as frequently as I'd like	39.3	**27.0**	50.0
Trend data does not exist / is not easily accessible so I am not clear on progress	33.7	24.7	40.6
Data is not available for the demographic group I need (i.e., sex, age, educational level, socioeconomic status)	30.6	29.2	31.1
Data is not available in raw format	28.1	25.8	29.2
Data quality cannot be trusted / is unreliable	27.0	23.6	30.2
Presented data is not adequately summarized (eg. no 95% CI's)	19.4	14.6	22.6
Data is not analyzed or visually presented so I find it difficult to interpret	17.9	21.3	14.2
The indicators I need do not have data	17.9	14.6	20.8
There are multiple statistics and definitions listed for the same indicator so I am unsure which one to reference	11.2	10.1	12.3
I am not sure which of the potential data sources is most appropriate for my needs	8.2	9.0	7.5
Data is analyzed or visually presented but I still find it difficult to interpret and translate into actionable takeaways	7.1	5.6	7.5
Others	1.5	1.1	1.9.

Open ended question to assess demand:

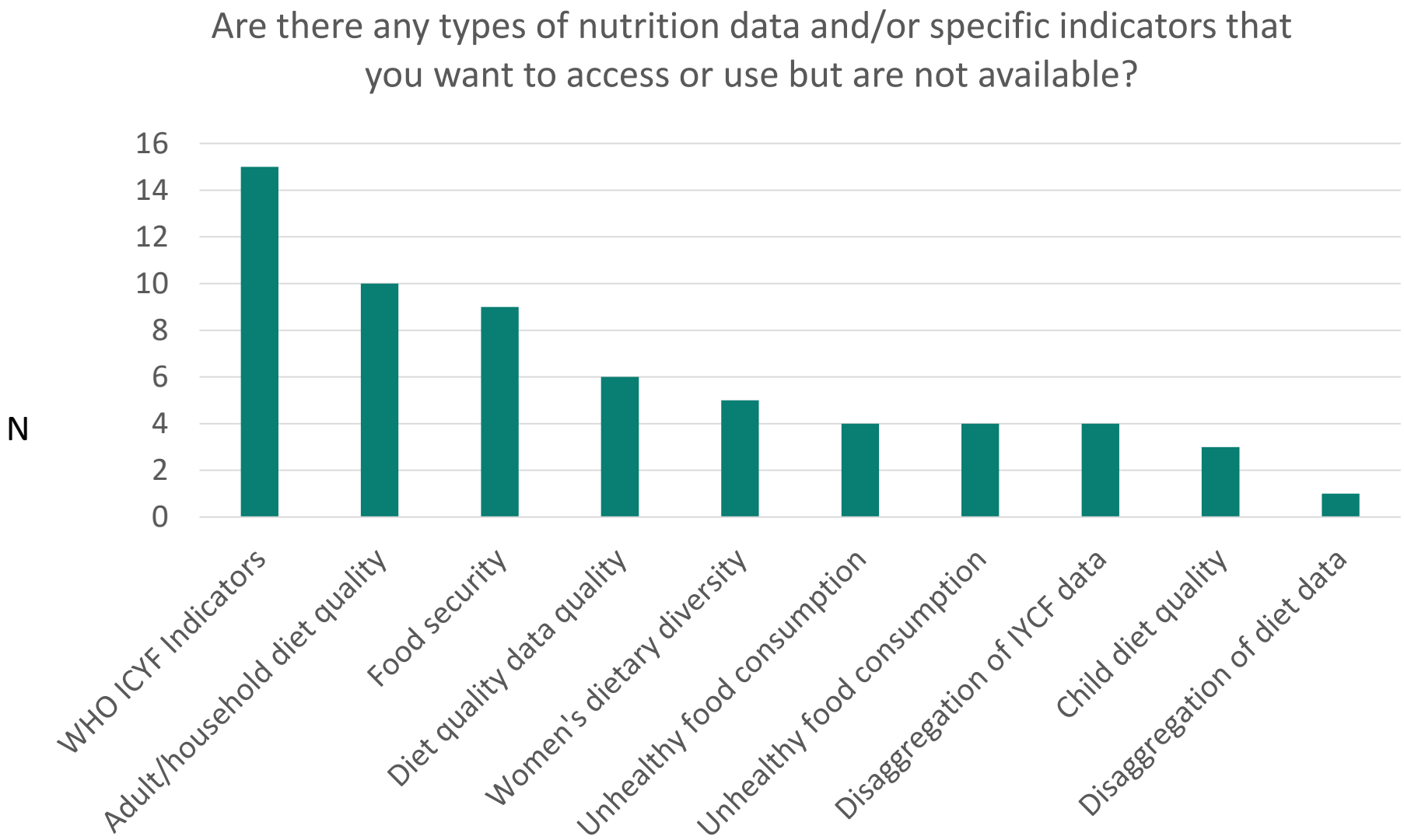
“Are there any types of nutrition data and/or specific indicators that you want to access or use but are not available?”

Excel sheet ”Open ended responses”

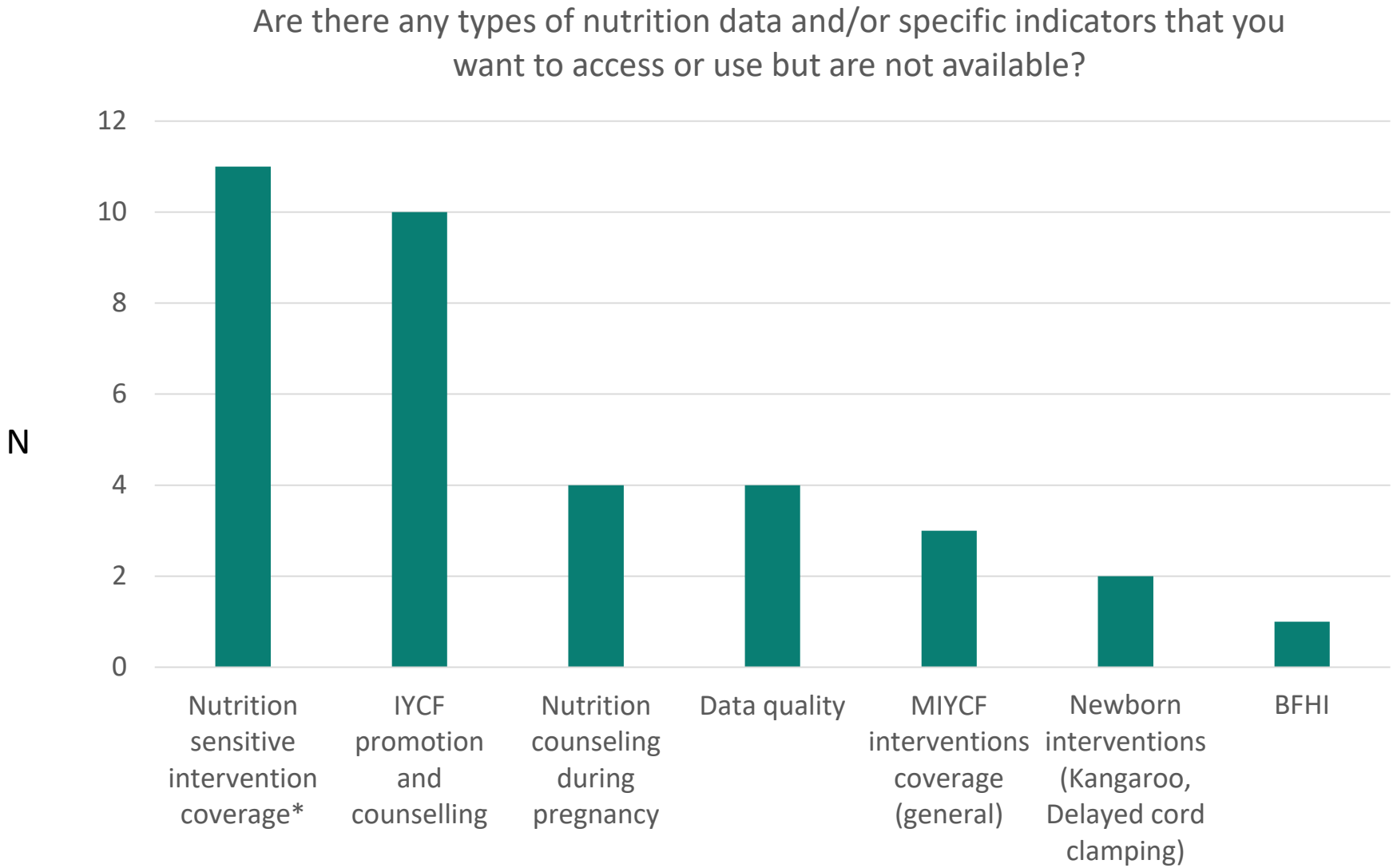
“Micronutrient status other than iron, vitamin A-particularly nutrients that may relate to anemia”

“Exclusive breastfeeding during the period since birth, not just on a single day”

Coverage data: Demand (IYCF practices/Diet)



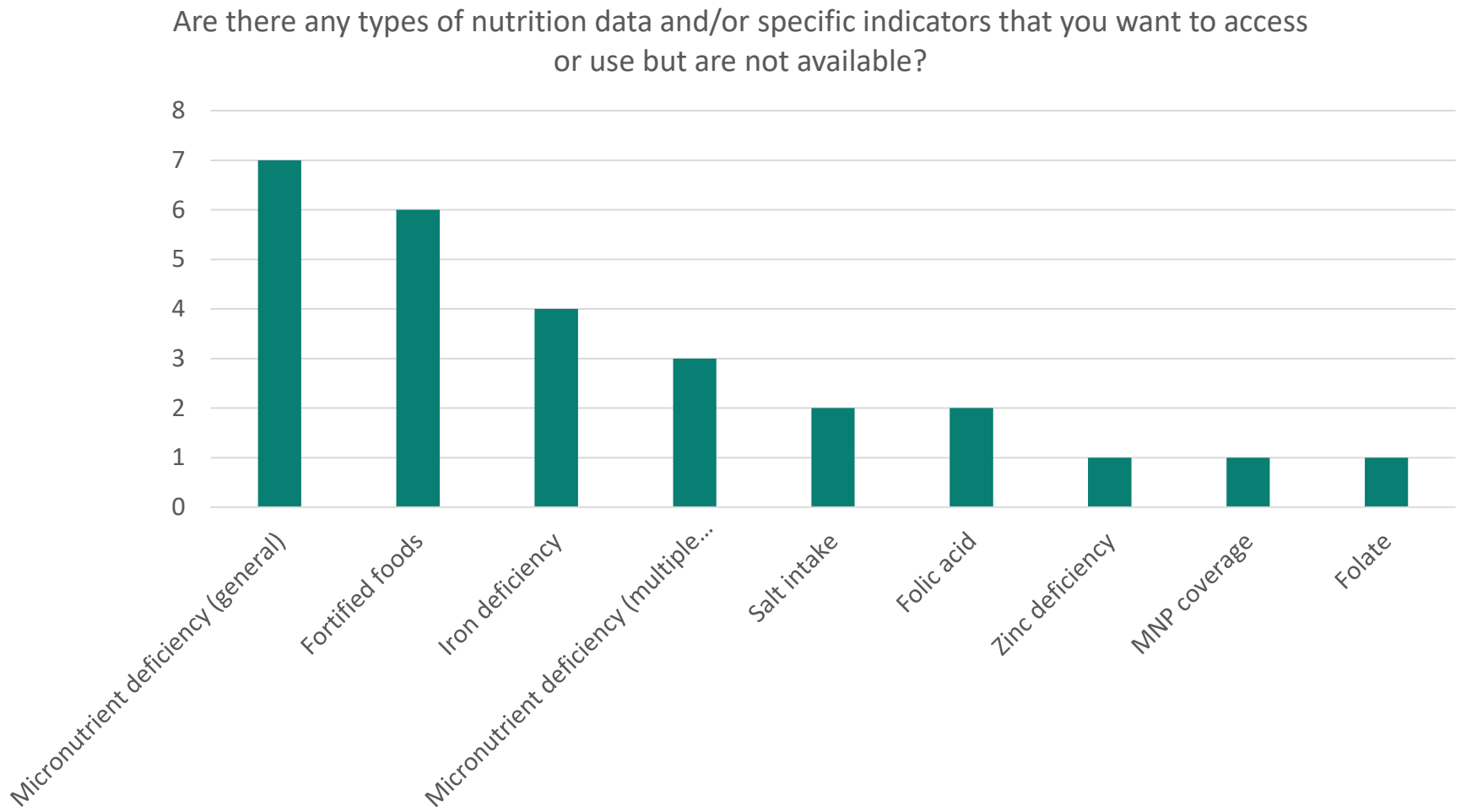
Coverage data: Demand related to MIYCN Coverage



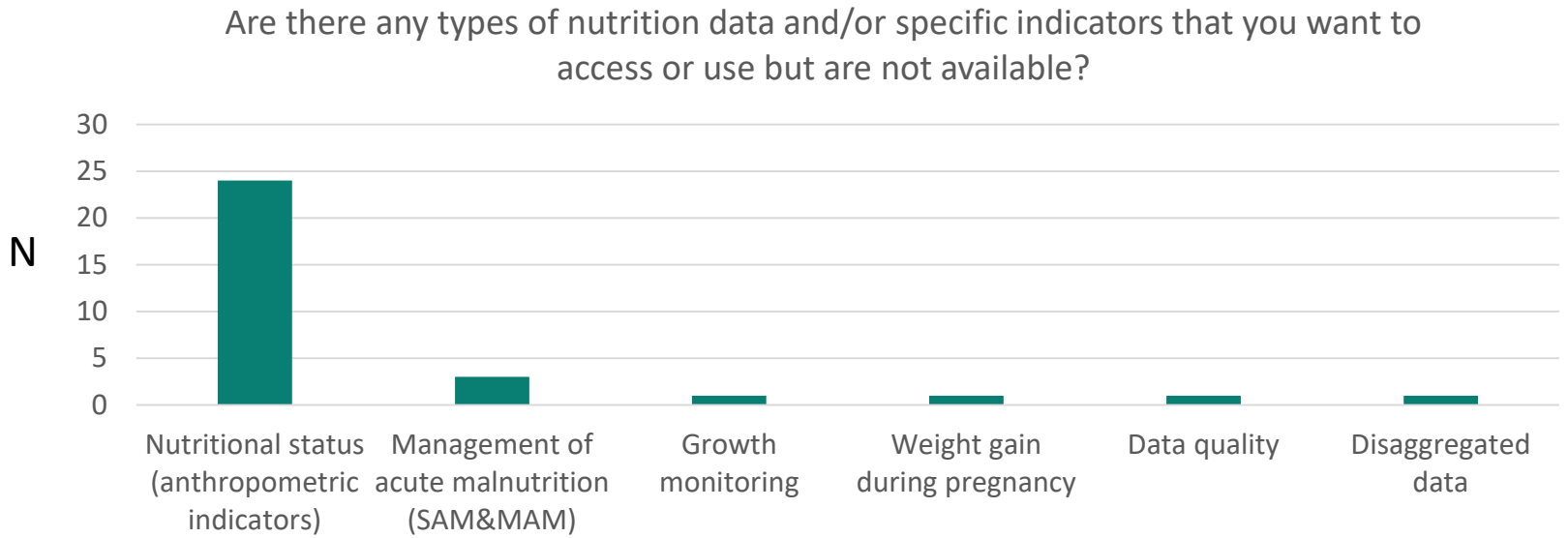
*WASH, Agriculture

Coverage data: Demand (Micronutrients)

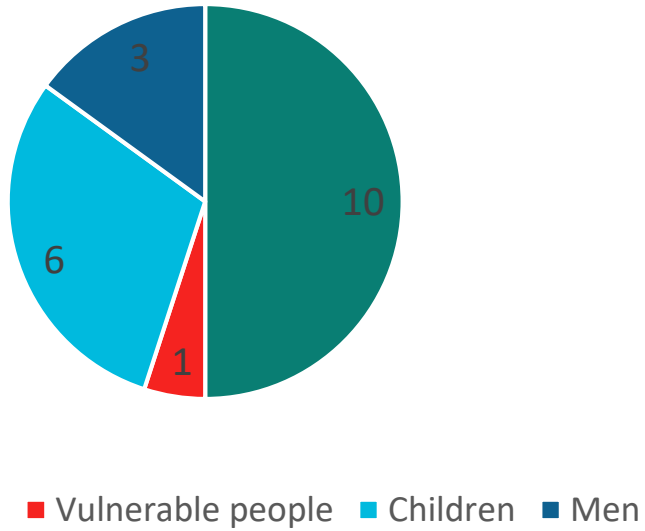
N



Coverage data: Demand (Growth)



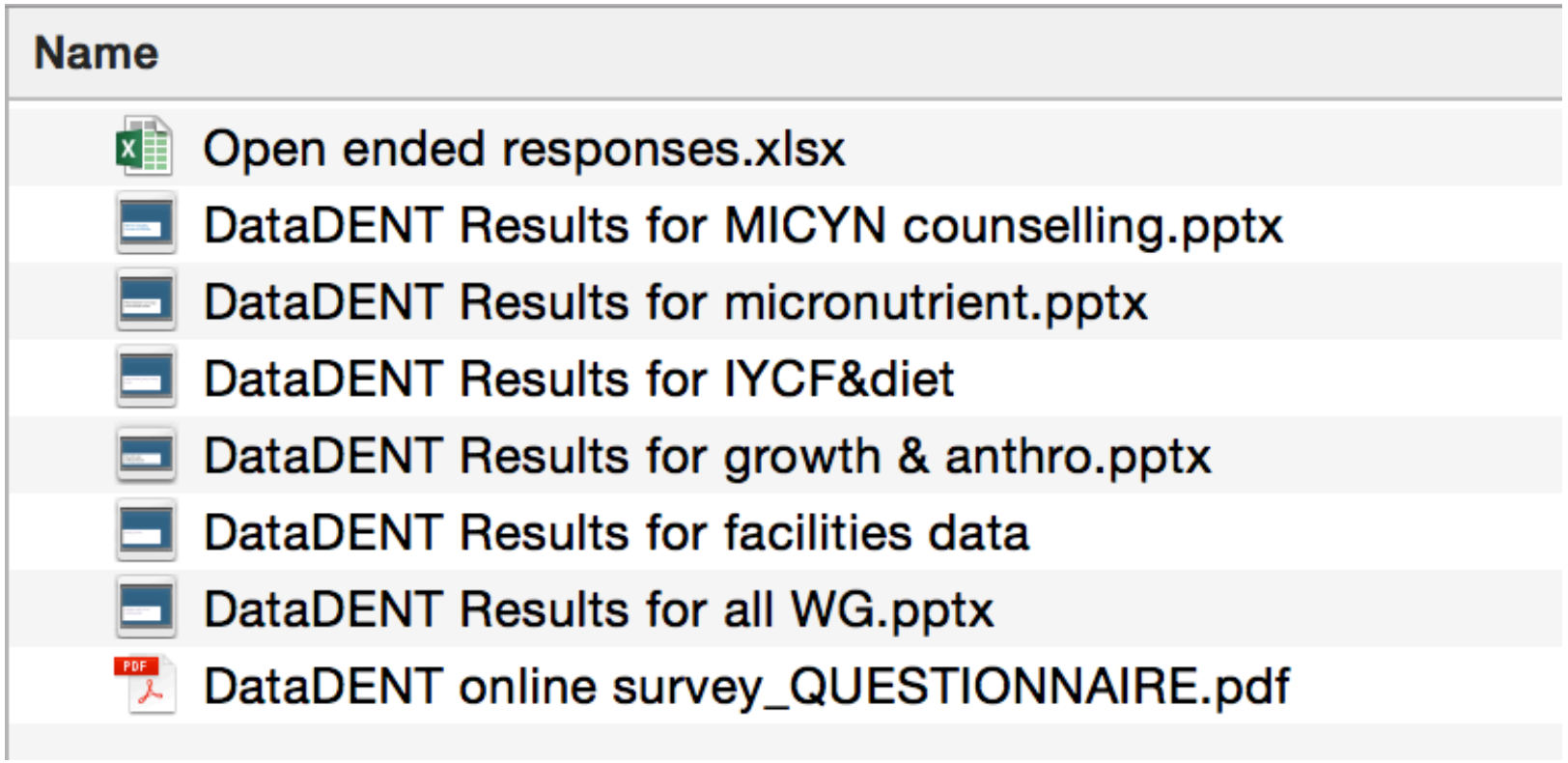
Nutritional status: Breakdown of populations mentioned



Of those who mentioned a specific population for nutritional status, half wanted data on adolescents.

More detailed analyses for each working group in Dropbox:

Working group resources->Findings from online demand survey



Discussion questions

- Did anything surprise you?
- Did you have any clarifications?
- How representative do you think the sample is of the nutrition community or your own personal observations?
- What are the implications of the findings for prioritization of data?
- Any additional analyses/follow up questions that you think would be useful?

Plenary 2

Overview of major nutrition-related household survey platforms

USAID
FROM THE AMERICAN PEOPLE

The DHS Program Demographic and Health Surveys

A Project Funded by
The United States Agency for International Development and
Implemented by ICF

Sorrel Namaste

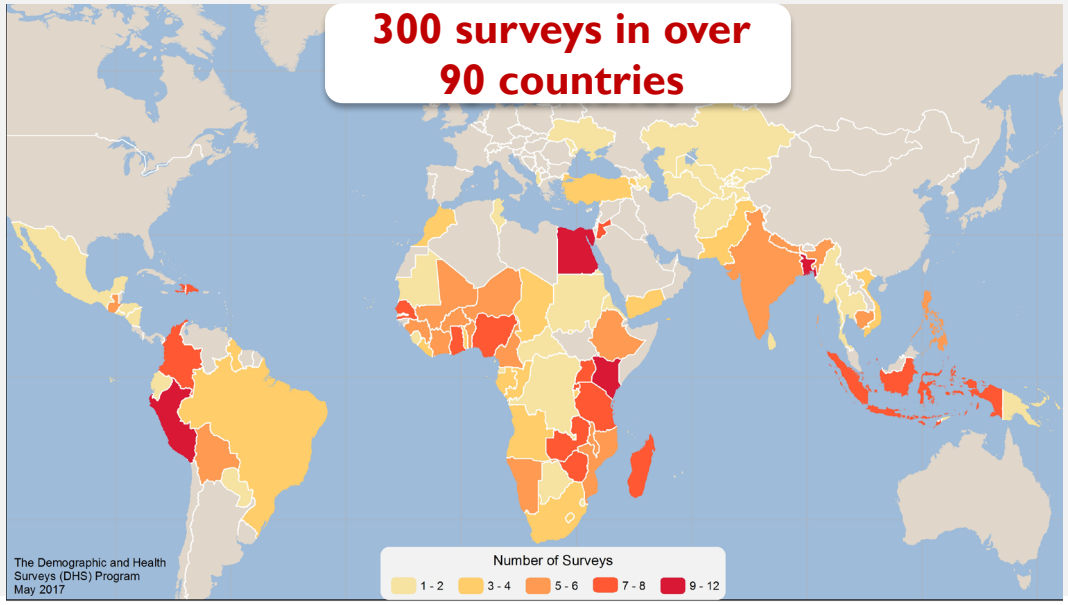
Senior Nutrition Technical Advisor

What is The DHS Program?

A USAID-funded project that provides technical assistance to:

- *improve* the collection, analysis and presentation of population, health, and nutrition data
- facilitate *use* of these data for planning, policy-making, and program management

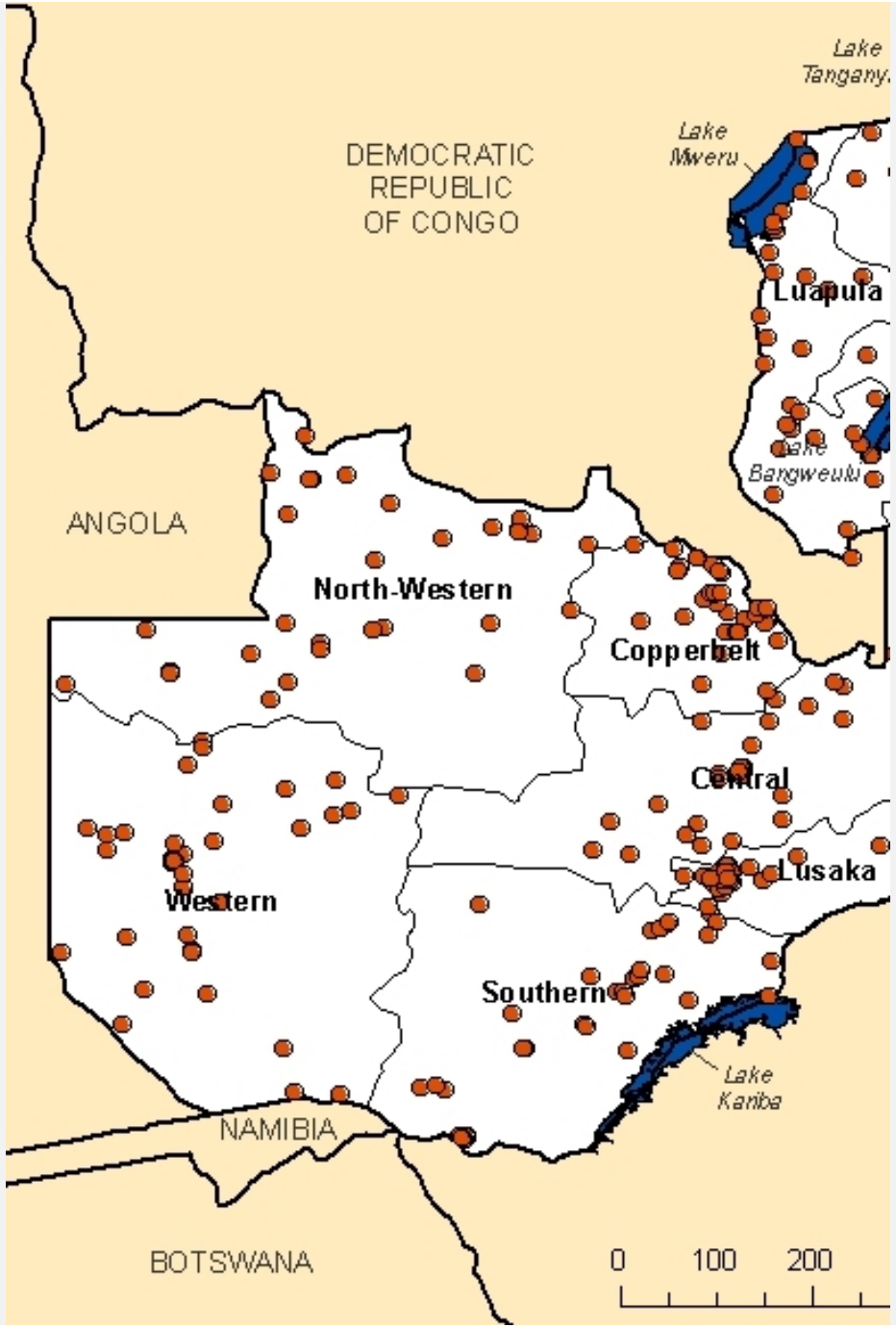
DHS-8 implemented by ICF with partners Johns Hopkins University, PATH, EnCompass, Avenir Health, Vysnova Partners, Blue Raster



DHS Sample

The DHS sample is typically representative at

- National level
- Urban and rural areas
- Regional level (sometimes groups of regions)
- Some surveys are representative at the state/provincial or district level



DHS Core Questionnaires

- Household questionnaire
- Woman's questionnaire
- Man's questionnaire
- Biomarker questionnaire
- Fieldworker questionnaire

DHS Modules

- Accident and Injury
- Adult and maternal mortality
- Disability
- Domestic violence
- Female genital cutting
- Fistula
- Male child circumcision
- Newborn care
- Non-communicable diseases
- Out-of-pocket health expenditures

Nutrition data

DHS

- Anemia
- Height and weight
- Breastfeeding/Complementary feeding
- Breastfeeding counselling
- Iodized salt in households
- Micronutrient supplementation

MIS survey

- Anemia

SPA survey

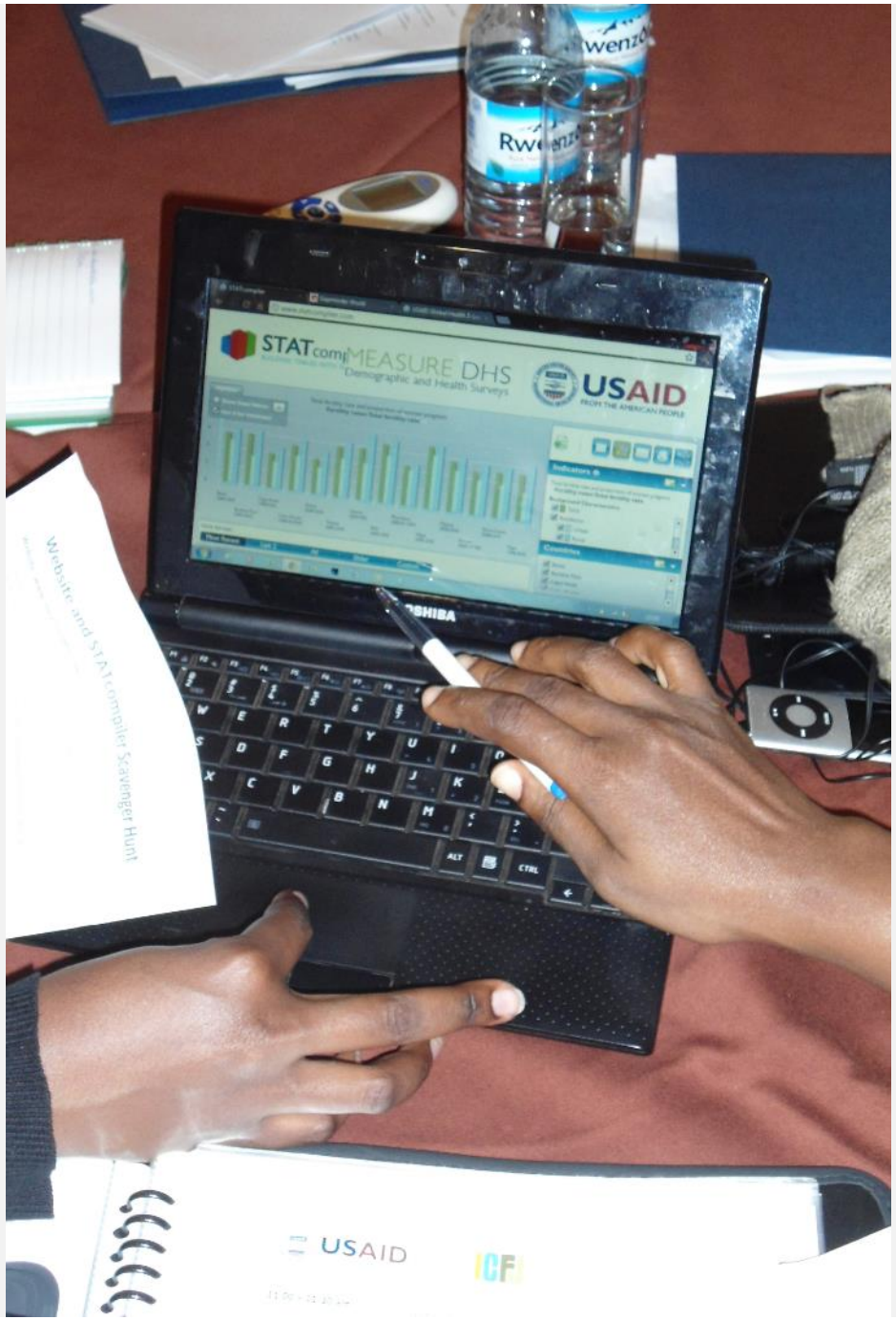
- Inventory of iron, zinc, vitamin A, scales
- Training IYCF and nutritional assessment during pregnancy
- Provision of nutrition counselling, IFA, growth monitoring, anemia assessment during pregnancy

Survey updates

- Major revisions to core questionnaire every 5 years
- Country needs met through country-specific questions
- Modules developed at any point in program cycle

DHS-7 process

- Sought public input through online platform
- DHS questionnaire design committee and content specific review groups
- Discussions with and final approval by USAID



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Plenary 2: Overview of major nutrition-related HH survey programs

Technical Consultation on Measuring Nutrition in Population-Based Household Surveys and Associated Facility Assessments

Washington DC, 19 September, 2018

Presented by:

Bo Robert Beshanski-Pedersen, Household Survey Consultant, UNICEF HQ MICS Team

MICS

Generating evidence to deliver for children

Overview

- Indicator-based survey
- Objective: A tool for countries to collect internationally comparable data on indicators of the situation of children, adolescents, women and households.
- Currently implementing a new overall management structure.
- Partnerships include
  - Groups: Intersecretariat Working Group on Household Surveys, International Household Survey Network and the DHS-MICS-LSMS Collaborative Group. The latter accompanied by (decades of) increasingly extensive informal communication.
  - Reference groups, often spearheaded by data focal points in UNICEF's Data & Analytics Section, developing "internationally agreed" indicators, supported or accompanied by MICS staff.
  - Globally, UN sister agencies are "partners": collaboration on indicators and modules suitable for MICS.
  - Locally and regionally, UN agencies partner on content, as do bilaterals and a variety of international organisations.

Geographical focus

22
Years

112
Countries

306
Surveys

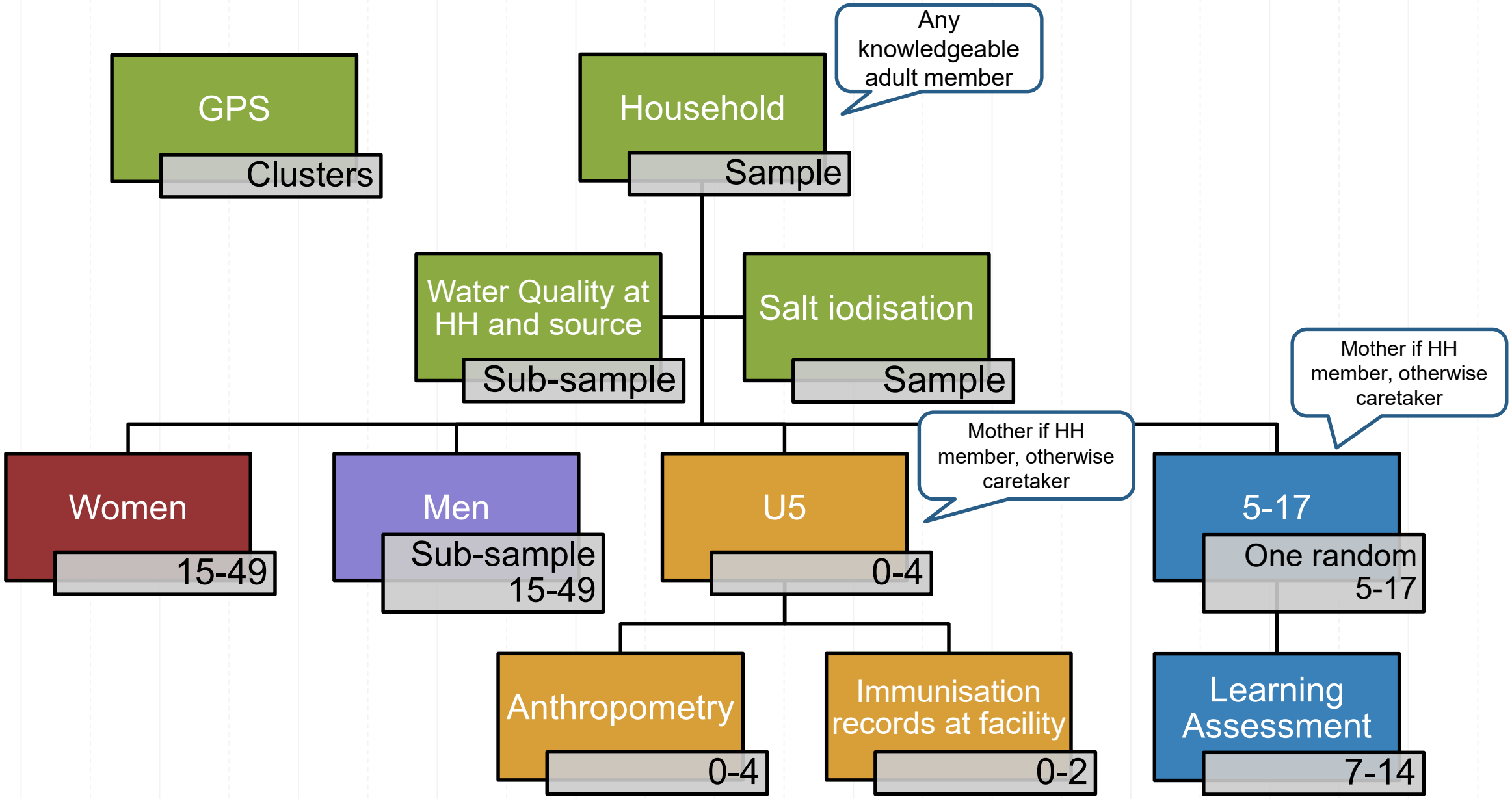
Historical emphasis

Round	Year/Period	Emphasis	# of Surveys
MICS1	1995	World Summit for Children Goals	63
MICS2	2000	World Summit for Children Goals	66
MICS3	2005-09	World Fit For Children Goals, MDGs, Other Global Monitoring Frameworks	53
MICS4	2009-13	MDGs, Other Global Monitoring Frameworks	60
MICS5	2013-16	Final MDG Assessment, A Promise Renewed, Other Global Monitoring Frameworks, baseline for post 2015 goals/targets	52
MICS6	2016-20	SDGs, other globally recommended indicators, new topics, emerging issues	60

Sampling Design

- Multi-stage, stratified cluster design, usually drawn on census with updated household listing
- National surveys, usually representative at 1st geographic division
- Frequent additional stratification with oversampling of target population: U5s, ethnic groups, geographic areas, women 15-24, and exclusive sub-national/population samples
- Median size currently at about 12,000, mean is increasing to above
- Foundation is key indicators, cost, feasibility

Survey Structure



Survey Structure

HOUSEHOLD

List of Household Members
Education [3+]
Household Characteristics
Social Transfers
Household Energy Use
Insecticide-Treated Nets
Water and Sanitation
Handwashing
Salt Iodisation

WATER QUALITY

GPS DATA COLLECTION

WOMEN AGE 15-49

Woman's Background
Mass Media and ICT
Fertility/Birth History
Desire for Last Birth
Maternal and Newborn Health
Post-natal Health Checks
Contraception
Unmet Need
Female Genital Mutilation
Attitudes toward Domestic Violence
Victimization
Marriage/Union
Adult Functioning [18-49]
Sexual Behaviour
HIV/AIDS
Maternal Mortality
Tobacco and Alcohol Use
Life Satisfaction

MEN AGE 15-49

Man's Background
Mass Media and ICT
Fertility
Attitudes toward Domestic Violence
Victimization
Marriage/Union
Adult Functioning [18-49]
Sexual Behaviour
HIV/AIDS
Circumcision
Tobacco and Alcohol Use
Life Satisfaction

CHILDREN AGE 5-17

Child's Background
Child Labour
Child Discipline [5-14]
Child Functioning
Parental Involvement [7-14]
Foundational Learning Skills [7-14]

CHILDREN UNDER 5

Under-Five's Background
Birth Registration
Early Childhood Development
Child Discipline [1-4 years]
Child Functioning [2-4 years]
Breastfeeding and Dietary Intake [0-2 years]
Immunisation [0-2 years] incl. Facility Form
Care of Illness
Anthropometry

Survey Structure

HOUSEHOLD

List of Household Members
Education [3+]
Household Characteristics
Social Transfers
Household Energy Use
Insecticide-Treated Nets
Water and Sanitation
Handwashing
Salt Iodisation

WATER QUALITY

GPS DATA COLLECTION

WOMEN AGE 15-49

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Maternal Mortality
Tobacco and Alcohol Use
Life Satisfaction

MEN AGE 15-49

Man's Background
Mass Media and ICT
Fertility
Attitudes toward Domestic Violence
Victimization
Marriage/Union
Adult Functioning [18-49]
Sexual Behaviour
HIV/AIDS
Circumcision
Tobacco and Alcohol Use
Life Satisfaction

CHILDREN AGE 5-17

Child's Background
Child Labour
Child Discipline [5-14]
Child Functioning
Parental Involvement [7-14]
Foundational Learning Skills [7-14]

CHILDREN UNDER 5

Under-Five's Background
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Child Functioning [2-4 years]
Breastfeeding and Dietary Intake [0-2 years]
Immunisation [0-2 years] incl. Facility Form
Care of Illness
Anthropometry

Nutrition content

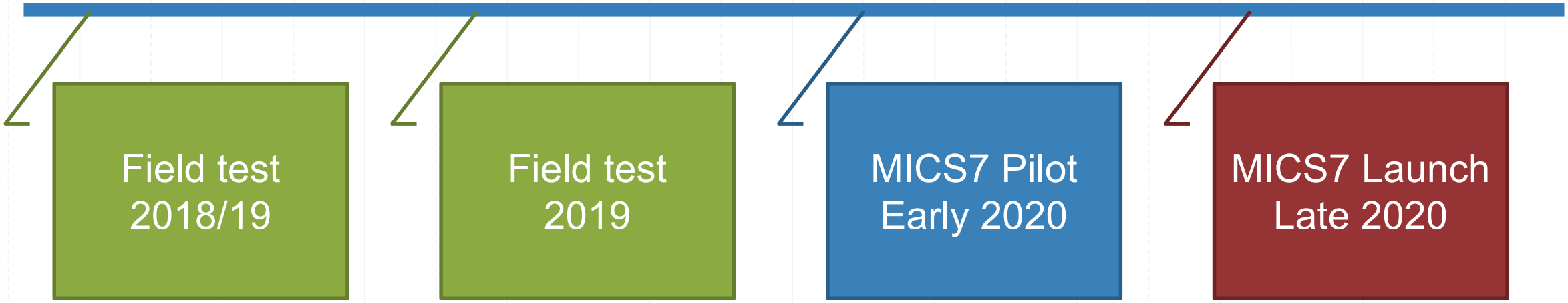
Salt
Iodized salt consumption

At birth
Children weighed at birth
Newborn feeding*
Post-natal signal care functions

IYCF	
Children ever breastfed	Introduction of solid, semi-solid or soft foods
Early initiation of breastfeeding	Minimum acceptable diet
Exclusive breastfeeding under 6 months	Milk feeding frequency for non-breastfed children
Predominant breastfeeding under 6 months	Minimum dietary diversity
Continued breastfeeding at 1 year	Minimum meal frequency
Continued breastfeeding at 2 years	Bottle feeding
Duration of breastfeeding	
Age-appropriate breastfeeding	

Anthropometry
Underweight prevalence
Stunting prevalence
Wasting prevalence
Overweight prevalence

Survey update timeline



- New or significantly changed content is typically individually tested, before inclusion in Field test, depending on source and history.
- MICS6 preceded by 1 Field test and Pilot (all rounds) in late 2015 and mid-2016, respectively. MICS6 launched late 2016
- Field test in 2017. Content for end-2018 Field test is currently in discussion and development.

Survey update process – MICS7

Already too big

Demand for new

Constant changes to old

CORE

CRITERIA CURRENTLY ALIGNING TOWARDS

- SDG indicator
- Universality

(demand/applicability)

- Child-specific
- Doable

(feasible, structurally appropriate, cost, burden, quality, utility, robust data)

+

THE REST:

Optional

(With criteria)

EVERYTHING NEW:

Validated

Tested by MICS

Plenary 1

Results from a nutrition stakeholder survey of data use and needs

Data DENT

Data for Decisions to Expand Nutrition Transformation

Results from a nutrition stakeholder survey of data use and needs

Andrew Thorne-Lyman

Johns Hopkins Bloomberg School of Public Health

Acknowledgements

From DataDENT/JHU

- Rebecca Heidkamp
- Audrey Buckland
- Shannon King
- Tricia Aung

From Bill & Melinda Gates Foundation

- Rahul Rawat
- Ellen Piwoz

Special thank you to all of you who took the survey!

Presentation overview

- Description of the survey sample
- Key high level findings of relevance to this meeting
- Examples of the types of data that are available in dropbox
- Disclaimer: Analysis is still preliminary (ideas welcome)
- Please do not circulate

Survey objectives

- Understand…
  - What types of data are the nutrition community using?
  - How does this vary by user types?
  - What data needs are not being met, and why not?
- Explore variation by different types of stakeholders
- Bring the perspectives of the wider community into this room
- Survey was also part of a bigger effort

Methods

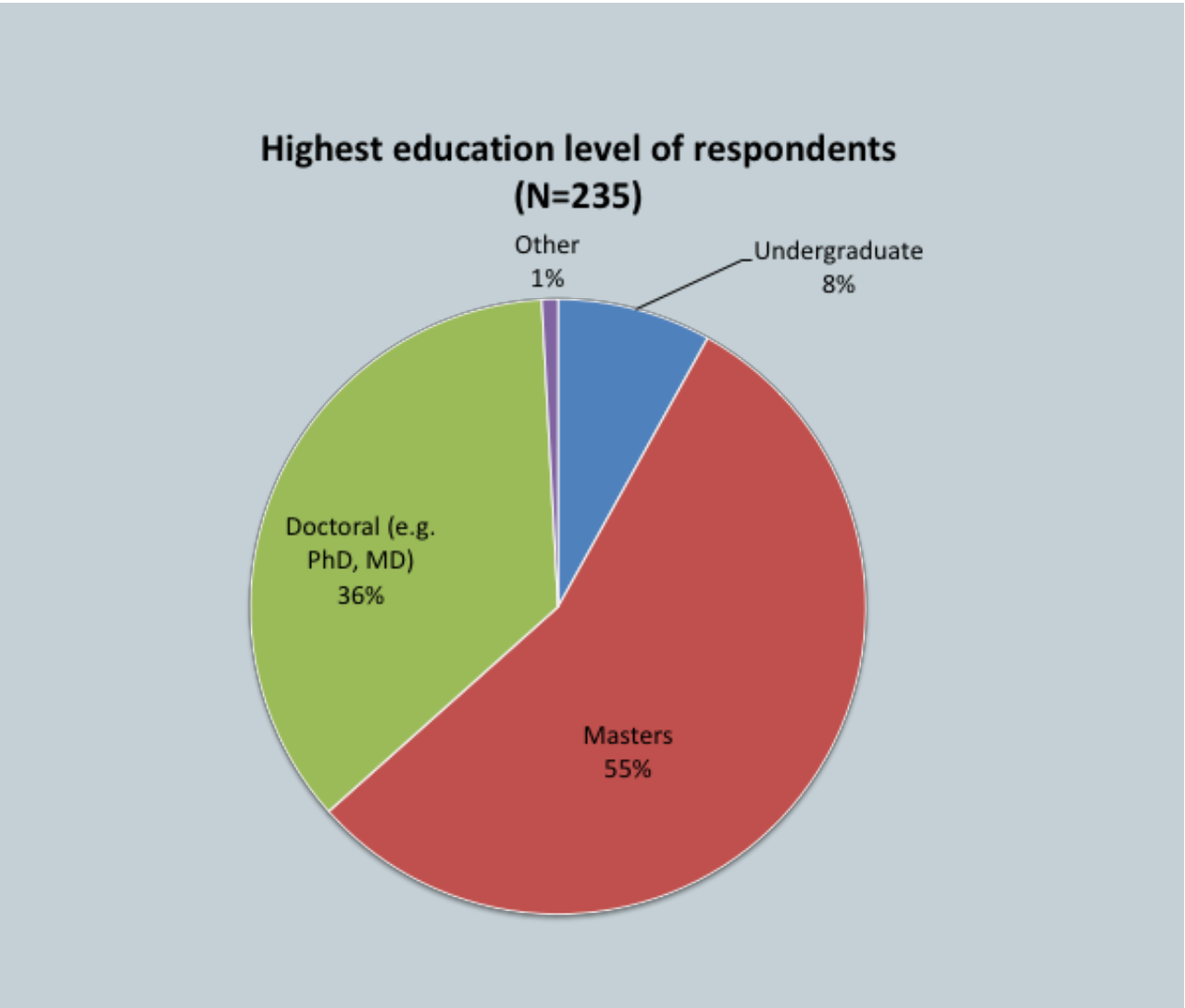
- Survey created using Qualtrics
- Disseminated through:
  - Online nutrition listservs (Ag2Nut etc)
  - Networks (SUN, Unicef, BMGF, JHU)
- Data collected July 16-August 16
- 264 survey responses received, 235 with responses beyond identifiers
- Denominator for questions varied due to non-completions
- Respondents made good use of multiple response options!

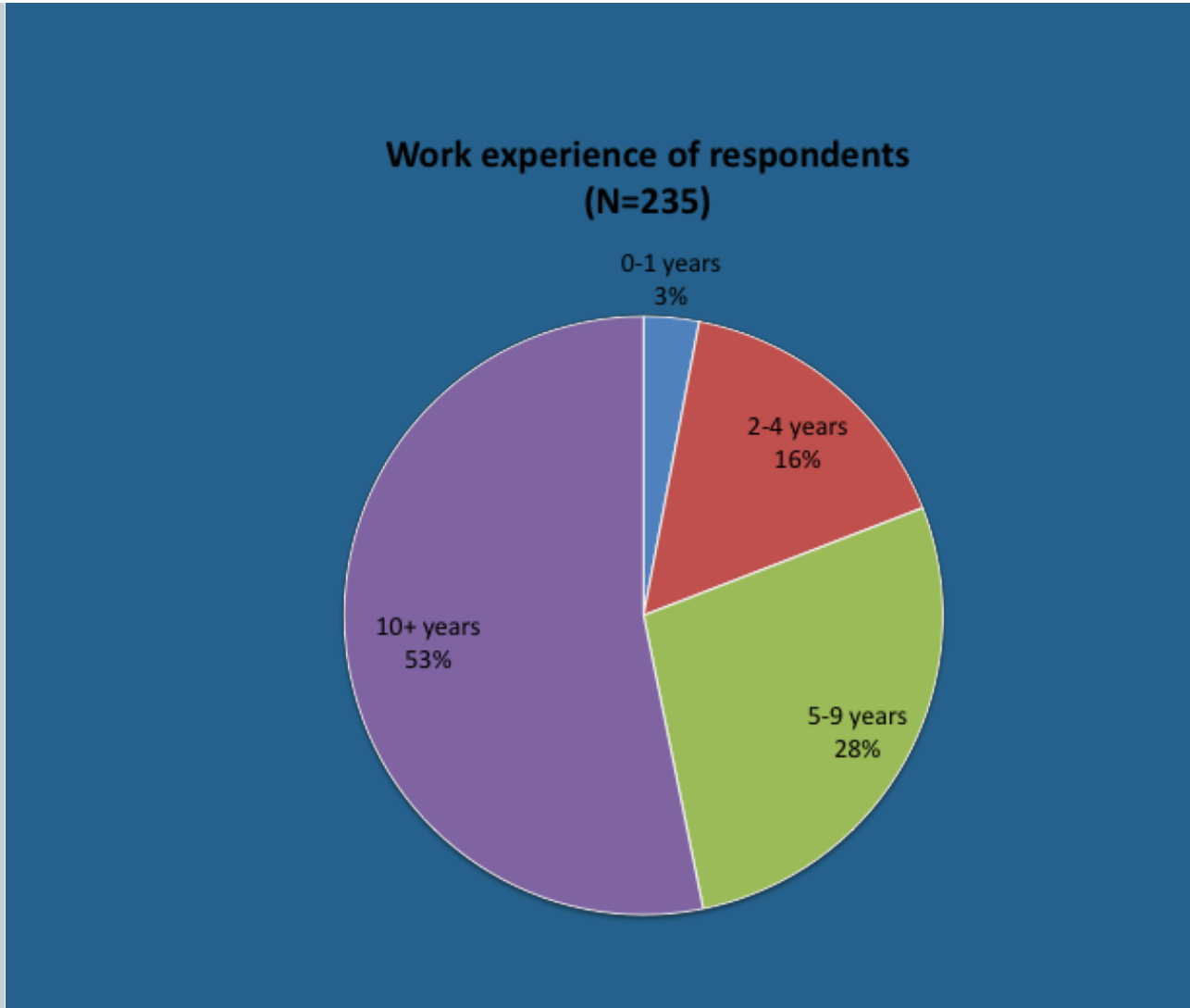
Factors we can disaggregate by:

- Single vs. multi country focus
- Type of organization
- Country or region (not in this presentation)

First a bit about the surveyed population

Respondents were well educated and experienced!

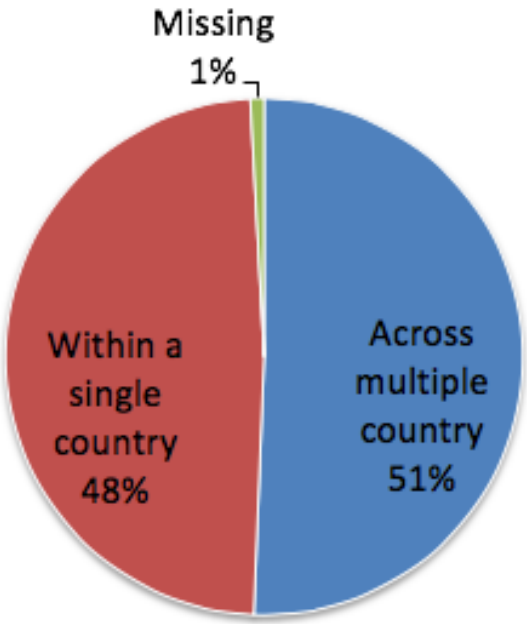




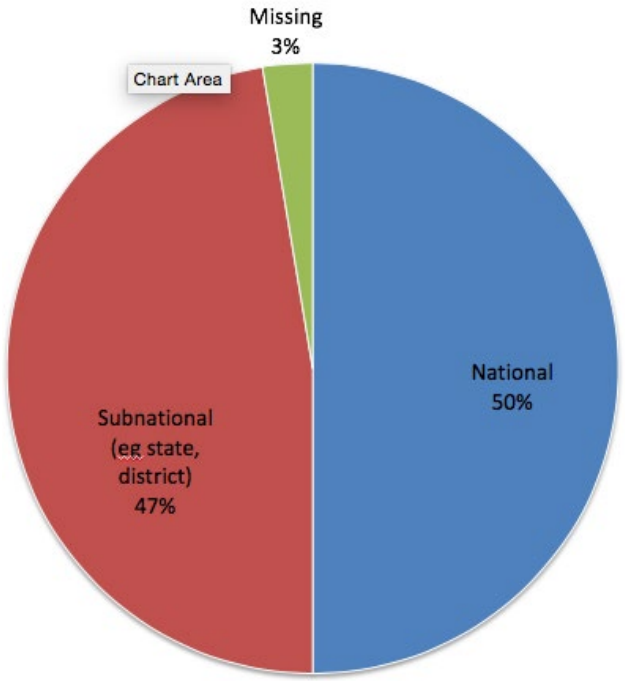
In the past 12 months, which countries has your work related to? (select all)

Country	Responses
Ethiopia	54
India	52
Kenya	42
Bangladesh	42
Nigeria	39

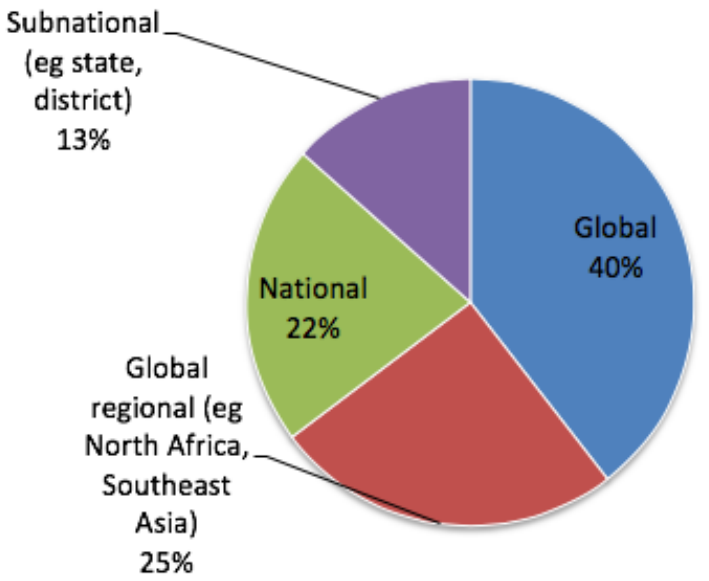
OVERALL SAMPLE
(N=235)



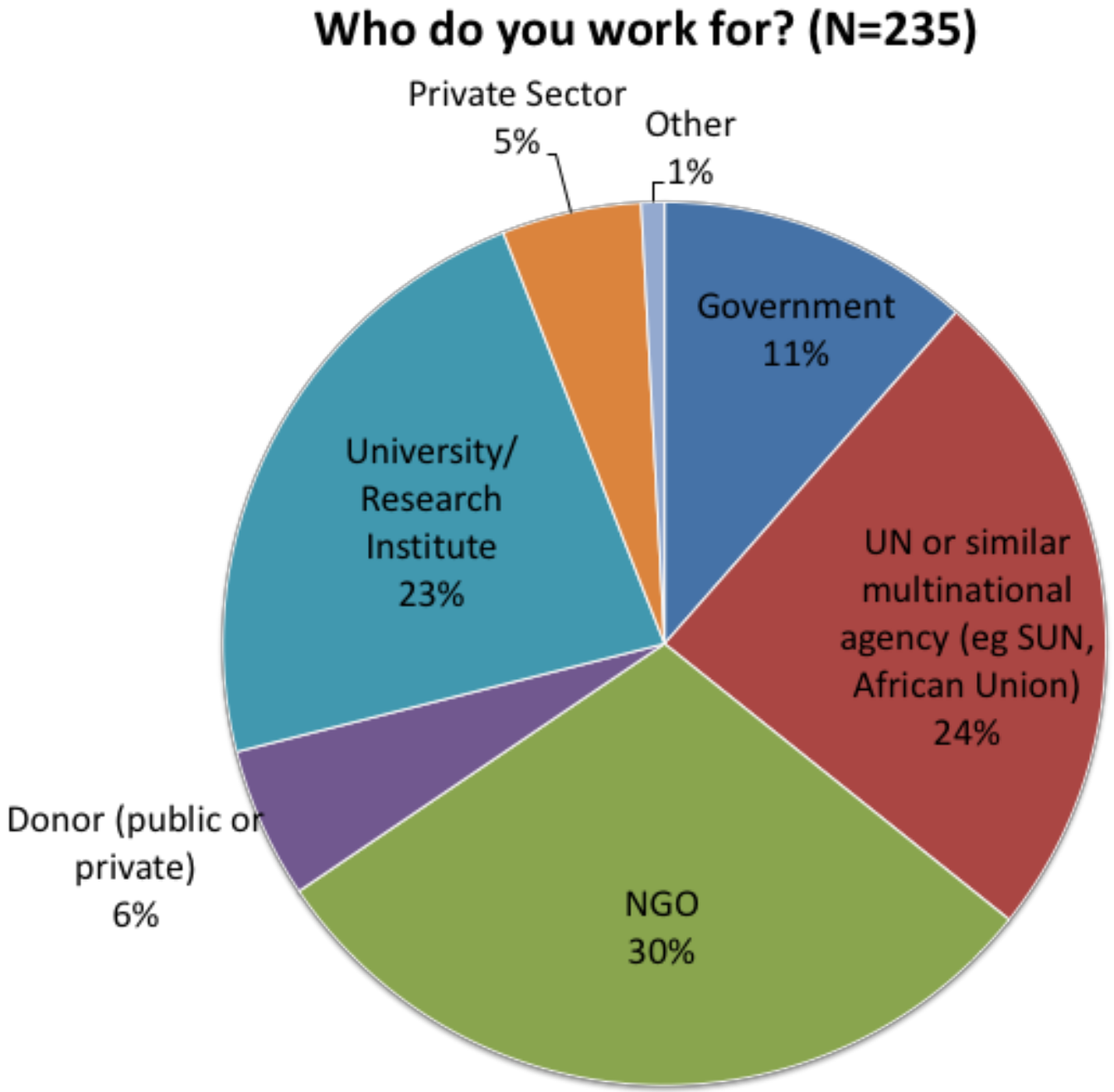
SINGLE COUNTRY FOCUS
(N=114)

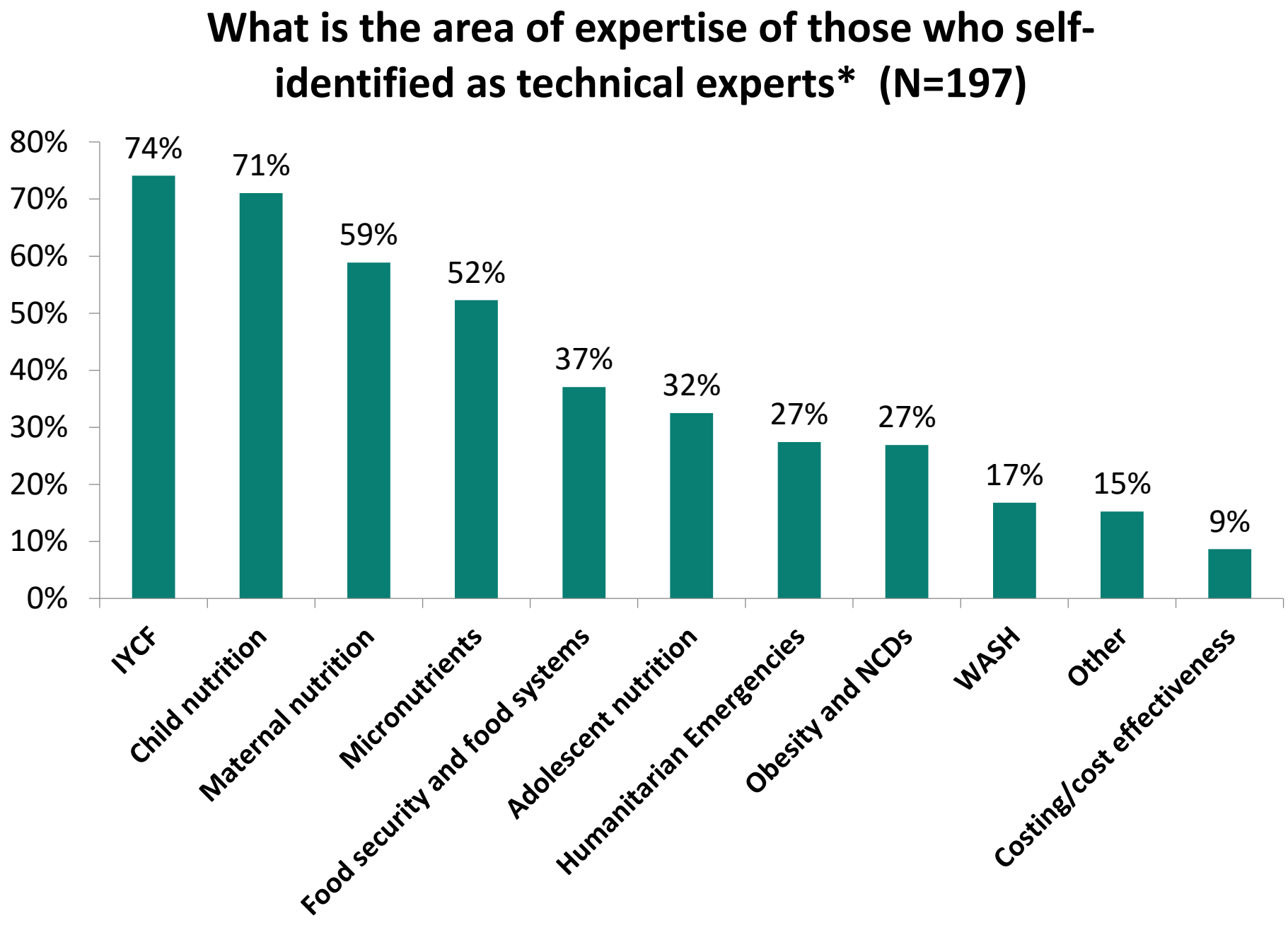


MULTI COUNTRY FOCUS
(N=119)

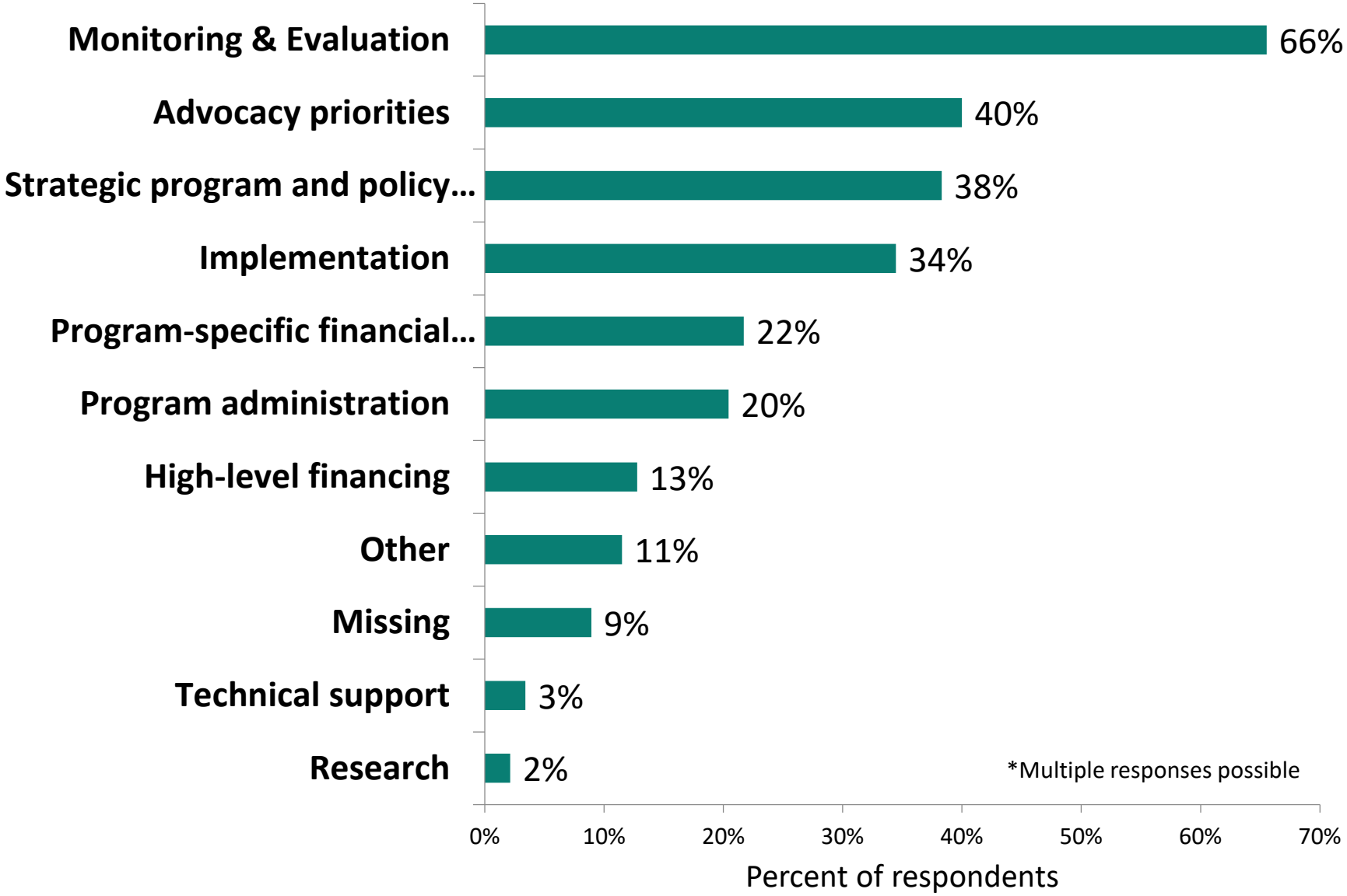


Sample included a good range of geographical focus


Who do you work for? (N=235)
Private Sector 5%
Other 1%
Government 11%
UN or similar multinational agency (eg SUN, African Union) 24%
NGO 30%
Donor (public or private) 6%
University/ Research Institute 23%


What is the area of expertise of those who self-identified as technical experts* (N=197)
80%
70%
60%
50%
40%
30%
20%
10%
0%
74%
71%
59%
52%
37%
32%
27%
27%
17%
15%
9%
IYCF
Child nutrition
Maternal nutrition
Micronutrients
Food security and food systems
Adolescent nutrition
Humanitarian Emergencies
Obesity and NCDs
WASH
Other
Costing/cost effectiveness

What type of decisions do you make in your current professional role?* (N=235)



Where do people access nutrition data?

National data sources accessed in the past year

	Overall	Single country focus	Multi-country focus
Individual (N)	**191**	**88**	**102**
Demographic Health Survey (DHS)	73.8	60.2	**85.3**
Multiple Indicator Cluster Survey (MICS)	41.9	15.9	64.7
Other National Nutrition Survey (e.g. micronutrient survey)	40.8	44.3	38.2
National survey using SMART methodology	39.3	29.5	48.0
National Dietary Intake / Food Consumption Survey	33.5	37.5	30.4
Sub-national survey using SMART methodology	33.0	26.1	38.2
DHIS-2 / similar online HMIS portal	32.5	33.0	31.4
Health Management Information System (HMIS) (not web-based portal)	28.3	26.1	29.4
Household, Income, Consumption & Expenditure survey	18.3	19.3	17.6
National food security "hot spot" monitoring system / FEWS-NET	18.3	15.9	19.6
World Bank Living Standard Measurement Studies(LSMS)	15.2	4.5	24.5
WFP Food Security Monitoring System (FSMS) (eg. mVAM monitoring/Food Security Bulletins)	13.6	6.8	19.6
Other survey specific to program or policy-(please specify all others used)	13.1	12.5	12.7
WFP Comprehensive Food Security and Vulnerability Assessments (CFSVA)	12.0	6.8	16.7
Other national household surveys with nutrition data (specify all name(s))	11.0	12.5	9.8
Service Provision Assessment (SPA)	11.0	6.8	14.7
WFP Emergency Food Security Assessment (EFSA)	9.9	6.8	12.7
Demographic surveillance sites (DSS)	9.9	13.6	6.9

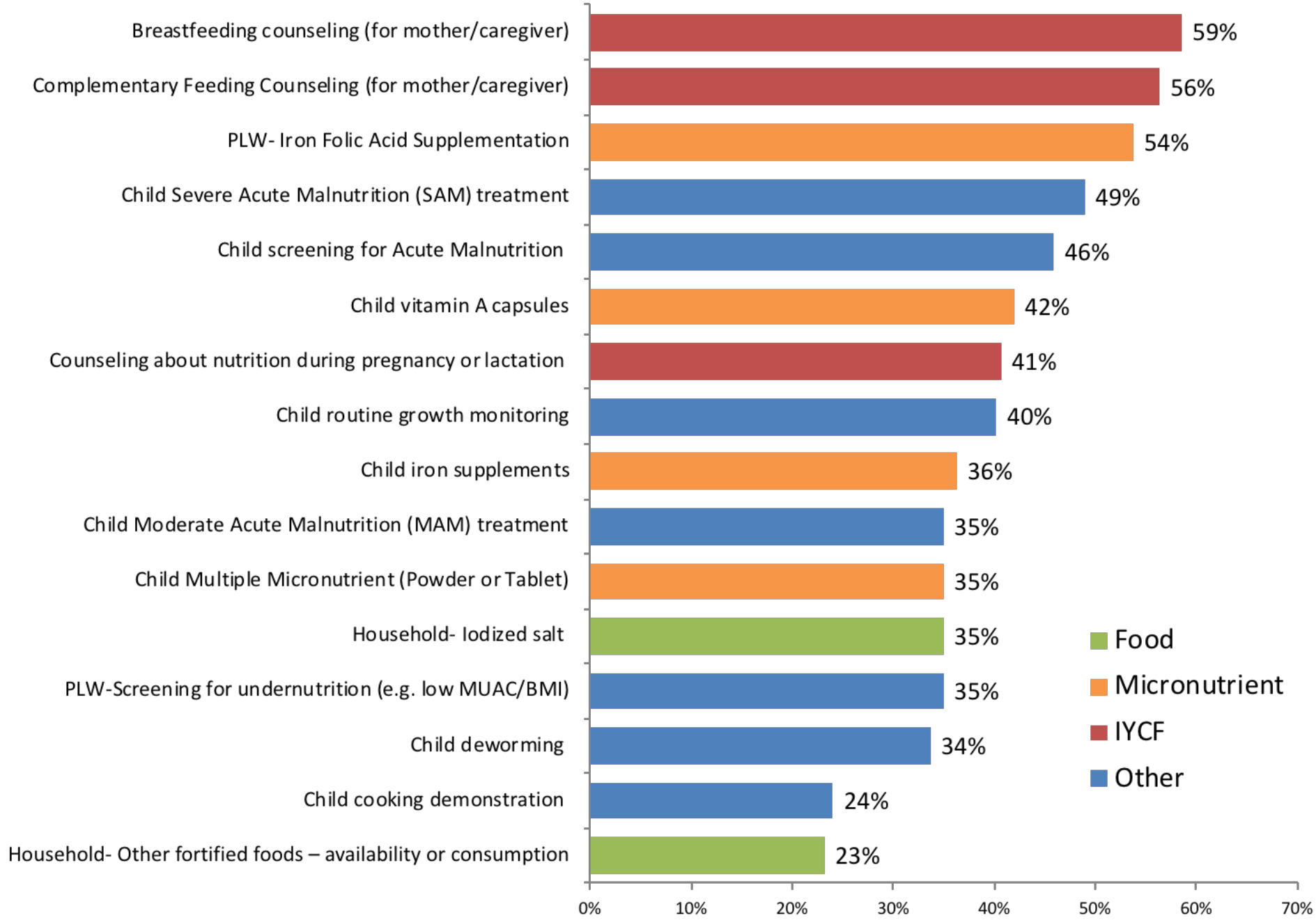
Global/Aggregated data sources accessed in the past year

	Overall	Single country focus	Multi-country focus
Individual (N)	**177**	**76**	**100**
Global Nutrition Report	**75.1**	65.8	82.0
UNICEF State of the World's Children Report	56.5	42.1	**68.0**
UNICEF, WHO and the World Bank Joint Malnutrition Estimates	39.0	28.9	**47.0**
UNICEF Nutrition datasets*	38.4	27.6	**46.0**
FAO The State of Food security and Nutrition in the World	36.2	30.3	40.0
World Bank Nutrition Country Profiles	35.6	30.3	39.0
Scaling up Nutrition Monitoring, Evaluation, Accountability and Learning (MEAL)	32.2	32.9	32.0
WHO Global Targets Tracking Tool	29.4	23.7	33.0
Countdown to 2030	28.8	21.1	35.0
WHO Global Health Observatory	24.3	21.1	27.0
FAO Country Indicators	19.8	14.5	24.0
WHO Vitamin & Mineral Nutrition Information Systems	18.6	13.2	22.0
WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene	14.1	3.9	22.0
IHME Global Burden of Disease	13.6	5.3	20.0
Hunger and Nutrition Commitment Index Global: Country profiles	11.3	7.9	14.0
FAO/WHO Global Individual Food Consumption Data Tool (GIFT)	11.3	6.6	14.0
IHME Child Growth Failure	6.2	1.3	10.0
Other global sources	2.8	1.3	4.0

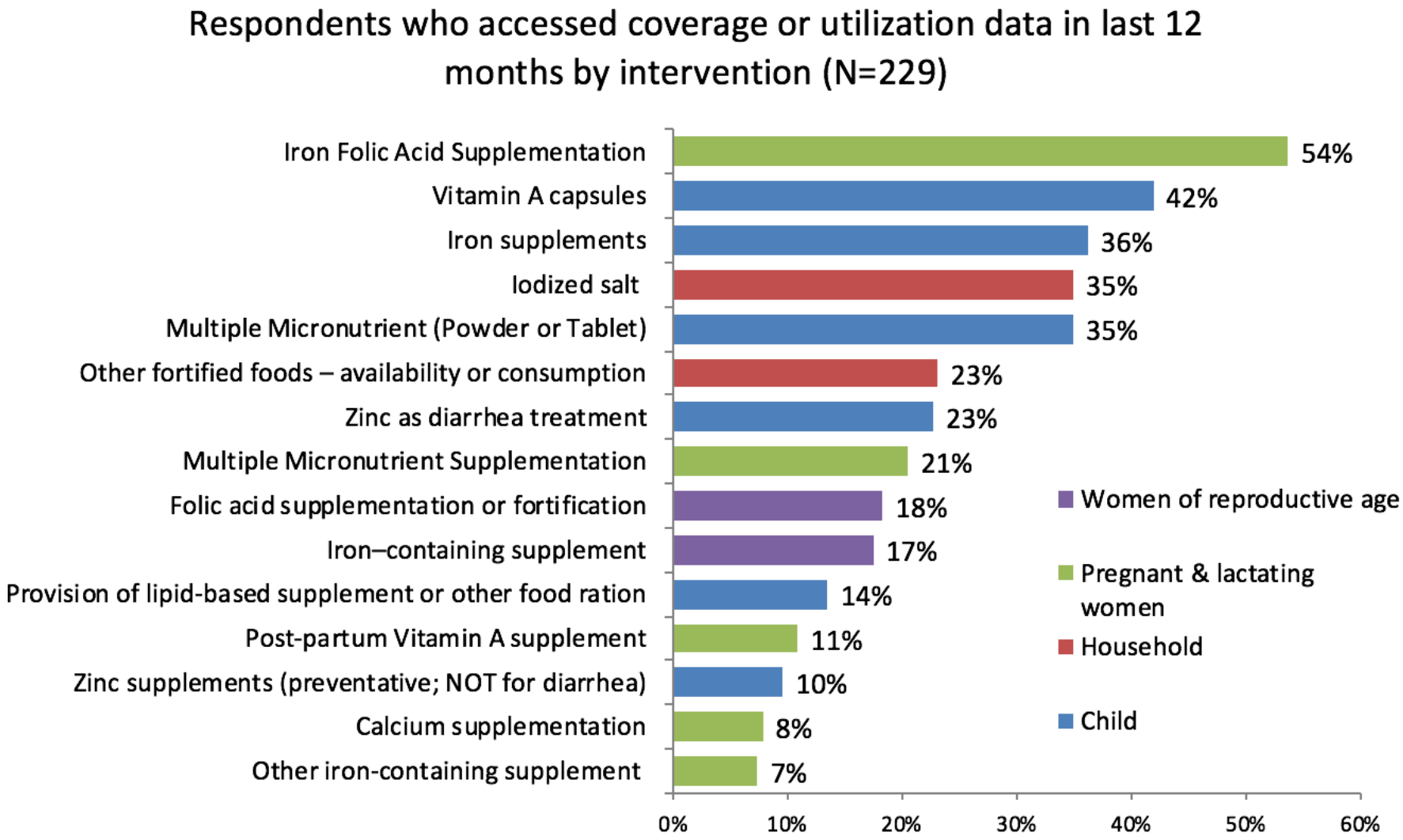
*Vitamin A indicators highlighted in VCE

What coverage data do people access?

Coverage or utilization data accessed in the past year (N=229) [1]



IFA supplementation of women was the indicator with greatest access, although child data on various micronutrients was also accessed frequently



How frequently do respondents want breastfeeding counselling data to be available?

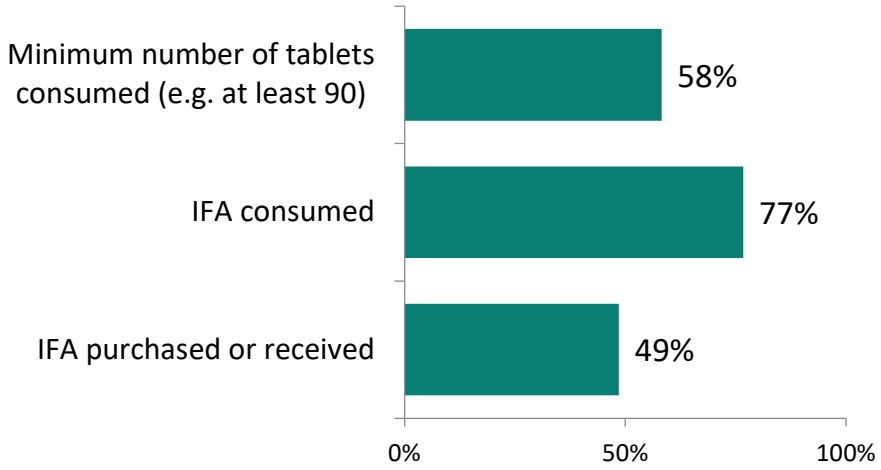
Is data available as frequently as you'd like it to be?		
	Single country focus (N=67)	Multi-country focus (N=60)
Yes	41.8	28.3
No	58.2	71.7

Preferred frequency of data availability			
	Single country focus (N=39)	Multi-country focus (N=43)	Overall (N=82)
Every 6-10 years	0.0	0.0	0.0
Every 2-5 years	12.8	14.0	13.4
Annual	48.7	51.2	50.0
Quarterly	12.8	23.3	18.3
Monthly	23.1	7.0	14.6
Other	2.6	4.7	3.7

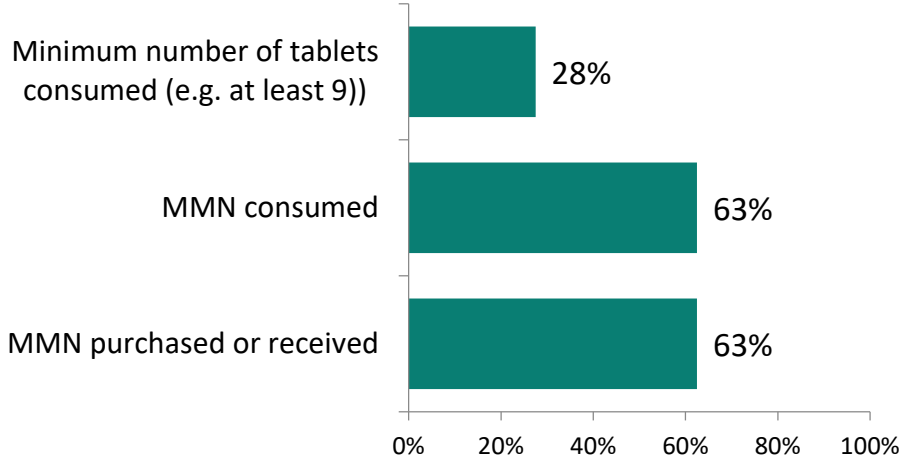
Iron Folic Acid & Multiple Micronutrients

Which indicators were used by those who reported accessing coverage or utilization data in the previous year:

Iron folic acid)
(N=103)



Multiple Micronutrient Supplementation (MMN) *
(N=40)



*Multiple responses possible

Challenges

Of those reporting data access and utilization challenges, what are the challenges you frequently experience with nutrition data?

	Overall	Single country focus	Multi-country focus
Individual (N)	**196**	**89**	**106**
Data is not available at the geographical level I need (i.e., subnational)	49.0	43.8	52.8
Data is often out-of-date so I cannot use data to make decisions as frequently as I'd like	39.3	**27.0**	50.0
Trend data does not exist / is not easily accessible so I am not clear on progress	33.7	24.7	40.6
Data is not available for the demographic group I need (i.e., sex, age, educational level, socioeconomic status)	30.6	29.2	31.1
Data is not available in raw format	28.1	25.8	29.2
Data quality cannot be trusted / is unreliable	27.0	23.6	30.2
Presented data is not adequately summarized (eg. no 95% CI's)	19.4	14.6	22.6
Data is not analyzed or visually presented so I find it difficult to interpret	17.9	21.3	14.2
The indicators I need do not have data	17.9	14.6	20.8
There are multiple statistics and definitions listed for the same indicator so I am unsure which one to reference	11.2	10.1	12.3
I am not sure which of the potential data sources is most appropriate for my needs	8.2	9.0	7.5
Data is analyzed or visually presented but I still find it difficult to interpret and translate into actionable takeaways	7.1	5.6	7.5
Others	1.5	1.1	1.9.

Open ended question to assess demand:

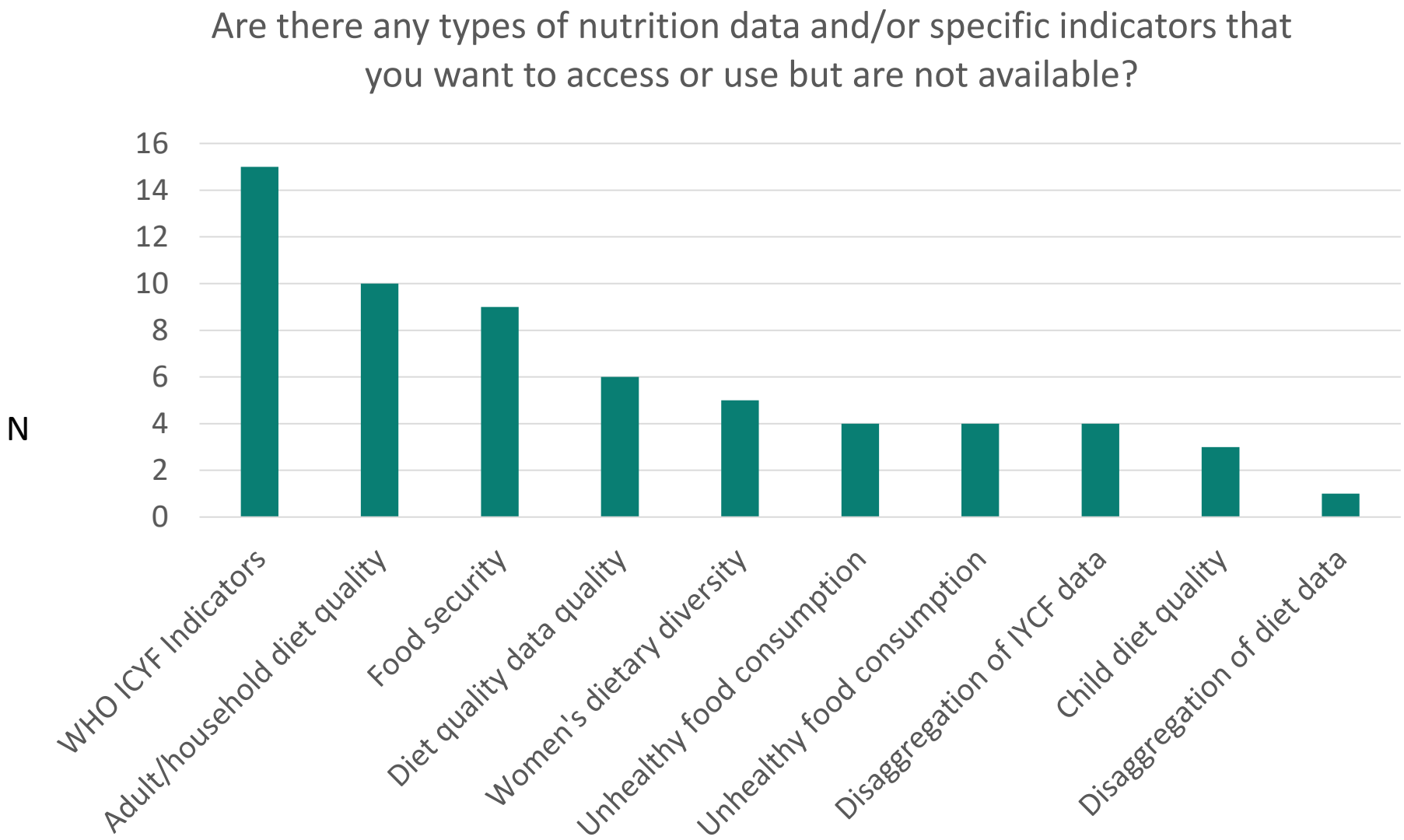
“Are there any types of nutrition data and/or specific indicators that you want to access or use but are not available?”

Excel sheet ”Open ended responses”

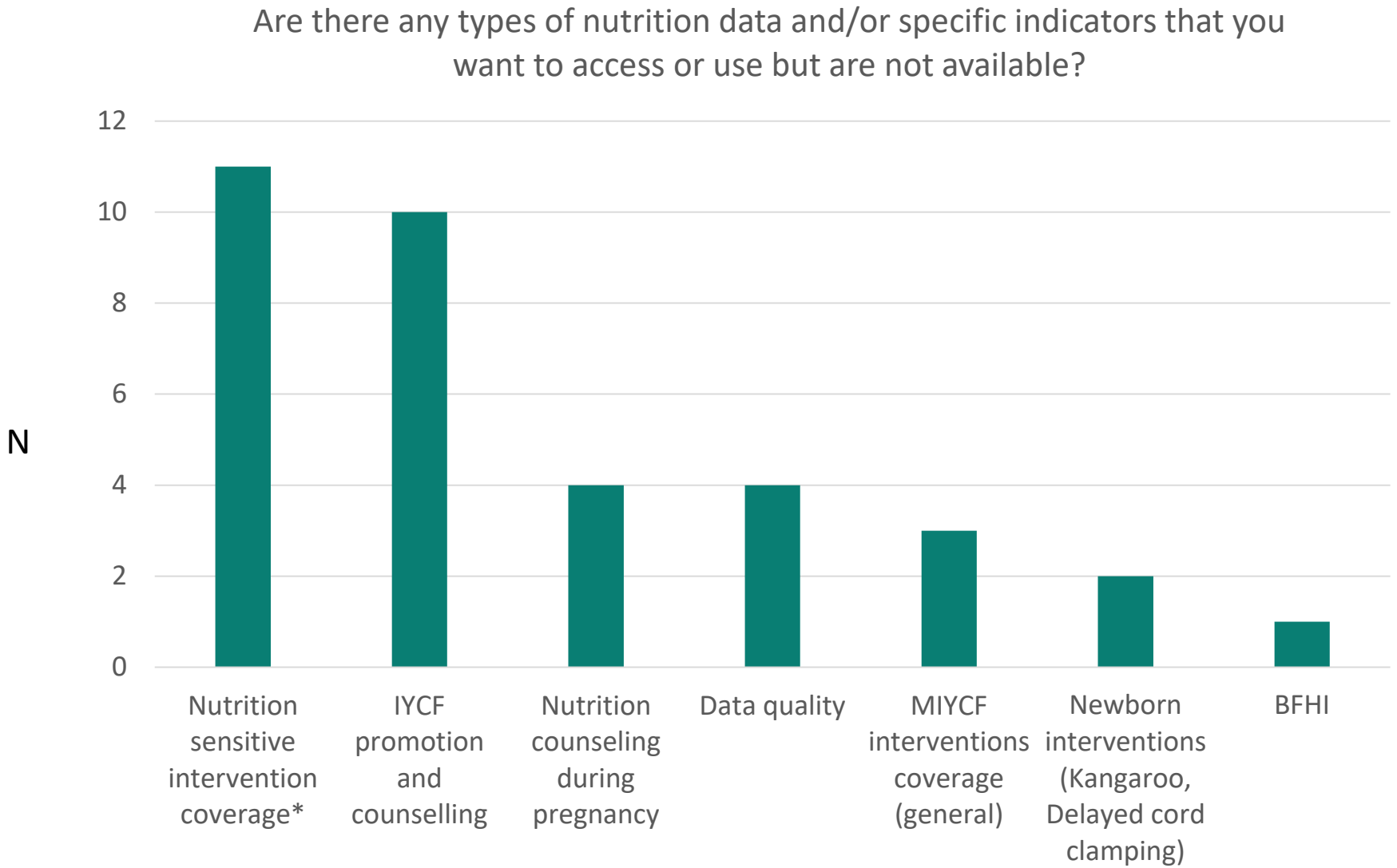
“Micronutrient status other than iron, vitamin A-particularly nutrients that may relate to anemia”

“Exclusive breastfeeding during the period since birth, not just on a single day”

Coverage data: Demand (IYCF practices/Diet)



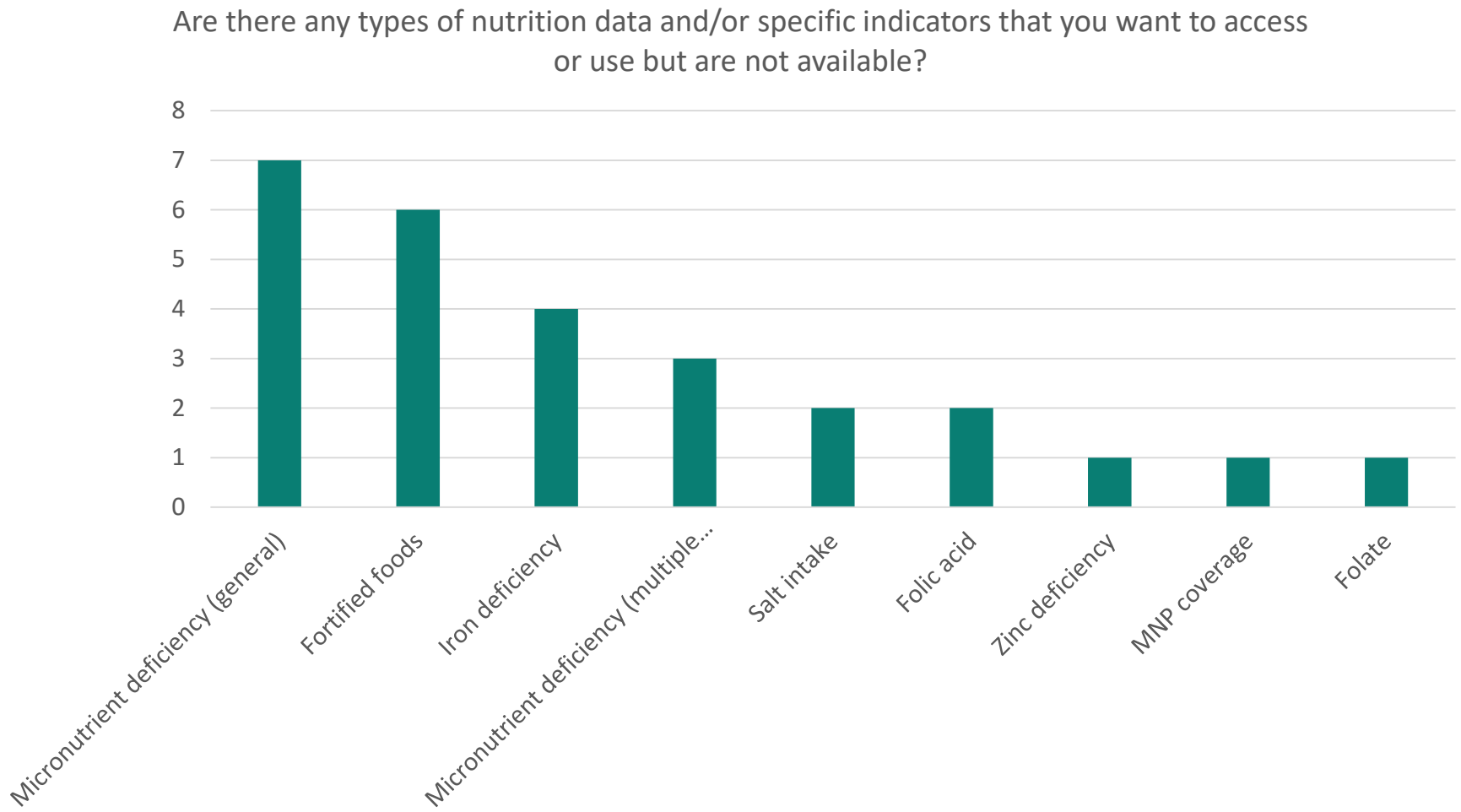
Coverage data: Demand related to MIYCN Coverage



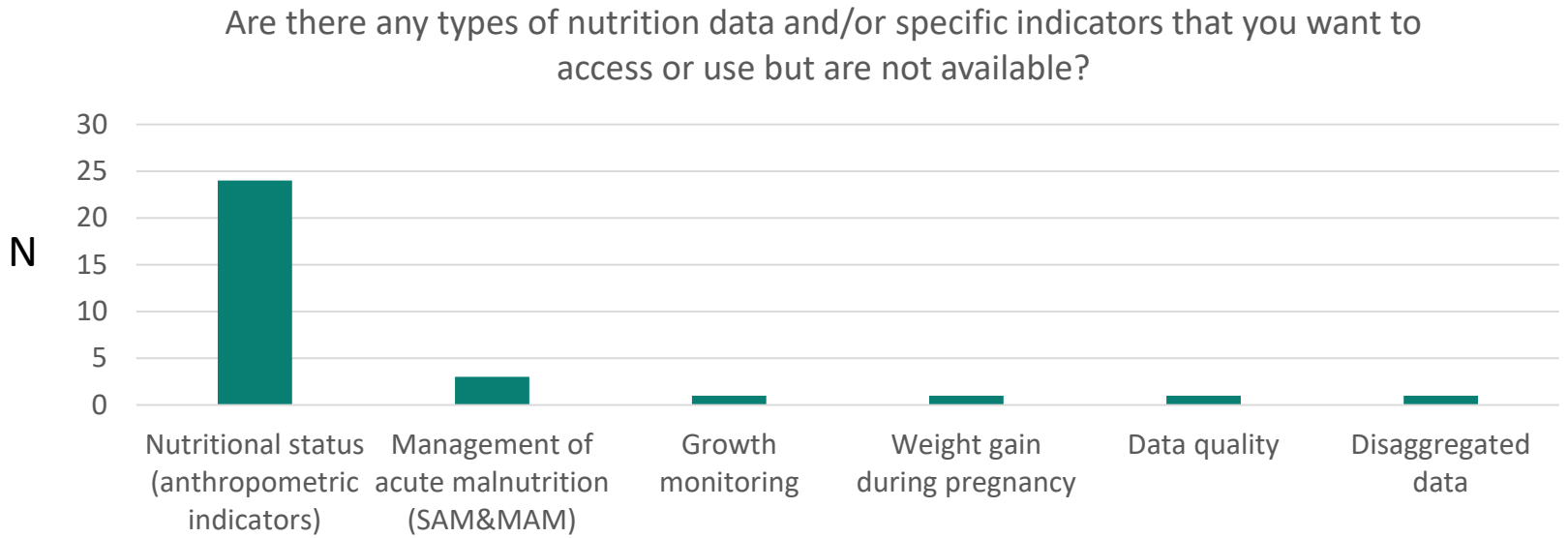
*WASH, Agriculture

Coverage data: Demand (Micronutrients)

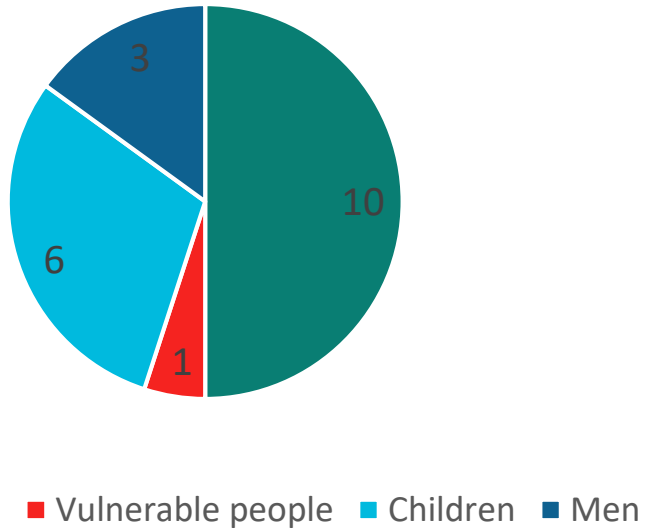
N



Coverage data: Demand (Growth)



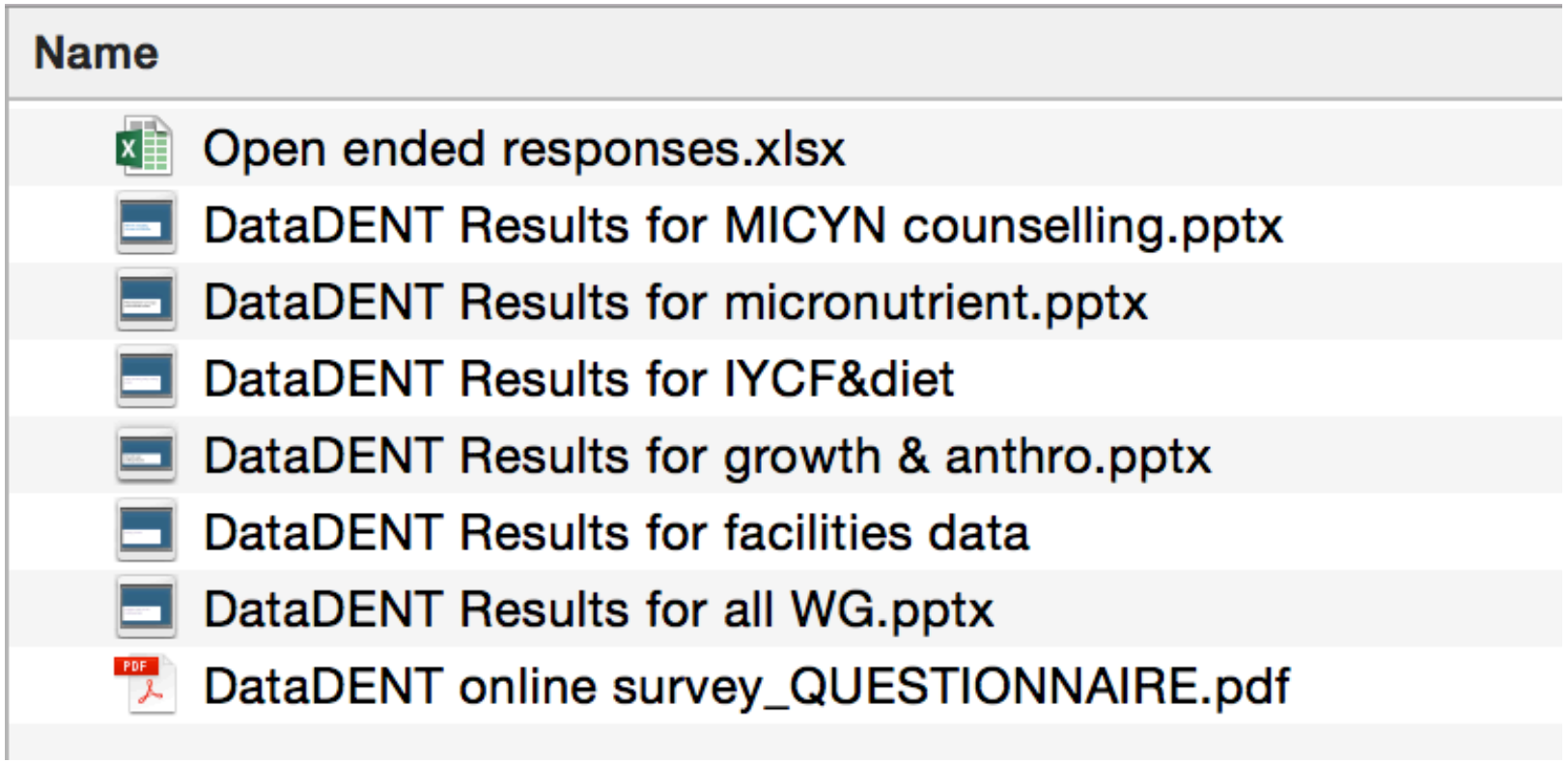
Nutritional status: Breakdown of populations mentioned



Of those who mentioned a specific population for nutritional status, half wanted data on adolescents.

More detailed analyses for each working group in Dropbox:

Working group resources->Findings from online demand survey



Discussion questions

- Did anything surprise you?
- Did you have any clarifications?
- How representative do you think the sample is of the nutrition community or your own personal observations?
- What are the implications of the findings for prioritization of data?
- Any additional analyses/follow up questions that you think would be useful?

The Nutrition Stakeholder Data Use Survey

Indicators that are highlighted have a set of follow-up questions for those who selected utilization of the indicators.

Sélectionnez français en utilisant le menu dans le coin supérieur droit de l'écran.
Seleccione español usando el menú en la esquina superior derecha de la pantalla.

The Nutrition Stakeholder Data Use Survey

We invite you to participate in a brief online survey about what types of nutrition data and data sources you access or use in your current work.

The survey will inform work being carried out under the Data for Decisions to Expand Nutrition Transformation (DataDENT) project - an initiative to address data gaps and improve the way that data systems are used for nutrition programs at national and global level. DataDENT is funded by the Bill & Melinda Gates Foundation and implemented by Johns Hopkins Bloomberg School of Public Health, the International Food Policy Research Institute (IFPRI) and the Results for Development Institute (R4D). To learn more about DataDENT please go to https://datadent.org/
The survey includes questions about 1) your professional background 2) whether you access or use specific nutrition-related data and data sources 3) gaps in data availability and 4) how you use data in your current role.
We will use the findings to inform DataDENT activities and to produce a report about data system strengthening. We will not report any individual-level responses. All survey results will be summarized in aggregate.

How to take the survey
- Most respondents complete the survey in 20 minutes.
- Use the “next” and “previous” buttons at the bottom of each screen to navigate through the survey.
- Your answers are automatically saved as you progress between screens. You may leave the survey and re-enter to edit or complete so long as you use your unique survey link provided via email.
- On the last page you will be invited, to provide contact information for a potential follow-up interview. You do not have to provide any contact information.

Q#	Question	Responses	Single (S) or multiple (M) responses allowed

	I agree to participate in the survey. I understand the purpose and nature of this activity and I am participating voluntarily. I understand that I can stop taking the survey at any time, without any penalty or consequences.	• Yes • No	
Section A: Respondent background information Please answer the following questions about your current role. If you have changed roles with in the past 12 months, please answer about the role that you have held for the majority of that time.			
A1	What type of organization do you work for?	○ Government ○ UN or similar multinational agency (eg SUN, African Union) ○ NGO ○ Donor (public or private) ○ University/Research institute ○ Private Sector ○ Other (please specify)	S
A2	What types of decisions related to nutrition do you make or support in your current professional role? Please check all that apply.	○ Implementation: manage day-to-day programming ○ Program administration: coordinate and manage program logistics ○ Monitoring & Evaluation: monitor progress of policy or program implementation ○ Program-specific financial management: management of the financial resources within specific programs or projects ○ Strategic program and policy planning: Sets strategic vision and allocates resources for policies or programs ○ Advocacy priorities: whether to raise awareness for a particular issue ○ High-level financing: investment decisions for an donor, government or other institution ○ Other: (please specify all other tasks)	M

A3	Do you consider yourself a technical expert on nutrition-related issues?	○ Yes → A3b ○ No	S
A3b	What do you consider your areas of focus or expertise ? Please check all that apply.	○ Infant and young child feeding (IYCF) ○ Micronutrients ○ Child nutrition ○ Adolescent nutrition ○ Maternal nutrition ○ Obesity and non-communicable diseases ○ Food security and food systems ○ Water, Sanitation & Hygiene (WASH) ○ Humanitarian Emergencies ○ Costing/cost effectiveness ○ Other (please specify all other areas of expertise)	M
A4	What is your highest education level achieved?	○ Secondary (high) school ○ Undergraduate ○ Masters ○ Doctoral (e.g. PhD, MD) ○ Other (please specify)	S
A5	For how many years have you worked on nutrition-related issues?	○ 0-1 years ○ 2-4 years ○ 5-9 years ○ 10+ years	S
A6	In the last 12 months, what has been the geographic scope of your nutrition-related work?	○ Within a single country→ A6a ○ Across multiple countries→A6b	S
A6a	Within that country, at what level are you primarily working? Please select one.	○ National ○ Subnational (eg state, district)	S
A6b	Across those countries, what is your level of primary focus? Please select one.	○ Global ○ Global regional (eg. North Africa, Southeast Asia) ○ National ○ Subnational (eg state, district)	M

A7	In the past 12 months, which country or countries has your work related to? Please select all that apply.	Africa: • Algeria • Angola • Benin • Botswana • Burkina Faso • Burundi • Cameroon • Cape Verde • Central African Republic • Chad • Comoros • Côte d'Ivoie • Democratic Republic of the Congo • Equatorial Guinea • Eritrea • Ethiopia • Gabon • Gambia • Ghana • Guinea	• Sao Tome and Principe • Senegal • Seychelles • Sierra Leone • South Africa • Swaziland • Togo • Uganda • United Republic of Tanzania • Zambia • Zimbabwe Americas: • Belize • Bolivia • Colombia • Costa Rica • Cuba • Dominica • Dominican Republic • Ecuador • El Salvador • Grenada • Guatemala • Guyana • Haiti • Honduras • Jamaica • Mexico • Nicaragua • Panama • Paraguay • Peru • Uruguay	South-East Asia: • Bangladesh • Bhutan • India • Indonesia • Myanmar • Nepal • Sri Lanka • Thailand • Timor-Leste Europe: • Kazakhstan • Kyrgyzstan • Tajikistan Eastern Mediterranean: • Afghanistan • Pakistan • Somalia • Sudan • Syrian Arab Republic Yemen Western Pacific: • Cambodia • Fiji • Lao People's Democratic Republic • Marshall Islands • Mongolia • Papua New Guinea • Philippines • Viet Nam Other (please specify	OtheM

		• Guinea-Bissau • Kenya • Lesotho • Liberia • Madagascar • Malawi • Mali • Mauritania • Mauritius • Mozambique • Namibia • Niger • Nigeria • Republic of the Congo • Rwanda •	Venezuela	all)	
A7b	Triggered if A7 is more than 3: Which three countries do you consider the primary focus in your current work? NOTE: Answer "NA" if no individual countries are given higher priority among those you selected in the previous question.	○ Country 1: <free response line 1> ○ Country 2: <free response line 2> ○ Country 3: <free response line 3>			M

A8	Which of the following describes how your current role involves working with data ? Please select all that apply.	○ I am directly involved in the collection of quantitative data through surveys, administrative systems, or other approaches ○ I manage or update a database or data repository ○ I consolidate and/or analyze data from one or more sources for internal decision making (by myself or my team) ○ I consolidate and/or analyze data from one or more sources for external decision making (by others outside my team) ○ I use data that has been consolidated and/or analyzed by others (e.g. in a report, presentation, or other format) for decision making	M
	Section B: Indicator use (Indicator: a measure that provides information about a specifically defined element)		
B1	In the last 12 months have you accessed or used coverage / utilization data for any of the following interventions? Select all that apply.	No - I have not accessed any data on coverage or utilization of nutrition interventions Child: Growth Monitoring or Screening Routine growth monitoring Screening for Acute Malnutrition Curative Interventions ORS for diarrhea Zinc as diarrhea treatment Severe Acute Malnutrition (SAM) treatment Moderate Acute Malnutrition (MAM) treatment Preventative Interventions Vitamin A capsules Deworming Multiple Micronutrient (Powder or Tablet) Women and/or adolescent girls: Specific to pregnant and/or lactating Iron Folic Acid Supplementation Multiple Micronutrient Supplementation Other iron-containing supplement Calcium supplementation Delayed cord clamping Post-partum Vitamin A supplement Deworming Counseling about nutrition during pregnancy or lactation Monitoring of weight gain during pregnancy Screening for undernutrition (e.g. low MUAC/BMI) Food supplementation or cash transfer For other women or adolescents (non-pregnant / non-lactating) Iron–containing supplement Folic acid supplementation or fortification	M

		Iron supplements Zinc supplements (preventative; NOT for diarrhea) Other IYCF-related Provision of lipid-based supplement or other food ration Breastfeeding Counseling (for mother/caregiver) Complementary Feeding Counseling (for mother/caregiver) Cooking demonstration Household: Iodized salt Other fortified foods – availability or consumption	
B1a: If selected using IFA	Which of the following indicators related to IFA did you access or use? Please select all that apply.	○ IFA purchased or received ○ IFA consumed ○ Minimum number of tablets consumed (e.g. at least 90)	M
B1b: If selected using MMN	Which of the following indicators related to Multiple Micronutrient Supplementation (MMN) did you access or use? Please select all that apply.	○ MMN purchased or received ○ MMN consumed ○ Minimum number of tablets consumed (e.g. at least 90)	M
B1c1 If selected growth monitoring	From what types of data source did you access growth monitoring data? Please select all that apply	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M

B1c2 If selected growth monitoring	In your work context, which of these data sources are considered the "official" / most often quoted for growth monitoring data? Please select all that apply.	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M
B1c3 if selected growth monitoring	Are new growth monitoring data available at a frequency/interval that meets your needs?	○ Yes ○ No→ B1c4	S
B1c4 if selected growth monitoring	How frequently would you prefer to have new growth monitoring data for your purposes?	○ Every 6-10 years ○ Every 2-5 years ○ Every year (annual) ○ Quarterly ○ Monthly ○ Other: Please specify	S
B1d1 If selected Screening for acute malnutrition	From what types of data source did you access acute malnutrition screening data? Please select all that apply	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M
B1d2 If selected Screening for acute malnutrition	In your work context, which of these data sources are considered the "official" / most often quoted for acute malnutrition screening data? Please select all that apply.	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M

B1d3 If selected Screening for acute malnutrition	Are new acute malnutrition screening data available at a frequency/interval that meets your needs?	○ Yes ○ No→ B1d4	S
B1d4 If selected Screening for acute malnutrition	How frequently would you prefer to have new acute malnutrition screening data for your purposes?	○ Every 6-10 years ○ Every 2-5 years ○ Every year (annual) ○ Quarterly ○ Monthly ○ Other: Please specify	S
B1e1 If selected either SAM or MAM	From what types of data source did you access Severe Acute Malnutrition (SAM) or Moderate Acute Malnutrition (MAM) treatment data? Please select all that apply	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M
B1e2 If selected either SAM or MAM	In your work context, which of these data sources are considered the "official" / most often quoted for Severe Acute Malnutrition (SAM) or Moderate Acute Malnutrition (MAM) treatment data? Please select all that apply.	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M

B1e3 If selected either SAM or MAM	Are Severe Acute Malnutrition (SAM) or Moderate Acute Malnutrition (MAM) treatment data available at a frequency/interval that meets your needs?	○ Yes ○ No→ B1e4	S
B1e4 If selected either SAM or MAM	How frequently would you prefer to have new Severe Acute Malnutrition (SAM) or Moderate Acute Malnutrition (MAM) treatment data for your purposes?	○ Every 6-10 years ○ Every 2-5 years ○ Every year (annual) ○ Quarterly ○ Monthly ○ Other: Please specify	S
B1f1 If selected vitamin A capsules	From what types of data source did you access preventative Vitamin A capsules coverage data? Please select all that apply	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M
B1f2 If selected vitamin A capsules	In your work context, which of these data sources are considered the "official" / most often quoted for preventative Vitamin A capsules coverage data? Please select all that apply.	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M

B1f3 If selected vitamin A capsules	Are new preventative Vitamin A capsules coverage data available at a frequency/interval that meets your needs?	○ Yes ○ No→ B1f4	S
B1f4 If selected vitamin A capsules	How frequently would you prefer to have new preventative Vitamin A capsules coverage data for your purposes?	○ Every 6-10 years ○ Every 2-5 years ○ Every year (annual) ○ Quarterly ○ Monthly ○ Other: Please specify	S
B1g1 If selected breastfeeding counselling	From what types of data source did you access breastfeeding counselling coverage data? Please select all that apply	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M
B1g2 If selected breastfeeding counselling	In your work context, which of these data sources are considered the "official" / most often quoted for breastfeeding counselling coverage data? Please select all that apply.	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M
B1g3 If selected breastfeeding counselling	Are new breastfeeding counselling coverage data available at a frequency/interval that meets your needs?	○ Yes ○ No→ B1g4	S

B1g4 If selected breastfeeding counselling	How frequently would you prefer to have new breastfeeding counselling coverage data for your purposes?	○ Every 6-10 years ○ Every 2-5 years ○ Every year (annual) ○ Quarterly ○ Monthly ○ Other: Please specify	S
B1h1 If selected complementary feeding counselling	From what types of data source did you access complementary feeding counseling coverage data? Please select all that apply	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M
B1h2 If selected complementary feeding counselling	In your work context, which of these data sources are considered the "official" / most often quoted for complementary feeding counseling coverage data? Please select all that apply.	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M
B1h3 If selected complementary feeding counselling	Are new complementary feeding counseling coverage data available at a frequency/interval that meets your needs?	○ Yes ○ No→ B1h4	S

B1h4 If selected complementary feeding counselling	How frequently would you prefer to have new complementary feeding counseling coverage data for your purposes?	○ Every 6-10 years ○ Every 2-5 years ○ Every year (annual) ○ Quarterly ○ Monthly ○ Other: Please specify	S
B1j If selected Iron–containing supplement	For which age group do you access iron-containing supplements data?	○ Adolescents ○ Women ○ Both adolescents and women	S
B1k If selected Folic acid supplementation or fortification	For which age group do you access folic acid supplementation or fortification supplements data?	○ Adolescents ○ Women ○ Both adolescents and women	S
B1l If selected Folic acid supplementation or fortification or Iron–containing supplement	From what types of data source did you access non-pregnant, non-lactating supplementation data? Please select all that apply	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify) ○ I don't know	

B2	In the last 12 months have you accessed or used data related to any of the following measures of nutritional status? Select all that apply.	No - I have not accessed or used any data on nutritional status measures Under-5: Wasting / WHZ Wasting / MUAC Stunting / HAZ Overweight (WHZ or %tile) Underweight / WAZ Low-birth weight (LBW) Global /Moderate Acute Malnutrition (Classified by MUAC or WHZ) Severe Acute Malnutrition (classified by MUAC, WHZ and/or oedema) Anemia (classified by hemoglobin) vitamin A deficiency other micronutrient deficiencies in under 5 (specify) School-age children: overweight anemia	Adolescents (male or female) underweight overweight Anemia (classified by hemoglobin) Adults: All adults 15-49 (male or female) Overweight or obesity / high BMI Diabetes Hypertension Women of reproductive age (WRA): short stature / stunting underweight / low BMI / low MUAC Anemia (classified by hemoglobin) Pregnant and lactating women: underweight / low BMI /low MUAC night blindness anemia Iron deficiency	M
B2a1 If selected low birth weight	From what types of data source did you access low-birth weight (LBW) data? Please select all that apply	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)		M

B2a2 If selected low birth weight	In your work context, which of these data sources are considered the "official" / most often quoted for low-birth weight (LBW) data? Please select all that apply.	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M
B2a3 If selected low birth weight	Are low-birth weight (LBW) data available at a frequency/interval that meets your needs?	○ Yes ○ No→ B2a4	S
B2a4 If selected low birth weight	How frequently would you prefer to have new low-birth weight (LBW) data available at a frequency/interval that meets your needs? for your purposes?	○ Every 6-10 years ○ Every 2-5 years ○ Every year (annual) ○ Quarterly ○ Monthly ○ Other: Please specify	S
B2b1 If selected vitamin A deficiency	From what types of data source did you vitamin A deficiency data? Please select all that apply	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) Other (please specify)	M
B2l2 If selected vitamin A deficiency	In your work context, which of these data sources are considered the "official" / most often quoted for vitamin A deficiency data? Please select all that apply.	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M

B2l3 If selected vitamin A deficiency	Are vitamin A deficiency data available at a frequency/interval that meets your needs?	○ Yes ○ No→ B2l4	S
B2l4 If selected vitamin A deficiency	How frequently would you prefer to have new vitamin A deficiency data available at a frequency/interval that meets your needs? for your purposes?	○ Every 6-10 years ○ Every 2-5 years ○ Every year (annual) ○ Quarterly ○ Monthly ○ Other: Please specify	S
B2b1 If selected adolescent underweight, overweight or anemia	You identified you access data on adolescents, does this include younger children 10-14?	○ Yes-> B2b2 ○ No	S
B2b2 If selected adolescent underweight, overweight or anemia	From what types of data source did you access adolescent data? Please select all that apply	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M
B2e1 If selected iron deficiency in pregnant and lactating women	From what types of data source did you access iron deficiency in pregnant and lactating women data? Please select all that apply	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M

B2e2 If selected iron deficiency in pregnant and lactating women	In your work context, which of these data sources are considered the "official" / most often quoted for iron deficiency in pregnant and lactating women data? Please select all that apply.	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M
B2e3 If selected iron deficiency in pregnant and lactating women	Are iron deficiency in pregnant and lactating women data available at a frequency/interval that meets your needs?	○ Yes ○ No→ B2e4	S
B2e4 If selected iron deficiency in pregnant and lactating women	How frequently would you prefer to have new iron deficiency in pregnant and lactating women data available at a frequency/interval that meets your needs for your purposes?	○ Every 6-10 years ○ Every 2-5 years ○ Every year (annual) ○ Quarterly ○ Monthly ○ Other: Please specify ○	S
B2f1 If selected diabetes	From what types of data source did you access diabetes data? Please select all that apply	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M

B2f2 If selected diabetes	In your work context, which of these data sources are considered the "official" / most often quoted for diabetes data? Please select all that apply.	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M
B2f3 If selected diabetes	Are diabetes data available at a frequency/interval that meets your needs?	○ Yes ○ No→ B2f4	S
B2f4 If selected diabetes	How frequently would you prefer to have new diabetes data available at a frequency/interval that meets your needs for your purposes?	○ Every 6-10 years ○ Every 2-5 years ○ Every year (annual) ○ Quarterly ○ Monthly ○ Other: Please specify	S
B2g1 If selected hypertension	From what types of data source did you access hypertension data? Please select all that apply	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M
B2g2 If selected hypertension	In your work context, which of these data sources are considered the "official" / most often quoted for hypertension data? Please select all that apply.	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) ○ Other (please specify)	M

B2g3 If selected hypertension	Are hypertension data available at a frequency/interval that meets your needs?	○ Yes ○ No→ B2g4		S
B2g4 If selected hypertension	How frequently would you prefer to have new hypertension data available at a frequency/interval that meets your needs for your purposes?	○ Every 6-10 years ○ Every 2-5 years ○ Every year (annual) ○ Quarterly ○ Monthly ○ Other: Please specify ○		S
B2h If selected overweight or obesity/high BMI	For which adult populations do you access overweight or obesity/ high BMI data?	○ Males ○ Females ○ Both males and females		S
B2j If selected diabetes	For which adult populations do you access diabetes data?	○ Males ○ Females ○ Both males and females		s
B2k If selected hypertension	For which adult populations do you access hypertension data?	○ Males ○ Females ○ Both males and females		S
B3	In the last 12 months have you accessed or used data related to these infant and young child feeding practices? Select all that apply.	No - I have not accessed or used any data on infant and young child feeding Breastfeeding Early initiation of breastfeeding Exclusive breastfeeding (Up to 6m) Breastfeeding patterns (0-23m)	Complementary feeding (6-23 months) • Dietary Diversity (e.g. Minimum Dietary Diversity- MDD; other food group scores) • Consumption of specific food groups (e.g. iron-rock, animal source, vitamin a rich, etc) • Frequency of feeding (e.g., Minimum Meal Frequency -	M

		(eg any, exclusive, predominant, etc) Duration of breastfeeding (eg in months, at 1 year, at 2 years, etc) Use of bottles Use of infant formula/ breastmilk substitute	MMF, other frequency score) • Combine score of quality, frequency other feeding practices (e.g. Minimum Acceptable Diet – MAD, other feeding index) • Age of Introduction of solid, semi-solid or soft foods • Milk feeding frequency for non-breastfed children Complementary feeding food group intake	
B3a1 If selected ANY IYCF indicators	From what types of data source did you access IYCF indicators? Please select all that apply	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) Other (please specify)		M
B3a2 If selected ANY IYCF indicators	In your work context, which of these data sources are considered the "official" / most often quoted for IYCF indicators? Please select all that apply.	○ Household survey (eg. DHS/MICS/SMART/other household survey) ○ Health facility survey (e.g. SPA, other) ○ Surveillance System (e.g. DSS, Hot Spot monitoring, etc) ○ Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data) Other (please specify)		M
B3a3 If selected ANY IYCF indicators	Are new IYCF data at a frequency/interval that meets your needs?	○ Yes ○ No→ B3a4		S
B3a4 If selected ANY IYCF indicators	How frequently would you prefer to have new IYCF data available at a frequency/interval that meets your needs for your	○ Every 6-10 years ○ Every 2-5 years ○ Every year (annual) ○ Quarterly		S

	purposes?	○ Monthly ○ Other: Please specify	
B4	In the last 12 months have you accessed or used any data related to population-level hunger or food security status?	• Yes-> trigger B4a • No	
B4a	Which of the following, if any, of the food security indicators have you accessed or used in the past 12 months? Select all that apply.	○ Prevalence of undernourishment (FAO) ○ HFIAS (Household Food Insecurity and Access Scale) ○ HFIES Household Food Insecurity Experience Scale (Gallup World Poll / FAO Voices of Hungry ○ HHS (Household Hunger Scale) ○ WFP FCS (Food consumption Scores) ○ Proportion of expenditure on food ○ CSI (Coping Strategies Index) ○ Other (please specify)	M
B5	In the last 12 months have you accessed or used data related to diet quality in adults and/or at household level? Select all that apply.	No - I have not accessed or used any data on diet quality in adults or households ○ Women-specific dietary diversity (e.g. MDD-W, WDDS, other score) ○ Household-level dietary diversity (e.g. HDDS, other index) ○ Any group: Intake of specific food groups (e.g. fruits and vegetable, animal source foods, etc) ○ Any group: Sodium intake ○ Any group: Consumption of unhealthy foods (e.g. sugar sweetened beverages, fatty foods, sugary foods)	M
B6	In the last 12 months have you accessed or used data related to nutrition-sensitive interventions or drivers? Select all that apply.	No - I have not accessed or used any data on nutrition sensitive interventions or determinants Education Level of education (e.g. by gender) Family planning	M

		WASH Access to drinking water (e.g. safe, improved, accessible, etc) Access to toilet/latrine (e.g. safe, improved, etc) Access to handwashing facilities Hygiene practices (e.g. handwashing behavior, disposal of stools, etc) Health Antenatal care Delivery (e.g. skilled birth attendants, Facility delivery) Immunizations in children Kangaroo mother care Malaria prevention (eg. IPTP, ITNs, indoor spraying) Availability of health workers (eg. Density)	Use of Family Planning Adolescent pregnancies or births Gender Gender Inequality (e.g. index) Income, disaggregated by gender Women's Empowerment in Agriculture Index (WEAI) Women's time use and labour Agriculture Home/kitchen gardens Production of specific crops Production of specific animals Use of irrigation / water technology Use of other improved agriculture practices Reach by agricultural extension agent Social Protection Participation in cash transfer / safety net program	
	Section C: Data sources used By data sources we mean source in any format that provides statistics relating to population nutritional status (anthropometry, micronutrient, etc.), behaviors (IYCF) and/or intervention coverage (vitamin A supplementation))			
C1	In the last 12 months, which of the following NATIONAL	National Household surveys: • Demographic Health Survey (DHS) • Multiple Indicator Cluster Survey (MICS) • National survey using SMART methodology • National Dietary Intake / Food Consumption Survey		M

	data sources have you accessed / used from a report, dataset or other format? Select all that apply.	• Other National Nutrition Survey (e.g. micronutrient survey) • World Bank Living Standard Measurement Studies(LSMS) • WFP Comprehensive Food Security and Vulnerability Assessments (CFSVA) • WFP Crop and Food Security Assessment Mission (CFSAM) • WFP Emergency Food Security Assessment (EFSA) • Other national household surveys with nutrition data (specify all name(s)) Subnational Household Survey • Sub-national survey using SMART methodology • Other survey specific to program or policy (please specify all others used) Health facility survey: • Service Provision Assessment (SPA) • Other facility surveys (please specify all others used) National monitoring /surveillance systems: • Demographic surveillance sites (DSS) • National food security "hot spot" monitoring system / FEWS-NET • WFP Food Security Monitoring System (FSMS) (eg. mVAM monitoring/Food Security Bulletins) • Other national surveillance system (specify) National administrative systems: • DHIS-2 / similar online HMIS portal • Health Management Information System (HMIS) (not web-based portal) • Agriculture sector MIS • WASH sector MIS • Education sector MIS • Other sector data systems (please specify all others used) OTHER- (Specify)	
C2	In the last 12 months,	Global reports/profile: • Countdown to 2030 (website/reports/country profiles)	M

	which of the following GLOBAL consolidated data sources have you accessed? Please select all that apply.	• Global Nutrition Report (website/reports/country profiles) • Scaling up Nutrition MEAL (website/reports/country profiles) • World Bank Nutrition Country Profiles (website/reports/country profiles) • FAO The State of Food security and Nutrition in the World • Hunger and Nutrition Commitment Index Global: Country profiles • UNICEF State of the World's Children Report Dashboard • WHO Global targets tracking tool Global Databases: • WHO Global Health Observatory • UNICEF, WHO and the World Bank Joint Malnutrition Estimates / JME Dashboard • Other UNICEF Nutrition datasets for specific topics (Vitamin A, iodine, low birthweight, IYCF) • WHO/UNICEF JMP (Joint Monitoring Programme for Water Supply, Sanitation and Hygiene) • FAO/WHO GIFT (Global Individual Food consumption data Tool) • FAO Country Indicators • WHO Vitamin & Mineral Nutrition Information Systems • IHME Global Burden of Disease Comparison • IHME Child Growth Failure Other (please specify)	
	Section D: Indicators missing generally		
E1	Thinking about the countries / contexts where you work, are there any types of nutrition data and/or specific	○ Intervention Coverage. [ADD RESPONSE BOX] ○ Nutritional Status [ADD RESPONSE BOX] ○ IYCF Practices [ADD RESPONSE BOX] ○ Diet quality in adults or household [ADD RESPONSE BOX] ○ Food Security or Hunger [ADD RESPONSE BOX] ○ Nutrition-sensitive or other determinants [ADD RESPONSE BOX] ○ Other [ADD RESPONSE BOX]	M

	indicators that you want to access or use but are not available? Please list/describe by category						
	Section E: Follow-up on data usability						
E1	Please select the challenges you currently experience in accessing and using data to support your work in nutrition. Please answer based on how frequently you experience these challenges. If you do not experience the challenge, please mark "Do not experience." (R4D)		Frequently experience	Sometimes experience	Rarely experience		Do not experience
		Data is not analyzed or visually presented so I find it difficult to interpret					
		Data is analyzed or visually presented but I still find it difficult to interpret and translate into actionable takeaways					
		There are multiple statistics and definitions listed for the same indicator so I am unsure which one to reference					
		Data is often out-of-date so I cannot use data to make decisions as frequently as I'd like					
		Data is not available at the geographical level I need (i.e., subnational)					
		Data is not available for the demographic group I need (i.e., sex, age, educational level, socioeconomic status)<					
		Trend data does not exist / is not easily accessible so I am not clear on progress					
		Data quality cannot be trusted / is unreliable					
		The indicators I need do not have data					
		Presented data is not adequately summarized (eg.					

		no 95% CI's)						
		Data is not available in raw format						
		I am not sure which of the potential data sources is most appropriate for my needs						
		Other (please specify)						
	Section G: Potential for Follow-Up							
G1	To further the goal of improving the usability of nutrition data, our research team would greatly appreciate the opportunity to follow up with some survey respondents to better understand how they are using data. If you are willing to speak with us further about this topic, please leave your name and email where our team can reach you. If you are not comfortable, that is ok.							
Thank you for helping us with our research into the use of nutrition data. We greatly appreciate your time and insights.								

Common slides for all working groups

Highlights: Background characteristics of survey respondents

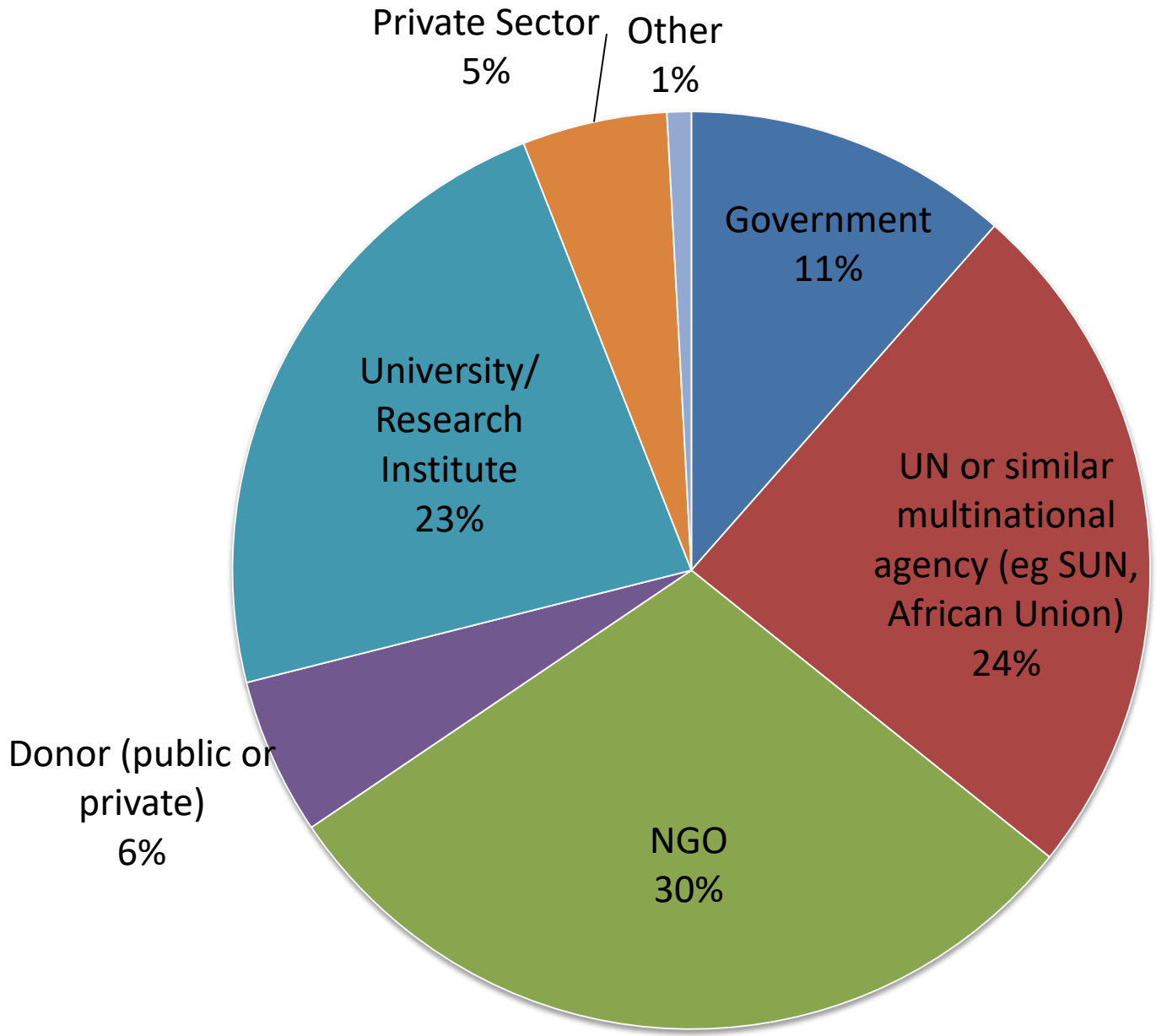
- The majority of the 235 survey participants were implementers (in total, 65% came from governments, multilaterals or NGO's), with 6% from donors and 23% from research institutions
- The majority (n=197) self-identified as technical experts, with >50% largely in infant and child nutrition, maternal nutrition and micronutrients.
- Respondents were well educated: >90% had at least a Master's degree.
- About half work at the country level and half work across countries

Data access quick summary

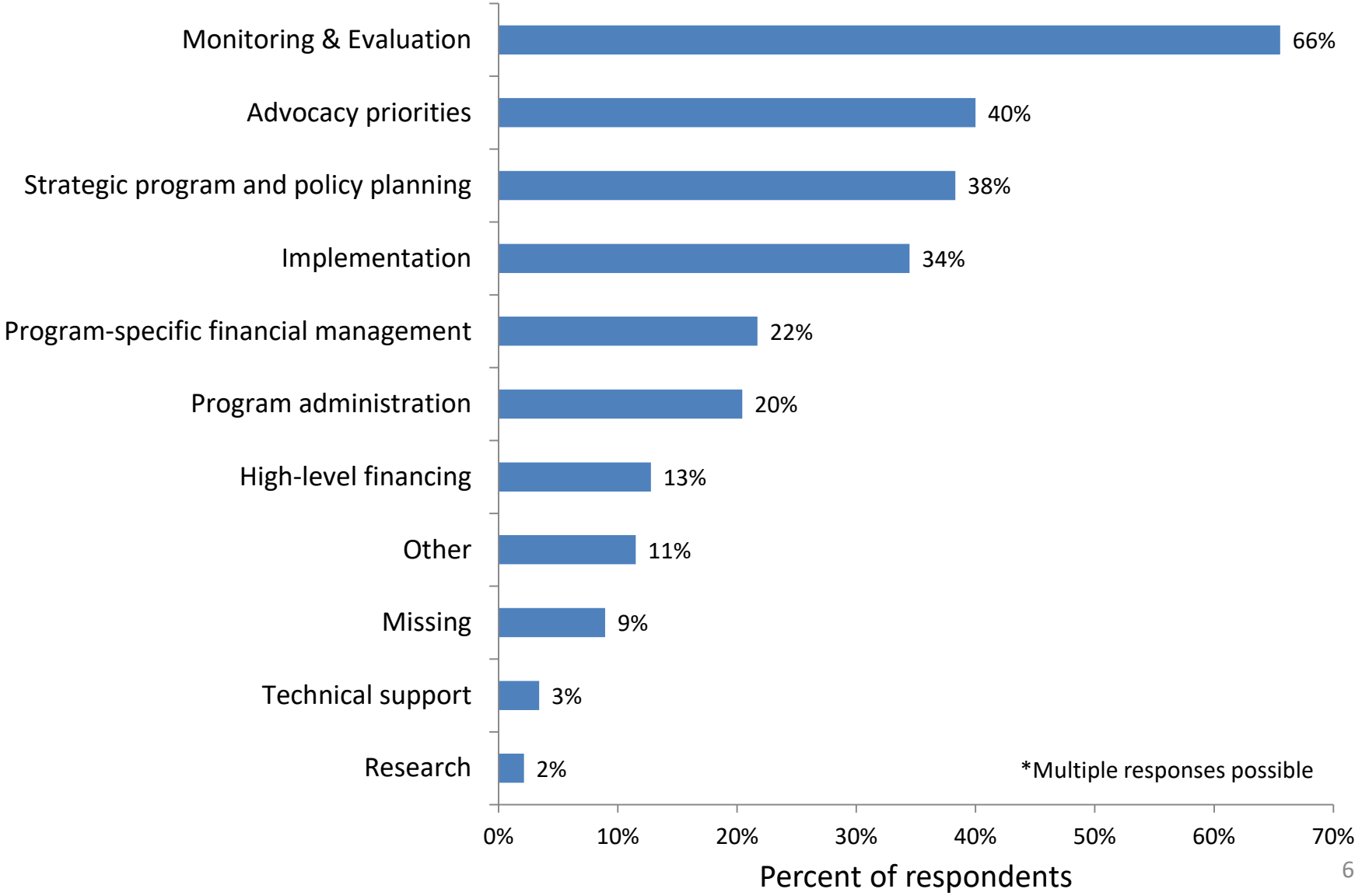
- **Access to national datasets**: Nearly ¾ of respondents had accessed the Demographic and Health Surveys, followed by MICS (41.9%) and other national surveys (40%) in the past year.
- **Access to global data**: Nearly ¾ of respondents accessed the Global Nutrition report, the Unicef State of the World's Children report (56.5%) and Unicef/WHO/World Bank joint malnutrition estimates (39%) as other major sources.
- The top coverage indicators accessed included breastfeeding counseling (59%), complementary feeding counseling (56%), iron folic acid supplementation (54%), and SAM/screening data (49% and 46% respectively).
- Respondents with a single country focus generally considered household survey data (DHS/MICS/SMART) to be the most official data source, although administrative data was also considered official by the majority of respondents for most indicators.
- Major challenges related to nutrition data included unavailability of data at geographical level, out of date data, and lack of trend data.

RESPONDENT CHARACTERISTICS

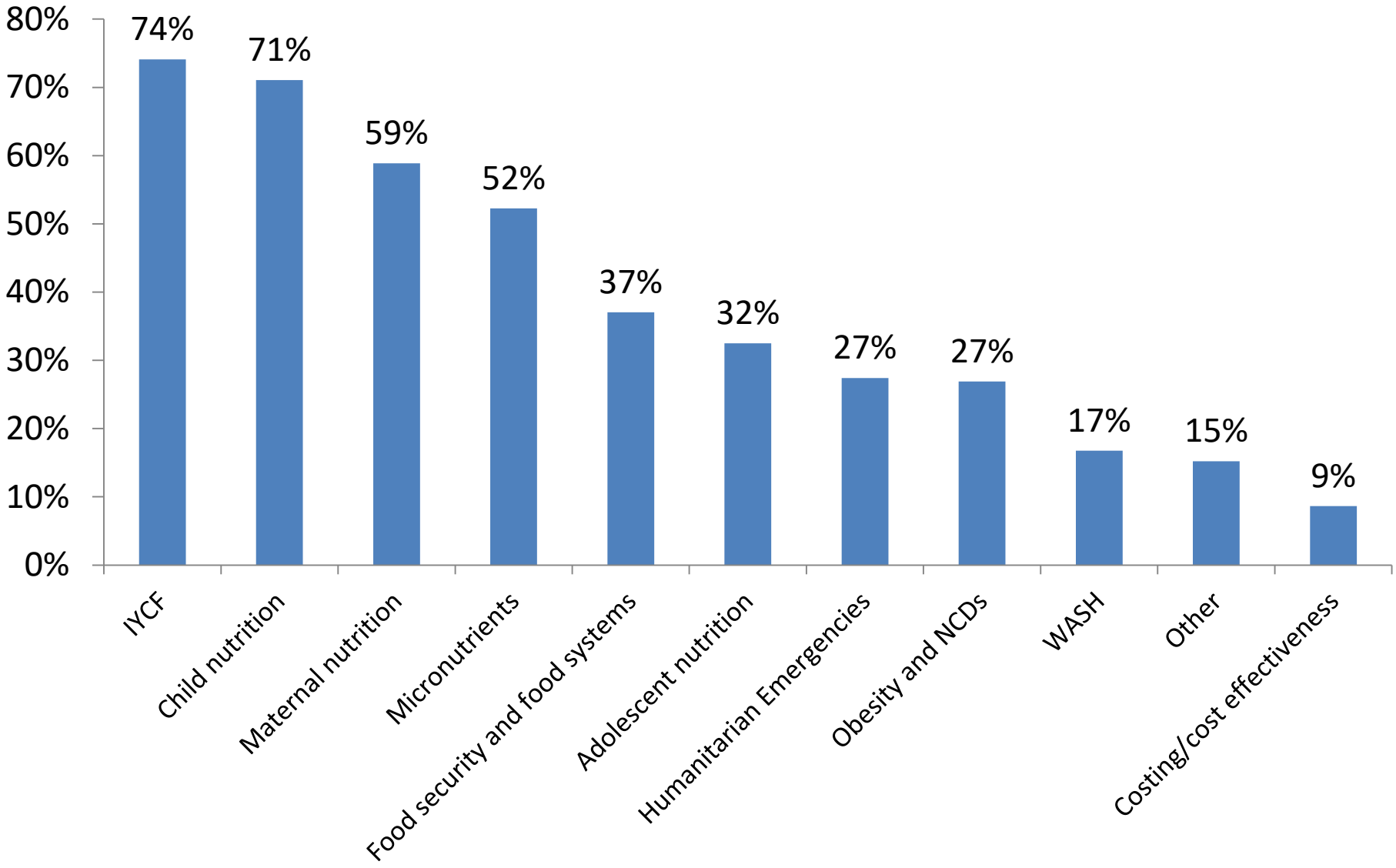
Who do you work for? (N=235)



What type of decisions do you make in your current professional role?* (N=235)



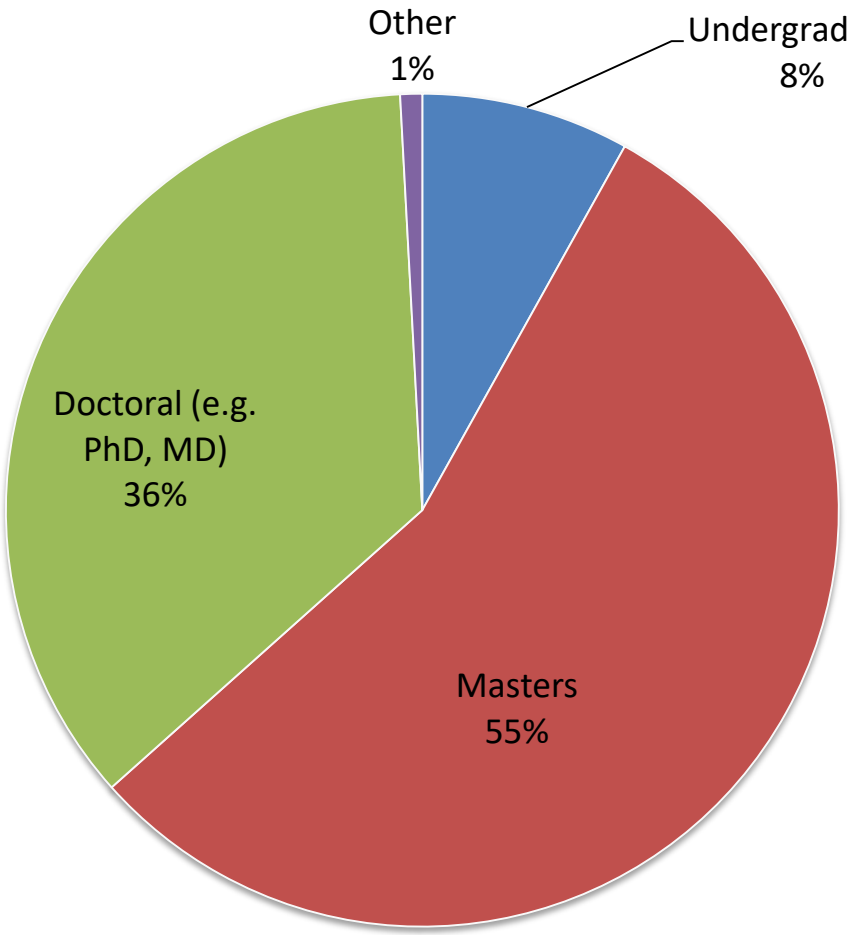
What is the area of expertise of those who self-identified as technical experts* (N=197)



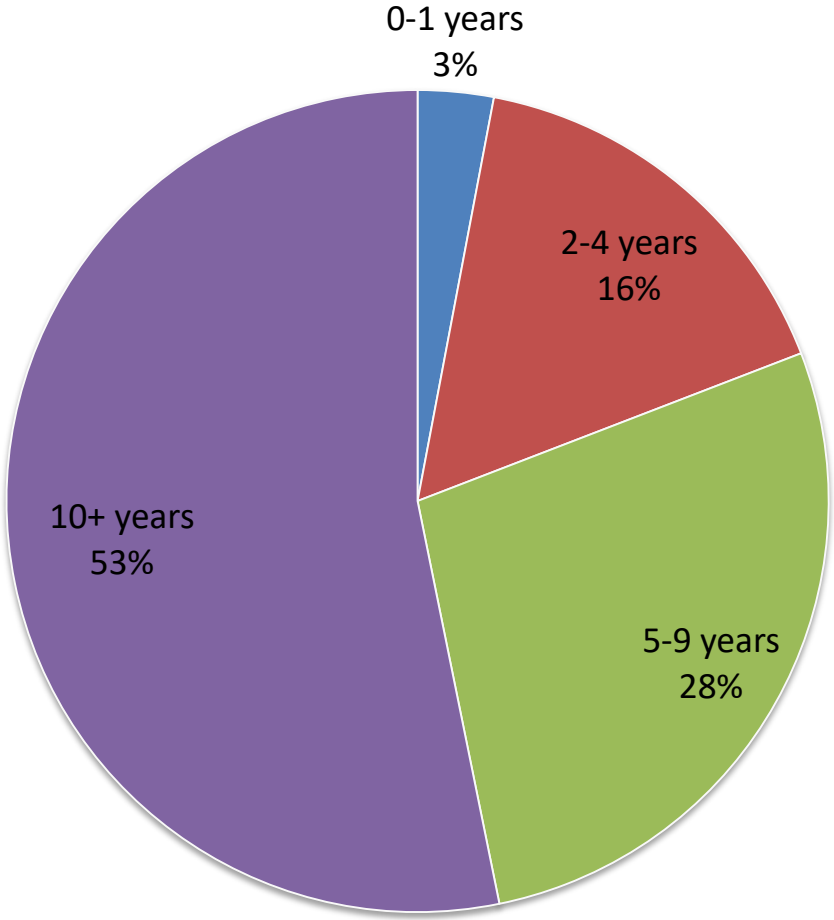
*Multiple responses possible

Education and work experience of survey respondents

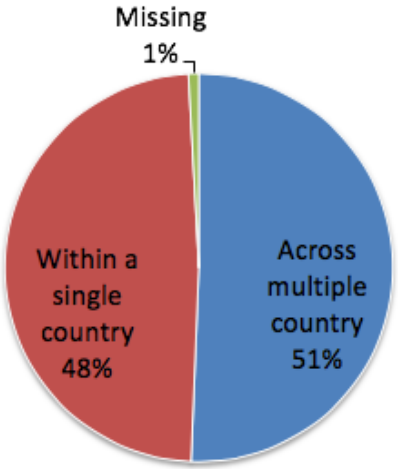
Highest education level of respondents (N=235)



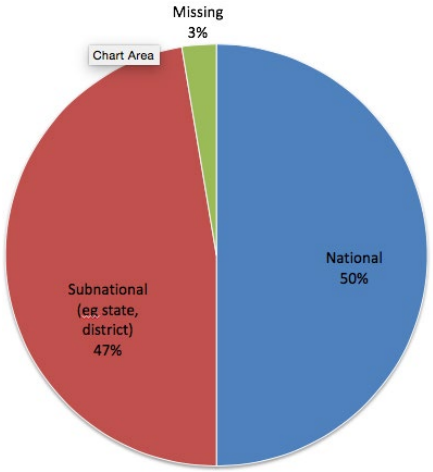
Work experience of respondents (N=235)



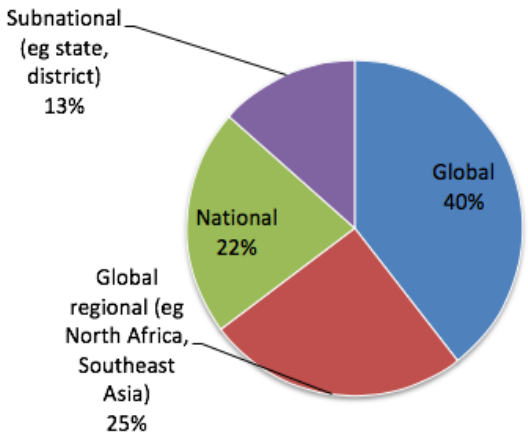
OVERALL SAMPLE
(N=235)



SINGLE COUNTRY FOCUS
(N=114)

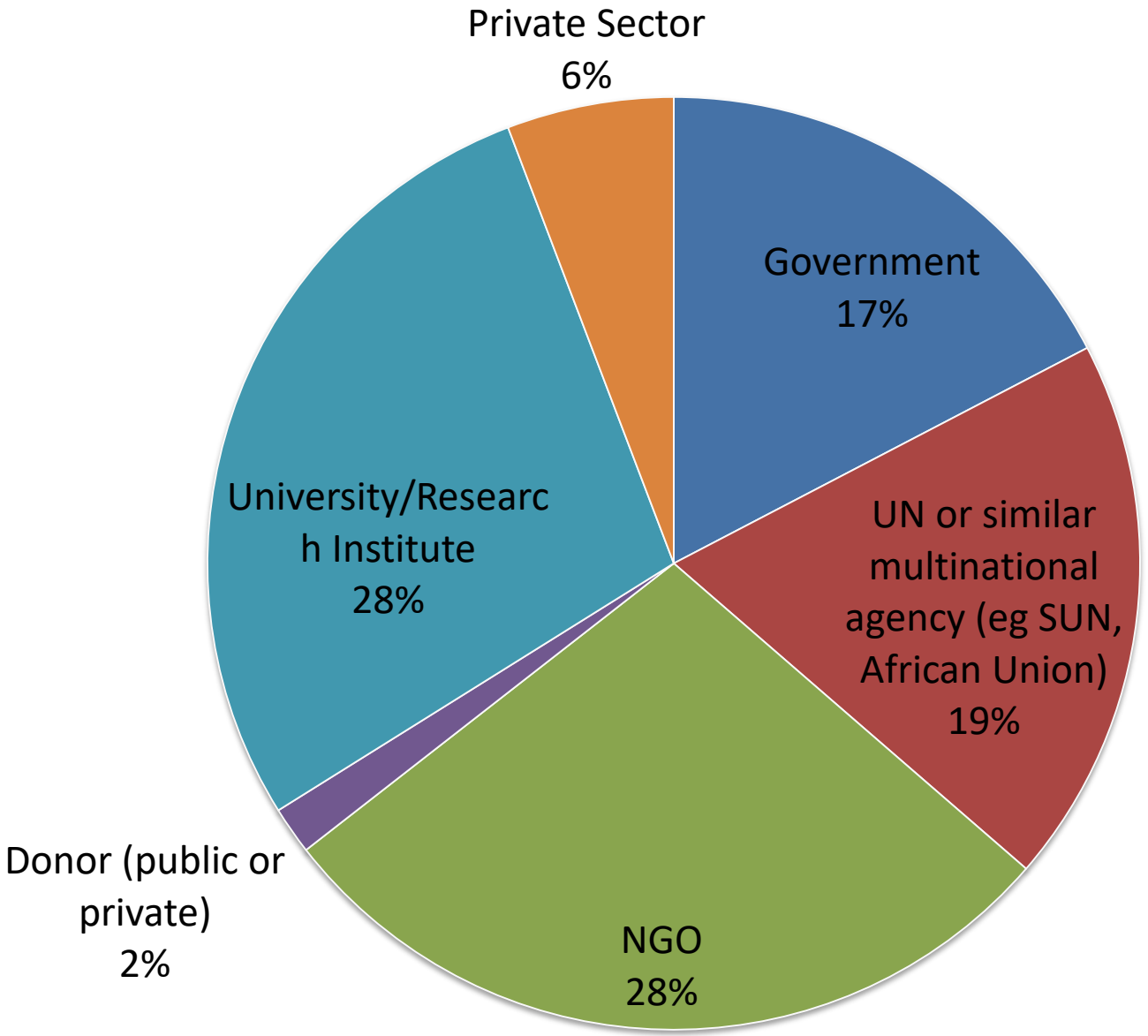


MULTI COUNTRY FOCUS
(N=119)



Geographic focus of work

For those with a single country focus, who do you work for?(N=121)



Accessing data sources in the past year

"What national data sources do you access?" aggregated by geographical scope of work

	Overall	Single country focus	Multi-country focus
Individual (N)	**191**	**88**	**102**
Demographic Health Survey (DHS)	73.8	60.2	85.3
Multiple Indicator Cluster Survey (MICS)	41.9	15.9	64.7
Other National Nutrition Survey (e.g. micronutrient survey)	40.8	44.3	38.2
National survey using SMART methodology	39.3	29.5	48.0
National Dietary Intake / Food Consumption Survey	33.5	37.5	30.4
Sub-national survey using SMART methodology	33.0	26.1	38.2
DHIS-2 / similar online HMIS portal	32.5	33.0	31.4
Health Management Information System (HMIS) (not web-based portal)	28.3	26.1	29.4
Household, Income, Consumption & Expenditure survey	18.3	19.3	17.6
National food security "hot spot" monitoring system / FEWS-NET	18.3	15.9	19.6
World Bank Living Standard Measurement Studies(LSMS)	15.2	4.5	24.5
WFP Food Security Monitoring System (FSMS) (eg. mVAM monitoring/Food Security Bulletins)	13.6	6.8	19.6
Other survey specific to program or policy-(please specify all others used)	13.1	12.5	12.7
WFP Comprehensive Food Security and Vulnerability Assessments (CFSVA)	12.0	6.8	16.7
Other national household surveys with nutrition data (specify all name(s))	11.0	12.5	9.8
Service Provision Assessment (SPA)	11.0	6.8	14.7
WFP Emergency Food Security Assessment (EFSA)	9.9	6.8	12.7
Demographic surveillance sites (DSS)	9.9	13.6	6.9
Other facility surveys (please specify all others used)	8.4	10.2	6.9
Other national surveillance system (specify)	5.2	4.5	5.9
Education sector MIS	5.2	6.8	3.9
WASH sector MIS	4.2	6.8	2.0
Other sector data systems (please specify all others used)	2.1	1.1	2.9
Agriculture sector MIS	1.6	2.3	1.0
Other national sources	1.0	0.0	2.0

"What global level data sources do you access?" aggregated by geographical scope of work

	Overall	Single country focus	Multi-country focus
Individual (N)	**177**	**76**	**100**
Global Nutrition Report	75.1	65.8	82.0
UNICEF State of the World's Children Report	56.5	42.1	68.0
UNICEF, WHO and the World Bank Joint Malnutrition Estimates	39.0	28.9	47.0
UNICEF Nutrition datasets*	38.4	27.6	46.0
FAO The State of Food security and Nutrition in the World	36.2	30.3	40.0
World Bank Nutrition Country Profiles	35.6	30.3	39.0
Scaling up Nutrition Monitoring, Evaluation, Accountability and Learning (MEAL)	32.2	32.9	32.0
WHO Global Targets Tracking Tool	29.4	23.7	33.0
Countdown to 2030	28.8	21.1	35.0
WHO Global Health Observatory	24.3	21.1	27.0
FAO Country Indicators	19.8	14.5	24.0
WHO Vitamin & Mineral Nutrition Information Systems	18.6	13.2	22.0
WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene	14.1	3.9	22.0
IHME Global Burden of Disease	13.6	5.3	20.0
Hunger and Nutrition Commitment Index Global: Country profiles	11.3	7.9	14.0
FAO/WHO Global Individual Food Consumption Data Tool (GIFT)	11.3	6.6	14.0
IHME Child Growth Failure	6.2	1.3	10.0
Other global sources	2.8	1.3	4.0

*Vitamin A, iodine, low birthweight, IYCF

"What national data sources do you access?" aggregated by geographical scope of work

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Other national sources	1.0	0.0	2.0

"What global level data sources do you access?" aggregated by geographical scope of work

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FAO The State of Food security and Nutrition in the World	36.2	30.3	40.0
World Bank Nutrition Country Profiles	35.6	30.3	39.0
Scaling up Nutrition Monitoring, Evaluation, Accountability and Learning (MEAL)	32.2	32.9	32.0
WHO Global Targets Tracking Tool	29.4	23.7	33.0
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WHO Global Health Observatory	24.3	21.1	27.0
FAO Country Indicators	19.8	14.5	24.0
WHO Vitamin & Mineral Nutrition Information Systems	18.6	13.2	22.0
WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene	14.1	3.9	22.0
IHME Global Burden of Disease	13.6	5.3	20.0
Hunger and Nutrition Commitment Index Global: Country profiles	11.3	7.9	14.0
FAO/WHO Global Individual Food Consumption Data Tool (GIFT)	11.3	6.6	14.0
IHME Child Growth Failure	6.2	1.3	10.0
Other global sources	2.8	1.3	4.0

*Vitamin A, iodine, low birthweight, IYCF

"What global level data sources do you access?" aggregated by type of work

	Overall	Government	UN/Multinational Orgs	NGO	Donor	Research/University	Private	Other
Individual (N)	**177**	**15**	**47**	**66**	**11**	**42**	**9**	**2**
Global Nutrition Report	75.1	73.3	72.3	62.1	90.9	73.8	44.4	100.0
UNICEF State of the World's Children Report	56.5	60.0	66.0	43.9	54.5	50.0	44.4	0.0
UNICEF, WHO and the World Bank Joint Malnutrition Estimates	39.0	26.7	55.3	24.2	45.5	35.7	33.3	0.0
UNICEF Nutrition datasets*	38.4	26.7	48.9	30.3	45.5	23.8	55.6	50.0
FAO The State of Food security and Nutrition in the World	36.2	26.7	44.7	27.3	45.5	33.3	22.2	0.0
World Bank Nutrition Country Profiles	35.6	20.0	42.6	31.8	36.4	31.0	22.2	0.0
Scaling up Nutrition Monitoring, Evaluation, Accountability and Learning (MEAL)	32.2	33.3	23.4	33.3	63.6	21.4	22.2	50.0
WHO Global Targets Tracking Tool	29.4	33.3	46.8	18.2	36.4	16.7	22.2	0.0
Countdown to 2030	28.8	26.7	38.3	22.7	45.5	14.3	33.3	0.0
WHO Global Health Observatory	24.3	26.7	31.9	15.2	18.2	23.8	22.2	0.0
FAO Country Indicators	19.8	20.0	10.6	16.7	18.2	23.8	33.3	50.0
WHO Vitamin & Mineral Nutrition Information Systems	18.6	20.0	14.9	13.6	18.2	23.8	22.2	0.0
WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene	14.1	13.3	14.9	13.6	18.2	7.1	22.2	0.0
IHME Global Burden of Disease	13.6	6.7	10.6	10.6	36.4	14.3	11.1	0.0
Hunger and Nutrition Commitment Index Global: Country profiles	11.3	0.0	10.6	15.2	27.3	2.4	11.1	0.0
FAO/WHO Global Individual Food Consumption Data Tool (GIFT)	11.3	6.7	8.5	7.6	18.2	11.9	33.3	0.0
IHME Child Growth Failure	6.2	0.0	4.3	6.1	18.2	2.4	22.2	0.0
Other global sources	2.8	0.0	0.0	1.5	0.0	7.1	0.0	50.0

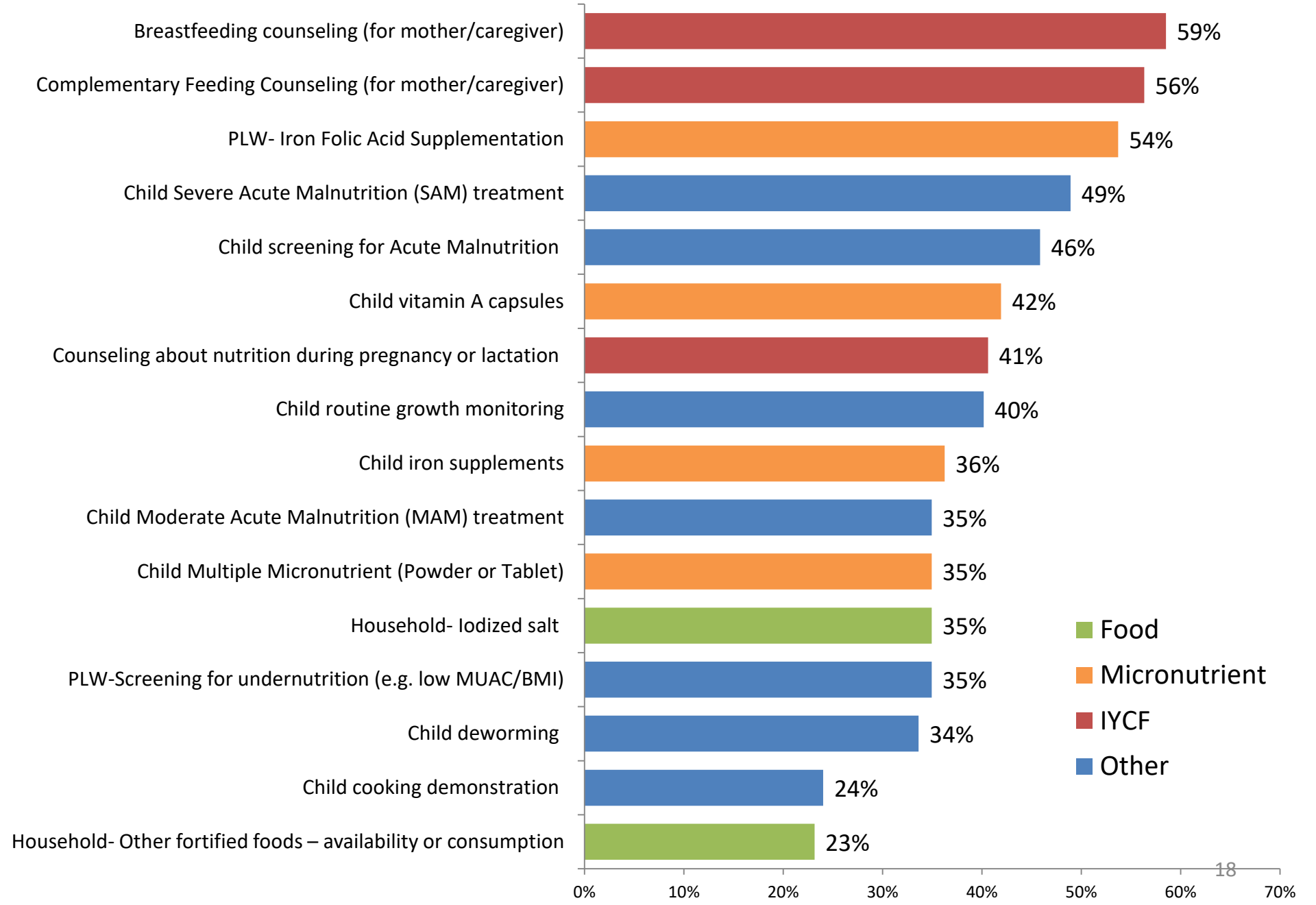
*Vitamin A, iodine, low birthweight, IYCF

"What global level data sources do you access?" aggregated by education level

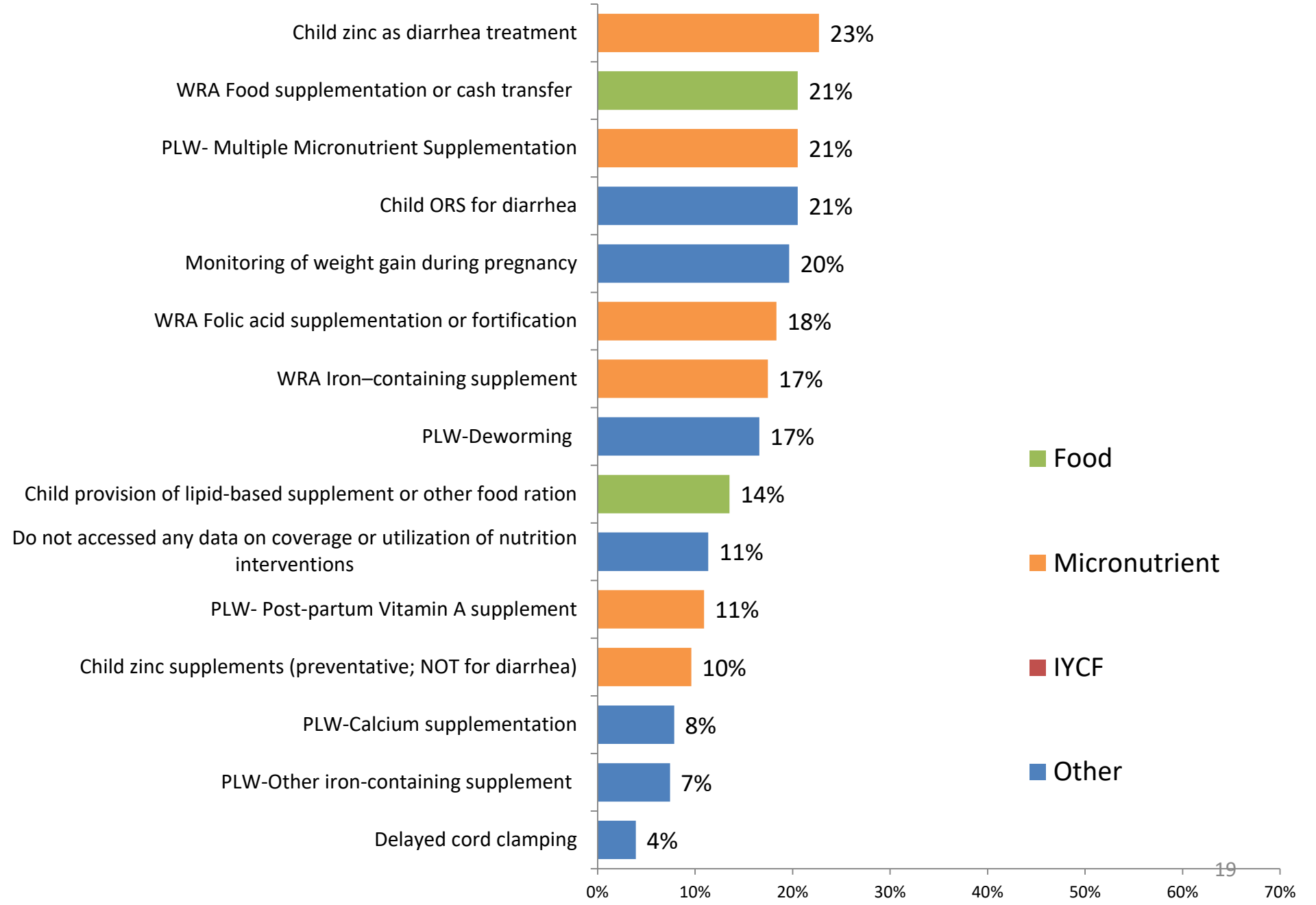
	Overall	Undergraduate	Masters	Doctoral (e.g. PhD, MD)
Individual (N)	**177**	**14**	**72**	**66**
Global Nutrition Report	75.1	71.4	75.0	89.4
UNICEF State of the World's Children Report	56.5	28.6	58.3%	59.1
UNICEF, WHO and the World Bank Joint Malnutrition Estimates	39.0	35.7	37.5	42.4
UNICEF Nutrition datasets*	38.4	28.6	46.9	28.8
FAO The State of Food security and Nutrition in the World	36.2	14.3	41.7	33.3
World Bank Nutrition Country Profiles	35.6	7.1	45.8	25.8
Scaling up Nutrition Monitoring, Evaluation, Accountability and Learning (MEAL)	32.2	50.0	30.2	31.8
WHO Global Targets Tracking Tool	29.4	7.1	33.3	27.3
Countdown to 2030	28.8	14.3	31.3	28.8
WHO Global Health Observatory	24.3	7.1	22.9	30.3
FAO Country Indicators	19.8	0.0	22.9	19.7
WHO Vitamin & Mineral Nutrition Information Systems	18.6	7.1	15.6	25.8
WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene	14.1	14.3	14.6	13.6
IHME Global Burden of Disease	13.6	7.1	11.5	18.2
Hunger and Nutrition Commitment Index Global: Country profiles	11.3	0.0	15.6	7.6
FAO/WHO Global Individual Food Consumption Data Tool (GIFT)	11.3	7.1	9.4	15.2
IHME Child Growth Failure	6.2	0.0	5.2	9.1
Other global sources	2.8	0.0	3.1	3.0

*Vitamin A, iodine, low birthweight, IYCF

Coverage or utilization data accessed in the past year (N=229) [1]



What type of coverage data have you accessed in the past year (N=229), [2]



What type of coverage data have you accessed in the past year, by type of organization [1]

	Government	UN/Multinational Orgs	NGO	Donor	Research/University	Private	Other
Individual (N)	**26**	**56**	**69**	**13**	**51**	**12**	**2**
Breastfeeding counseling (for mother/caregiver)	61.5	64.3	68.1	**76.9**	37.3	50.0	0.0
Complementary Feeding Counseling (for mother/caregiver)	61.5	62.5	62.3	69.2	39.2	50.0	0.0
PLW- Iron Folic Acid Supplementation	57.7	55.4	63.8	**76.9**	35.3	41.7	0.0
Child Severe Acute Malnutrition (SAM) treatment	50.0	64.3	53.6	69.2	27.5	16.7	50.0
Child screening for Acute Malnutrition	53.8	57.1	52.2	46.2	7.8	16.7	50.0
Child vitamin A capsules	53.8	62.5	37.7	61.5	19.6	16.7	50.0
Counseling about nutrition during pregnancy or lactation	**38.5**	37.5	55.1	46.2	25.5	41.7	0.0
Child routine growth monitoring	**53.8**	41.1	42.0	**53.8**	29.4	33.3	0.0
Child iron supplements	50.0	44.6	**31.9**	53.8	25.5	25.0	0.0
Child Moderate Acute Malnutrition (MAM) treatment	42.3	35.7	49.3	30.8	17.6	16.7	0.0
Child Multiple Micronutrient (Powder or Tablet)	50.0	50.0	**21.7**	53.8	29.4	16.7	0.0
Household- Iodized salt	53.8	51.8	**24.6**	23.1	25.5	33.3	0.0
PLW-Screening for undernutrition (e.g. low MUAC/BMI)	42.3	35.7	44.9	23.1	27.5	8.3	0.0
Child deworming	38.5	51.8	34.8	46.2	13.7	8.3	0.0
Child cooking demonstration	42.3	16.1	33.3	23.1	11.8	25.0	0.0
Household- Other fortified foods – availability or consumption	42.3	16.1	18.8	30.8	21.6	41.7	0.0

What type of coverage data have you accessed in the past year, by working organization [2]

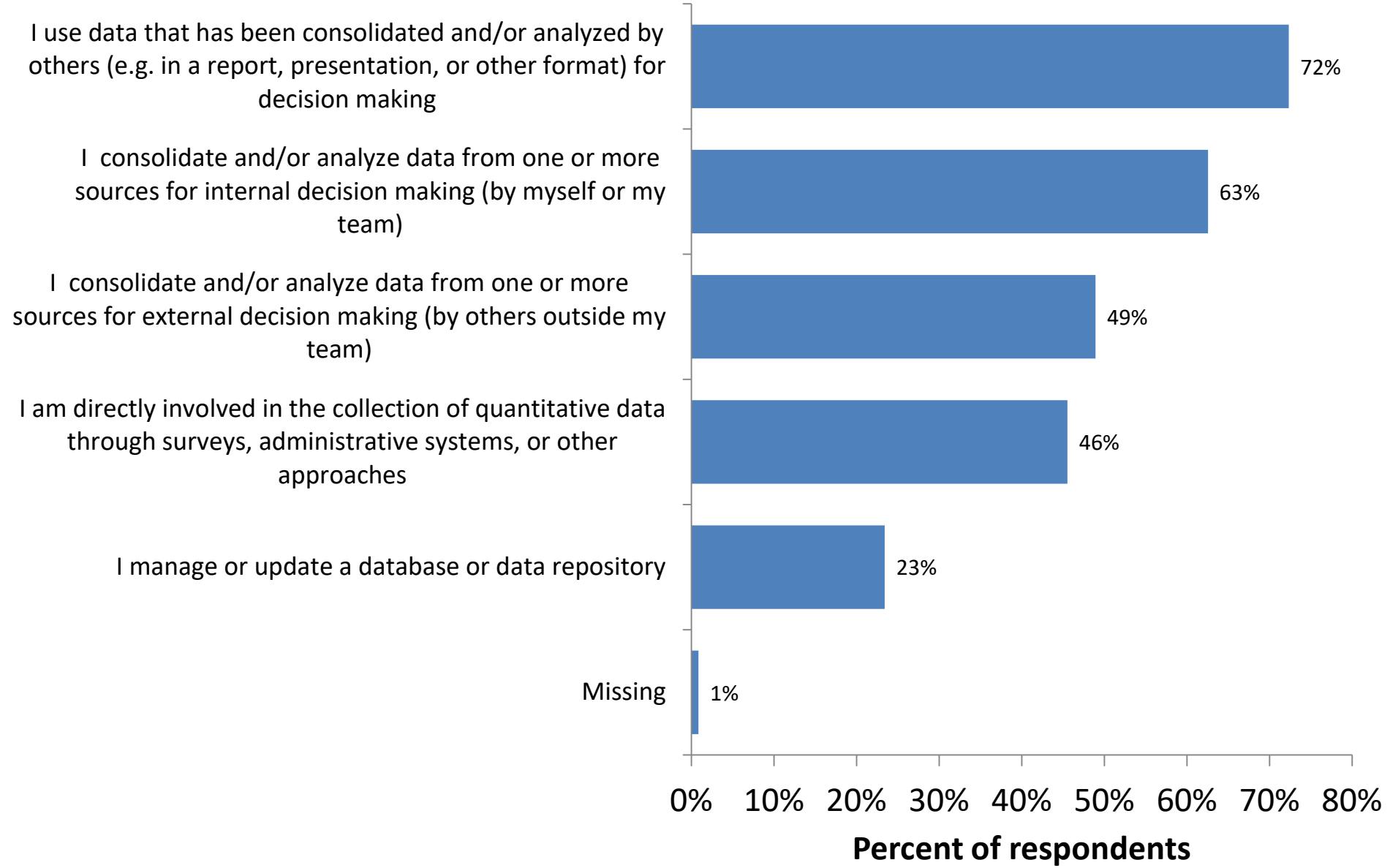
	Government	UN/Multinational Orgs	NGO	Donor	Research/University	Private	Other
Individual (N)	**26**	**56**	**69**	**13**	**51**	**12**	**2**
Child zinc as diarrhea treatment	26.9	26.8	27.5	23.1	11.8	16.7	0.0
Child ORS for diarrhea	23.1	26.8	18.8	38.5	11.8	16.7	0.0
PLW- Multiple Micronutrient Supplementation	26.9	21.4	15.9	38.5	19.6	16.7	0.0
WRA Food supplementation or cash transfer	26.9	**14.3**	23.2	53.8	11.8	16.7	50.0
Monitoring of weight gain during pregnancy	30.8	7.1	27.5	30.8	15.7	16.7	0.0
WRA Folic acid supplementation or fortification	30.8	12.5	21.7	30.8	13.7	8.3	0.0
WRA Iron–containing supplement	30.8	7.1	21.7	30.8	13.7	16.7	0.0
PLW-Deworming	23.1	19.6	21.7	15.4	7.8	0.0	0.0
Child provision of lipid-based supplement or other food ration	19.2	7.1	10.1	30.8	15.7	25.0	0.0
Do not accessed any data on coverage or utilization of nutrition interventions	7.7	7.1	7.2	15.4	19.6	16.7	50.0
PLW- Post-partum Vitamin A supplement	11.5	10.7	15.9	23.1	3.9	0.0	0.0
Child zinc supplements (preventative; NOT for diarrhea)	11.5	10.7	5.8	15.4	11.8	8.3	0.0
PLW-Calcium supplementation	11.5	1.8	11.6	23.1	5.9	0.0	0.0
PLW-Other iron-containing supplement	11.5	1.8	8.7	7.7	11.8	0.0	0.0
Delayed cord clamping	3.8	3.6	7.2	0.0	2.0	0.0	0.0

Among respondents with a single country focus, what type of coverage data have you accessed in past year (N=112)

Complementary Feeding Counseling (for mother/caregiver)	61.6
Breastfeeding counseling (for mother/caregiver)	60.7
PLW- Iron Folic Acid Supplementation	55.4
Routine growth monitoring	51.8
Child- Severe Acute Malnutrition (SAM) treatment	48.2
Screening for Acute Malnutrition	47.3
Counseling about nutrition during pregnancy or lactation	46.4
PLW-Screening for undernutrition (e.g. low MUAC/BMI)	41.1
Child-Iron supplements	38.4
Child-Vitamin A capsules	37.5
Iodized salt	36.6
Child-Moderate Acute Malnutrition (MAM) treatment	35.7
Child-Deworming	34.8
Child-Multiple Micronutrient (Powder or Tablet)	33.0
Cooking demonstration	32.1
Other fortified foods – availability or consumption	26.8
PLW- Monitoring of weight gain during pregnancy	26.8
Child- Zinc as diarrhea treatment	22.3
Child- ORS for diarrhea	21.4
PLW-Food supplementation or cash transfer	19.6
WRA-Folic acid supplementation or fortification	19.6
WRA Iron–containing supplement	18.8
PLW- Multiple Micronutrient Supplementation	17.9
PLW-Deworming	17.9
Child-Provision of lipid-based supplement or other food ration	11.6
PLW- Post-partum Vitamin A supplement	10.7
PLW-Calcium supplementation	7.1
PLW-Other iron-containing supplement	7.1
Child-Zinc supplements (preventative; NOT for diarrhea)	6.3
Delayed cord clamping	3.6
Do not accessed any data on coverage or utilization of nutrition interventions	8.0

Use and perceptions of data

How do you work with/use data in your role?* (N=235)



*Multiple responses possible

Among those with a single country focus, what data sources are considered the "official"/most often quoted for each indicator?*

	Individual (N)	Household survey (eg. DHS/MICS/SMART /other household survey)	Health facility survey (e.g. SPA, other)	Surveillance System (e.g. DSS, Hot Spot monitoring, etc)	Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data)	Other
Growth monitoring data	**56**	**76.8**	42.9	32.1	**55.4**	10.7
Acute Malnutrition screening	**52**	**67.3**	28.9	34.6	**53.8**	9.6
SAM/MAM treatment data	**55**	**49.1**	54.6	30.9	**70.9**	1.8
Vitamin A coverage	**42**	**61.9**	28.6	23.8	**76.2**	7.1
Breastfeeding counselling	**61**	70.5	23.0	21.3	52.5	8.2
Complementary feeding counselling	**66**	74.2	21.2	22.7	36.4	7.6
Low birth weight	**28**	60.5	23.7	15.8	60.5	2.6
U5 Vitamin A deficiency	**20**	**80.0**	25.0	35.0	30.0	10.0
Iron deficiency in pregnant/lactating women	**25**	**80.0**	36.0	28.0	60.0	12.0
Diabetes	**16**	43.8	12.5	31.2	50.0	18.8
Hypertension	**19**	47.4	26.3	36.8	42.1	10.5

*Multiple responses possible

Challenges with nutrition data

Of those reporting data access and utilization challenges, what are the challenges you frequently experience with nutrition data?

	Overall	Single country focus	Multi-country focus
Individual (N)	**196**	**89**	**106**
Data is not available at the geographical level I need (i.e., subnational)	49.0	43.8	52.8
Data is often out-of-date so I cannot use data to make decisions as frequently as I'd like	39.3	**27.0**	50.0
Trend data does not exist / is not easily accessible so I am not clear on progress	33.7	24.7	40.6
Data is not available for the demographic group I need (i.e., sex, age, educational level, socioeconomic status)	30.6	29.2	31.1
Data is not available in raw format	28.1	25.8	29.2
Data quality cannot be trusted / is unreliable	27.0	23.6	30.2
Presented data is not adequately summarized (eg. no 95% CI's)	19.4	14.6	22.6
Data is not analyzed or visually presented so I find it difficult to interpret	17.9	21.3	14.2
The indicators I need do not have data	17.9	14.6	20.8
There are multiple statistics and definitions listed for the same indicator so I am unsure which one to reference	11.2	10.1	12.3
I am not sure which of the potential data sources is most appropriate for my needs	8.2	9.0	7.5
Data is analyzed or visually presented but I still find it difficult to interpret and translate into actionable takeaways	7.1	5.6	7.5
Others	1.5	1.1	1.9.

Of those reporting data access and utilization challenges, what are the challenges you frequently and sometimes experience with nutrition data by work organization?

	Overall	Government	UN/Multinational Orgs	NGO	Donor	Research/University	Private	Other
Individual (N)	**196**	**22**	**50**	**54**	**12**	**47**	**9**	**2**
Data is not available at the geographical level I need (i.e., subnational)	81.6	59.1	60.0	59.3	83.3	55.3	77.8	50.0
Data is often out-of-date so I cannot use data to make decisions as frequently as I'd like	76.5	27.3	30.0	38.9	75.0	87.2	11.1	50.0
Data is not available for the demographic group I need (i.e., sex, age, educational level, socioeconomic status)<	76.5	63.6	76.0	85.2	91.7	68.1	77.8	100.0
Trend data does not exist / is not easily accessible so I am not clear on progress	73.0	50.0	42.0	42.6	66.7	46.8	33.3	100.0
Data quality cannot be trusted / is unreliable	69.4	63.6	76.0	81.5	83.3	76.6	77.8	50.0
Data is not available in raw format	64.3	86.4	74.0	85.2	83.3	83.0	88.9	50.0
Presented data is not adequately summarized (eg. no 95% CI's)	61.2	68.2	72.0	77.8	83.3	68.1	77.8	50.0
Data is not analyzed or visually presented so I find it difficult to interpret	58.2	63.6	72.0	70.4	91.7	61.7	66.7	100.0
The indicators I need do not have data	58.2	50.0	54.0	59.3	66.7	68.1	44.4	50.0
There are multiple statistics and definitions listed for the same indicator so I am unsure which one to reference	45.9	54.5	58.0	66.7	66.7	63.8	77.8	50.0
I am not sure which of the potential data sources is most appropriate for my needs	43.9	68.2	62.0	68.5	58.3	68.1	33.3	50.0
Data is analyzed or visually presented but I still find it difficult to interpret and translate into actionable takeaways	36.7	27.3	40.0	40.7	83.3	55.3	33.3	50.0
Others	2.6	0.0	4.0	5.6	0.0	0.0	0.0	0.0

Of those reporting data access and utilization challenges, what are the challenges you frequently and sometimes experience with nutrition data by work organization?

	Overall	Government	UN/Multinational Orgs	NGO	Donor	Research/University	Private	Other
Individual (N)	**196**	**22**	**50**	**54**	**12**	**47**	**9**	**2**
Data is not available at the geographical level I need (i.e., subnational)	81.6	86.4	74.0	85.2	83.3	83.0	88.9	50.0
Data is often out-of-date so I cannot use data to make decisions as frequently as I'd like	76.5	63.6	76.0	85.2	91.7	68.1	77.8	100.0
Data is not available for the demographic group I need (i.e., sex, age, educational level, socioeconomic status)<	76.5	68.2	72.0	77.8	83.3	68.1	77.8	50.0
Trend data does not exist / is not easily accessible so I am not clear on progress	73.0	63.6	76.0	81.5	83.3	76.6	77.8	50.0
Data quality cannot be trusted / is unreliable	69.4	68.2	62.0	68.5	58.3	68.1	33.3	50.0
Data is not available in raw format	64.3	63.6	72.0	70.4	91.7	61.7	66.7	100.0
Presented data is not adequately summarized (eg. no 95% CI's)	61.2	54.5	58.0	64.8	66.7	63.8	44.4	50.0
Data is not analyzed or visually presented so I find it difficult to interpret	58.2	59.1	60.0	59.3	83.3	55.3	22.2	50.0
The indicators I need do not have data	58.2	50.0	54.0	59.3	66.7	66.0	44.4	50.0
There are multiple statistics and definitions listed for the same indicator so I am unsure which one to reference	45.9	50.0	42.0	42.6	66.7	46.8	33.3	100.0
I am not sure which of the potential data sources is most appropriate for my needs	43.9	27.3	40.0	40.7	66.7	55.3	33.3	50.0
Data is analyzed or visually presented but I still find it difficult to interpret and translate into actionable takeaways	36.7	27.3	30.0	38.9	75.0	40.4	11.1	50.0
Others	2.6	0.0	4.0	5.6	0.0	0.0	0.0	0.0

Of those reporting data access and utilization challenges in a single country focus, what are the challenges you frequently and sometimes experience with nutrition data by work organization?

	Overall	Government	UN/Multinational Orgs	NGO	Donor	Research/University	Private
Individual (N)	**89**	**16**	**19**	**22**	**2**	**25**	**5**
Data is not available at the geographical level I need (i.e., subnational)	79.8	87.5	78.9	72.7	100.0	80.0	80.0
Data is not available for the demographic group I need (i.e., sex, age, educational level, socioeconomic status)<	74.2	68.8	78.9	77.3	100.0	72.0	60.0
Data is often out-of-date so I cannot use data to make decisions as frequently as I'd like	68.5	56.3	68.4	77.3	100.0	68.0	60.0
Trend data does not exist / is not easily accessible so I am not clear on progress	64.0	62.5	63.2	54.5	100.0	72.0	60.0
Data quality cannot be trusted / is unreliable	61.8	62.5	78.9	59.1	50.0	52.0	60.0
Data is not available in raw format	59.6	62.5	57.9	59.1	50.0	64.0	40.0
Presented data is not adequately summarized (eg. no 95% CI's)	56.2	50.0	52.6	59.1	50.0	64.0	40.0
Data is not analyzed or visually presented so I find it difficult to interpret	55.1	62.5	52.6	54.5	100.0	56.0	20.0
The indicators I need do not have data	52.8	56.3	47.4	54.5	50.0	60.0	20.0
There are multiple statistics and definitions listed for the same indicator so I am unsure which one to reference	44.9	62.5	31.6	36.4	100.0	44.0	60.0
I am not sure which of the potential data sources is most appropriate for my needs	44.9	37.5	36.8	36.4	100.0	56.0	60.0
Data is analyzed or visually presented but I still find it difficult to interpret and translate into actionable takeaways	37.1	31.3	26.3	45.5	50.0	44.0	20.0
Others	3.4	0.0	5.3	9.1	0.0	0.0	0.0

Percent of respondents frequently and sometimes experiencing challenges with current nutrition data data by organization of work by those with a multiple country focus

	Overall	Government	UN/Multinational Orgs	NGO	Donor	Research/University	Private	Other
Individual (N)	**106**	**6**	**30**	**32**	**10**	**22**	**4**	**2**
Data is often out-of-date so I cannot use data to make decisions as frequently as I'd like	83.0	83.3	80.0	90.6	90.0	68.2	100.0	100.0
Data is not available at the geographical level I need (i.e., subnational)	83.0	83.3	70.0	93.8	80.0	86.4	100.0	50.0
Trend data does not exist / is not easily accessible so I am not clear on progress	80.2	83.3	76.7	93.8	80.0	63.6	100.0	50.0
Data is not available for the demographic group I need (i.e., sex, age, educational level, socioeconomic status)<	78.3	50.0	73.3	84.4	80.0	81.8	100.0	50.0
Data quality cannot be trusted / is unreliable	76.4	66.7	70.0	78.1	100.0	72.7	75.0	100.0
Data is not available in raw format	67.9	83.3	63.3	75.0	60.0	72.7	25.0	50.0
Presented data is not adequately summarized (eg. no 95% CI's)	65.1	66.7	60.0	71.9	70.0	63.6	50.0	50.0
The indicators I need do not have data	62.3	33.3	56.7	62.5	70.0	72.7	75.0	50.0
Data is not analyzed or visually presented so I find it difficult to interpret	60.4	50.0	63.3	62.5	80.0	54.5	25.0	50.0
There are multiple statistics and definitions listed for the same indicator so I am unsure which one to reference	46.2	16.7	46.7	46.9	60.0	50.0	0.0	100.0
I am not sure which of the potential data sources is most appropriate for my needs	42.5	0.0	40.0	43.8	60.0	54.5	0.0	50.0
Data is analyzed or visually presented but I still find it difficult to interpret and translate into actionable takeaways	35.8	16.7	30.0	34.4	80.0	36.4	0.0	50.0
Others	1.9	0.0	3.3	3.1	0.0	0.0	0.0	0.0

Facility session

Use of facility data to estimate coverage

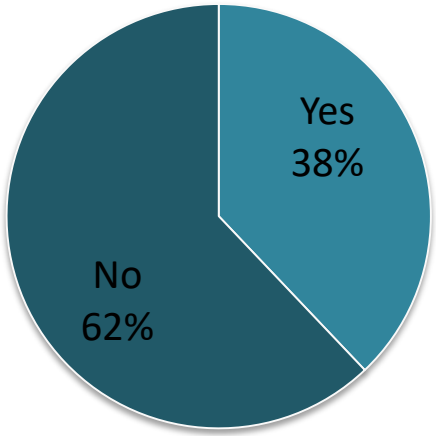
- Facility data looks like it is used more often to estimate coverage by those working with a single country focus.
- Some large differences for vitamin A, breastfeeding counselling in this compared with those who use a multi country focus

Percentage of respondents accessing facility data to measure coverage of interventions

	Overall		Single country focus		Multi-country focus	
	N	%	N	%	N	%
Growth monitoring coverage	86	41.9%	55	**49.1%**	31	**29.0%**
SAM/MAM treatment coverage	110	27.3%	53	34.0%	56	21.4%
Acute malnutrition screening coverage	100	26.0%	51	35.3%	48	16.7%
Breastfeeding counselling coverage	126	23.0%	65	**35.4%**	60	**10.0%**
Vitamin A coverage	91	18.7%	40	**37.5%**	51	**3.9%**
Non-pregnant, non-lactating iron or folic acid supplementation	23	17.4%	11	27.3%	12	8.3%
Complementary feeding counselling coverage	121	16.5%	65	24.6%	54	7.4%
IYCF data	173	12.1%	81	21.0%	91	4.4%

Percent of respondents utilizing facility data*

Respondents who have accessed facility level data (N=211)



Accessed facility data		
	Single country focus (N=103)	**Multi-country focus (N=106)**
Yes	45.6	30.2
No	54.4	69.8

Accessed facility data							
	Government	**UN/Multinational Orgs**	**NGO**	**Donor**	**Research**	**Private**	**Other**
N	**24**	**53**	**65**	**12**	**48**	**8**	**1**
Yes	58.3	30.2	43.1	41.7	31.3	25.0	0.0
No	41.7	69.8	56.9	58.3	68.8	75.0	100.0

*denominators reflect those who were answered at least one of several follow-up question about data sourced

Data on coverage/utilization of growth interventions

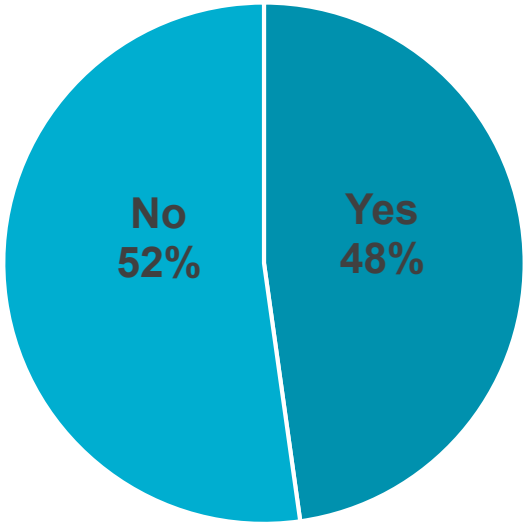
Who uses data on growth-related interventions?

By geographical scope of work		
	Acute malnutrition screening	Routine growth monitoring
Single country (N=112)	47.3	51.8
Multi country (N=115)	44.3	29.6
Overall (N=227)	45.8	40.2

By institutional affiliation			
	N	Acute malnutrition screening	Routine growth monitoring
Government	26	53.8	53.8
UN/ Multilateral	56	57.1	41.1
NGO	69	52.2	42.0
Donor	13	46.2	53.8
Research/ University	51	7.8	29.4
Private	12	16.7	33.3
Other	2	50.0	0
Total	229	45.8	40.2

How frequently do respondents want growth monitoring screening data to be available

Is the data available as frequently as you would like it to be?



Preferred frequency of data availability			
	Single country (N=29)	**Multi-country (N=17)**	**Overall (N=46)**
Every 6-10 years	0.0	0.0	0.0
Every 2-5 years	13.8	29.4	19.6
Annual	31.0	35.3	32.6
Quarterly	20.7	17.6	19.6
Monthly	24.1	5.9	17.4
Other	10.3	11.8	10.9

How frequently do respondents want acute malnutrition screening data to be available?

Is data available as frequently as you'd like it to be?		
	Single country focus (N=53)	**Multi-country focus (N=48)**
Yes	58.5	43.8
No	41.5	56.3

Preferred frequency of data availability			
	Single country focus (N=21)	**Multi-country focus (N=27)**	**Overall (N=48)**
Every 6-10 years	0.0	0.0	0.0
Every 2-5 years	19.0	7.0	12.5
Annual	23.8	19.0	20.8
Quarterly	23.8	37.0	31.3
Monthly	28.6	19.0	22.9
Other	4.8	19.0	12.5

What data sources do respondents access for growth monitoring data?*

Data sources	Overall (N=86)	Single country focus (N=55)	Multi-country focus (N=31)
Household survey (eg. DHS/MICS/SMART/other household survey)	66.0	64.7	66.7
Health facility survey (e.g. SPA, other)	26.0	35.3	16.7
Surveillance System (e.g. DSS, Hot Spot monitoring, etc)	34.0	41.2	25.0
Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data)	56.0	60.8	50.0
Other	17.0	17.6	16.7

*Multiple responses possible, denominators reflect those who reported using growth monitoring data

What data sources do respondents access for growth monitoring data for respondents with a single country focus by working organization?*

Data sources	Overall (N=55)	Government (N=14)	UN/Multinational Orgs (N=12)	NGO (N=16)	Donor (N=2)	Research (N=10)	Private (N=1)
Household survey (eg. DHS/MICS/SMART/other household survey)	64.7	57.1	58.3	87.5	100.0	70.0	100.0
Health facility survey (e.g. SPA, other)	35.3	57.1	25.0	62.5	50.0	50.0	0.0
Surveillance System (e.g. DSS, Hot Spot monitoring, etc)	41.2	35.7	25.0	43.8	50.0	10.0	0.0
Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data)	60.8	57.1	91.7	56.3	50.0	30.0	100.0
Other	17.6	7.1	8.3	18.8	50.0	10.0	100.0

*Multiple responses possible, denominators reflect those who reported using growth monitoring data

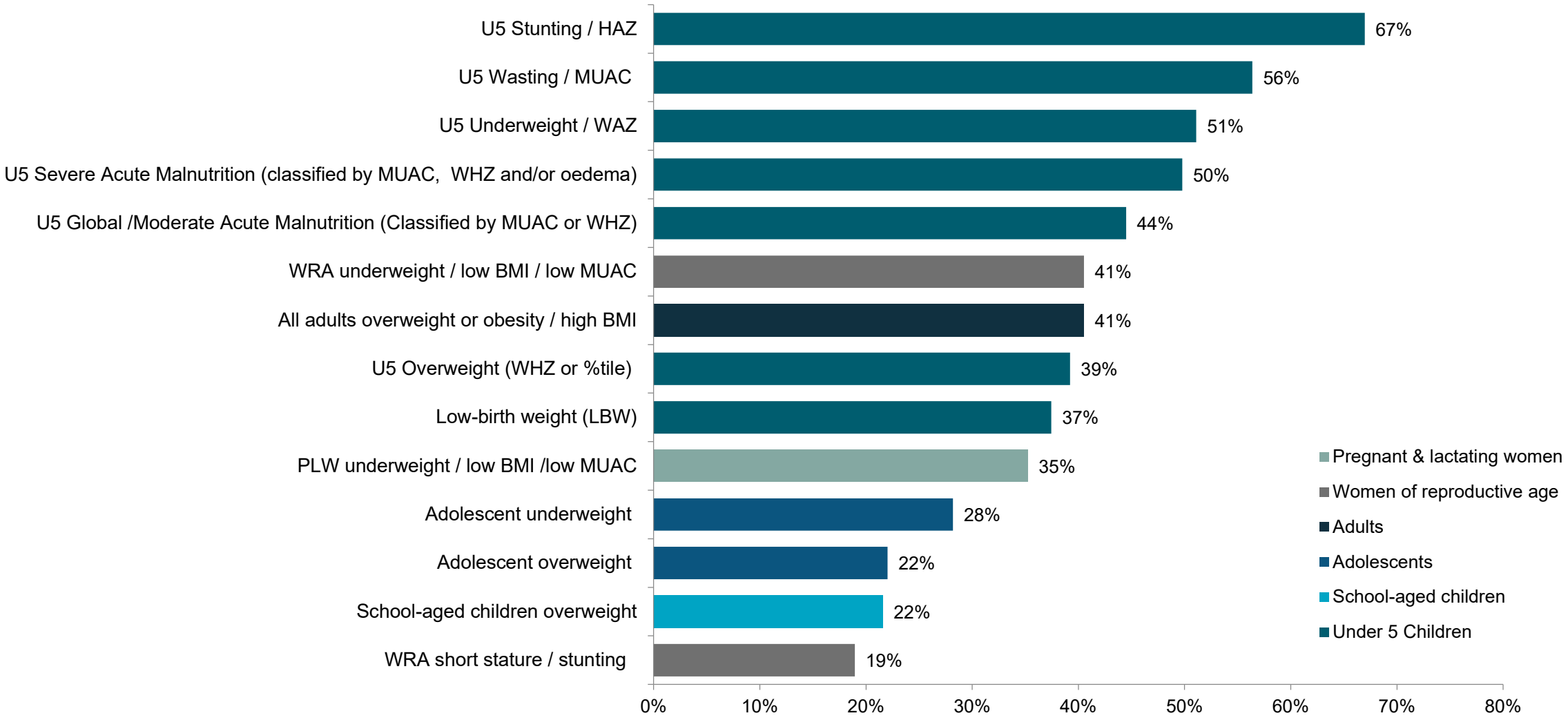
What data sources do respondents access for acute malnutrition screening coverage data?*

Data sources	Overall (N=100)	Single country focus (N=51)	Multi-country focus (N=48)
Household survey (eg. DHS/MICS/SMART/other household survey)	66.0	64.7	66.7
Health facility survey (e.g. SPA, other)	26.0	35.3	16.7
Surveillance System (e.g. DSS, Hot Spot monitoring, etc)	34.0	41.2	25.0
Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data)	56.0	60.8	50.0
Other	17.0	17.6	16.7

*Multiple responses possible, denominators reflect those who reported using acute malnutrition screening data

Data on nutritional status

Respondents who accessed nutritional status data within the past year (N=229)



Respondents who accessed nutrition status data by institutional affiliation (n=227)

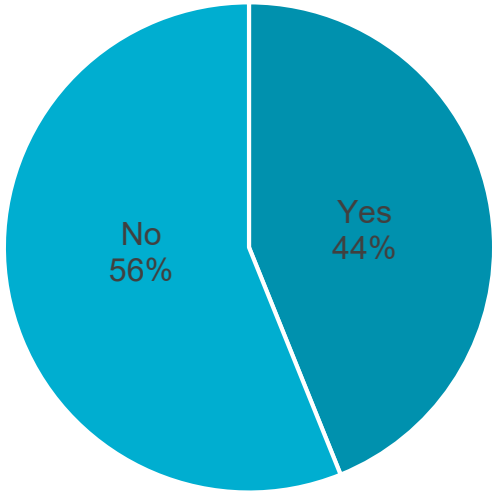
	Overall	Government	UN/ Multinational Orgs	NGO	Donor	Research/ University	Private	Other
N	227	24	57	66	13	53	12	2
U5 Wasting / WHZ	67.0	70.8	71.9	66.7	69.2	62.3	50	100
U5 Stunting / HAZ	67.0	75	70.2	66.7	76.9	66	33.3	50
U5 Wasting / MUAC	56.4	66.7	61.4	65.2	76.9	39.6	25	0
U5 Underweight / WAZ	51.1	54.2	47.4	56.1	30.8	52.8	50	50
U5 Severe Acute Malnutrition (classified by MUAC, WHZ and/or oedema)	49.8	54.2	61.4	56.1	69.2	32.1	16.7	0
U5 Global /Moderate Acute Malnutrition (Classified by MUAC or WHZ)	44.5	45.8	50.9	53	61.5	24.5	33.3	50
All adults overweight or obesity / high BMI	40.5	45.8	36.8	31.8	38.5	47.2	58.3	100
WRA underweight / low BMI / low MUAC	40.5	45.8	36.8	40.9	61.5	41.5	25	0
U5 Overweight (WHZ or tile)	39.2	33.3	49.1	28.8	38.5	41.5	50	50
Low-birth weight (LBW)	37.4	37.5	36.8	45.5	61.5	28.3	16.7	0
PLW underweight / low BMI /low MUAC	35.2	29.2	31.6	45.5	53.8	26.4	33.3	0
Adolescent underweight	28.2	25	28.1	28.8	38.5	28.3	16.7	50
Adolescent overweight	22	16.7	22.8	15.2	15.4	26.4	50	50
School-aged children overweight	21.6	16.7	21.1	13.6	15.4	28.3	50	50
WRA short stature / stunting	18.9	12.5	10.5	19.7	53.8	20.8	25	0

Respondents who accessed nutritional status data by geographical scope of work (N=227)

	Overall (N=227)	Single country focus (N=109)	Multi-country focus (N=116)
U5 Wasting / WHZ	67	57.8	75.9
U5 Stunting / HAZ	67	61.5	72.4
U5 Wasting / MUAC	56.4	55	57.8
U5 Underweight / WAZ	51.1	49.5	52.6
U5 Severe Acute Malnutrition (classified by MUAC, WHZ and/or oedema)	49.8	47.7	51.7
U5 Global /Moderate Acute Malnutrition (Classified by MUAC or WHZ)	44.5	39.4	49.1
Adult Overweight or obesity / high BMI	40.5	34.9	45.7
WRA underweight / low BMI / low MUAC	40.5	33	46.6
U5 Overweight (WHZ or tile)	39.2	31.2	46.6
Low-birth weight (LBW)	37.4	34.9	39.7
PLW underweight / low BMI /low MUAC	35.2	33	37.1
Adolescents underweight	28.2	24.8	31
Adolescents overweight	22	16.5	27.6
School aged overweight	21.6	19.3	24.1
WRA short stature / stunting	18.9	13.8	24.1

How frequently do respondents want low birthweight data to be available

Is LBW data available as frequently as you would like it to be? (overall)



Preferred frequency of data availability			
	Single country focus (N=20)	**Multi-country focus (N=25)**	**Overall (N=45)**
Every 6-10 years	0.0	0.0	0.0
Every 2-5 years	15.0	20.0	17.8
Annual	40.0	60.0	51.1
Quarterly	10.0	0.0	4.4
Monthly	30.0	4.0	15.6
Other	5.0	16.0	11.1

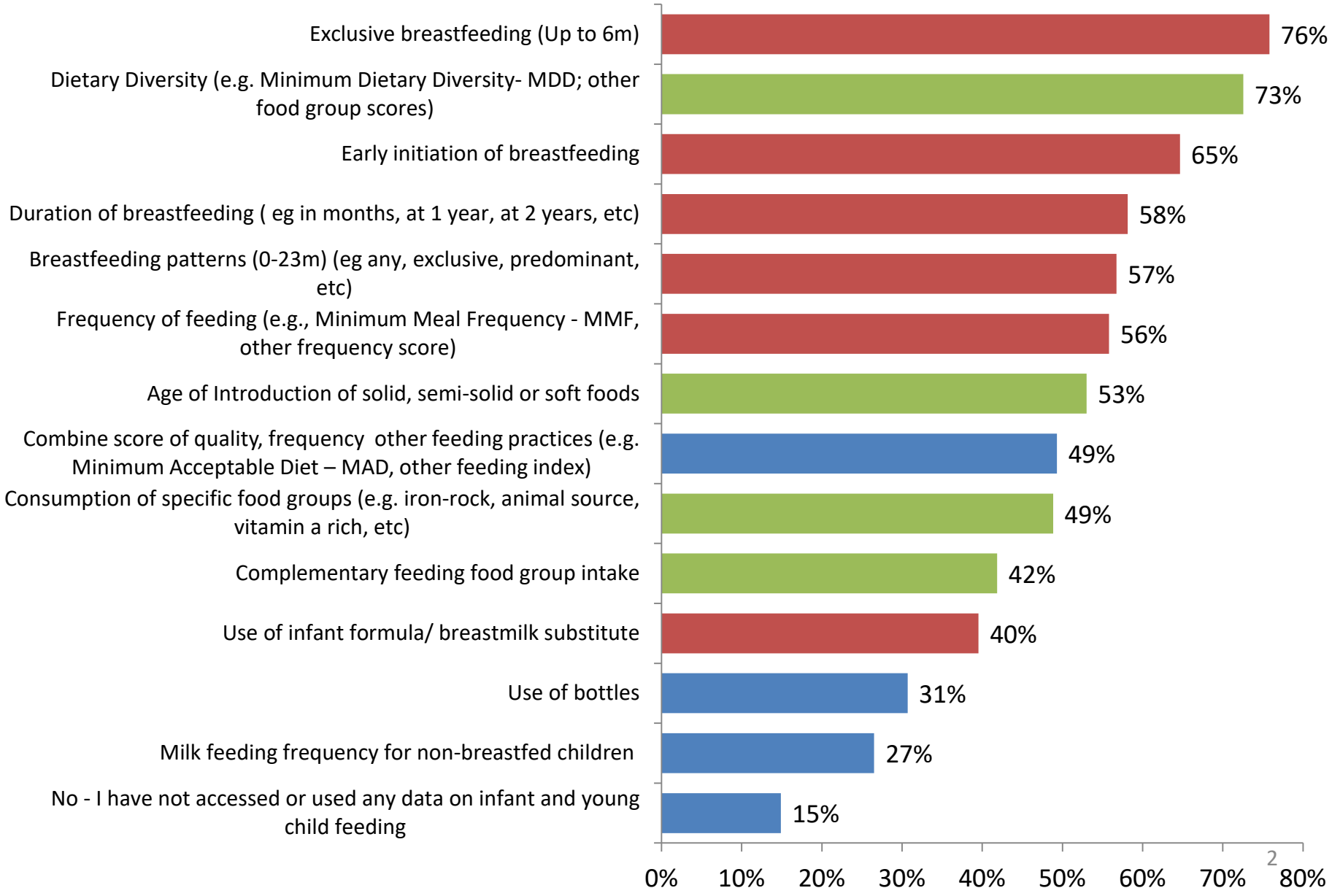
What data sources do respondents access for low birthweight data?*

Data sources	Overall (N=83)	Single country focus (N=38)	Multi-country focus (N=44)
Household survey (eg. DHS/MICS/SMART/other household survey)	75.9	55.3	95.4
Health facility survey (e.g. SPA, other)	14.5	21.0	6.8
Surveillance System (e.g. DSS, Hot Spot monitoring, etc)	15.7	21.0	11.4
Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data)	45.8	63.2	31.8
Other	6.0	0.0	11.4

*Multiple responses possible, denominators reflect those who reported using low birthweight data

IYCF practices data

Respondents who accessed IYCF data within the past year by intervention (N=229)



Percent of respondents who accessed IYCF data by working organization

	Overall	Government	UN/Multinational Orgs	NGO	Donor	Research/University	Private	Other
Number of individuals working for that organization group (N)	**215**	**24**	**55**	**62**	**12**	**49**	**11**	**2**
Exclusive breastfeeding (Up to 6m)	75.8	75.0	81.8	82.3	75.0	65.3	72.7	0.0
Dietary Diversity (e.g. Minimum Dietary Diversity- MDD; other food group scores)	72.6	83.3	69.1	83.9	75.0	61.2	54.5	50.0
Early initiation of breastfeeding	64.7	58.3	72.7	74.2	75.0	49.0	54.5	0.0
Duration of breastfeeding (eg in months, at 1 year, at 2 years, etc)	58.1	50.0	58.2	71.0	50.0	51.0	54.5	0.0
Breastfeeding patterns (0-23m) (eg any, exclusive, predominant, etc)	56.7	50.0	60.0	64.5	50.0	49.0	63.6	0.0
Frequency of feeding (e.g., Minimum Meal Frequency - MMF, other frequency score)	55.8	70.8	52.7	69.4	41.7	40.8	45.5	50.0
Age of Introduction of solid, semi-solid or soft foods	53.0	62.5	56.4	62.9	33.3	36.7	63.6	0.0
Combine score of quality, frequency other feeding practices (e.g. Minimum Acceptable Diet – MAD, other feeding index)	49.3	58.3	52.7	56.5	50.0	36.7	27.3	50.0
Consumption of specific food groups (e.g. iron-rock, animal source, vitamin a rich, etc)	48.8	50.0	47.3	54.8	58.3	40.8	45.5	50.0
Complementary feeding food group intake	41.9	54.2	36.4	48.4	41.7	36.7	27.3	50.0
Use of infant formula/ breastmilk substitute	39.5	45.8	38.2	46.8	25.0	30.6	54.5	0.0
Use of bottles	30.7	41.7	34.5	38.7	16.7	16.3	27.3	0.0
Milk feeding frequency for non-breastfed children	26.5	37.5	32.7	25.8	8.3	24.5	0.0	50.0

Percent of respondents working who accessed IYCF data aggregated by geographical scope of work

	Overall (N=215)	Single country focus (N=101)	Multi-country focus (N=112)
Exclusive breastfeeding (Up to 6m)	75.8	78.2	74.1
Dietary Diversity (e.g. Minimum Dietary Diversity- MDD; other food group scores)	72.6	70.3	75.0
Early initiation of breastfeeding	64.7	64.4	66.1
Duration of breastfeeding (eg in months, at 1 year, at 2 years, etc)	58.1	52.5	64.3
Breastfeeding patterns (0-23m) (eg any, exclusive, predominant, etc)	56.7	56.4	58.0
Frequency of feeding (e.g., Minimum Meal Frequency - MMF, other frequency score)	55.8	57.4	54.5
Age of Introduction of solid, semi-solid or soft foods	53.0	56.4	50.0
Combine score of quality, frequency other feeding practices (e.g. Minimum Acceptable Diet – MAD, other feeding index)	49.3	42.6	55.4
Consumption of specific food groups (e.g. iron-rock, animal source, vitamin a rich, etc)	48.8	44.6	52.7
Complementary feeding food group intake	41.9	47.5	36.6
Use of infant formula/ breastmilk substitute	39.5	38.6	41.1
Use of bottles	30.7	30.7	31.3
Milk feeding frequency for non-breastfed children	26.5	27.7	25.9
No - I have not accessed or used any data on infant and young child feeding	14.9	14.9	14.3

What data sources do respondents access for IYCF data?*

Data sources	Overall (N=173)	Single country focus (N=81)	Multi-country focus (N=91)
Household survey (eg. DHS/MICS/SMART/other household survey)	85.5	80.2	91.2
Health facility survey (e.g. SPA, other)	12.1	21.0	4.4
Surveillance System (e.g. DSS, Hot Spot monitoring, etc)	16.8	19.8	14.3
Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data)	24.3	30.9	18.7
Other	17.9	13.6	22.0

*Multiple responses possible, denominators reflect those who reported using growth monitoring data

Is IYCF data available as frequently as you'd like it to be?

Preferred frequency of data availability			
	Overall (N=82)	Single country focus (N=38)	Multi-country focus (N=43)
Yes	38.6	42.9	35.2
No	60.2	57.1	64.8

How frequently do respondents who were not satisfied with frequency of availability want IYCF data to be available?

Preferred frequency of data availability			
	Overall (N=48)	Single country focus (N=20)	Multi-country focus (N=25)
Every 6-10 years	0.0	0.0	0.0
Every 2-5 years	26.7	25.5	27.6
Annual	46.7	40.4	53.4
Quarterly	11.4	12.8	10.3
Monthly	10.5	17.0	5.2
Other	3.8	4.3	3.4

IYCF coverage indicators

Who uses data on complementary feeding or breastfeeding interventions?

By geographical scope of work		
	Comp. Feeding counseling coverage (%)	Breastfeeding counseling coverage (%)
Single country (N=112)	61.6	60.7
Multi country (N=115)	50.4	56.5
Overall (N=227)	58.5	56.3

By institutional affiliation			
	N	Comp. Feeding counseling coverage (%)	Breastfeeding counseling coverage (%)
Government	26	61.5	56.3
UN/ Multilateral	56	62.5	61.5
NGO	69	62.5	64.3
Donor	13	62.3	68.1
Research/ University	51	69.2	76.9
Private	12	39.2	373
Other	2	50.0	50.0
Total	229		

What data sources do respondents access for breastfeeding counselling coverage data?*

Data sources	Overall (N=126)	Single country focus (N=61)	Multi-country focus (N=60)
Household survey (eg. DHS/MICS/SMART/other household survey)	**73.8**	**70.5**	**81.7**
Health facility survey (e.g. SPA, other)	23.0	37.7	10.0
Surveillance System (e.g. DSS, Hot Spot monitoring, etc)	12.7	18.0	6.7
Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data)	41.3	**50.8**	33.3
Other	15.1	11.5	20.0

*Multiple responses possible, denominators reflect those who reported using breastfeeding counselling data

How frequently do respondents want breastfeeding counselling data to be available?

Is data available as frequently as you'd like it to be?		
	Single country focus (N=67)	Multi-country focus (N=60)
Yes	41.8	28.3
No	58.2	71.7

Preferred frequency of data availability			
	Single country focus (N=39)	**Multi-country focus (N=43)**	**Overall (N=82)**
Every 6-10 years	0.0	0.0	0.0
Every 2-5 years	12.8	14.0	13.4
Annual	**48.7**	**51.2**	**50.0**
Quarterly	12.8	23.3	18.3
Monthly	23.1	7.0	14.6
Other	2.6	4.7	3.7

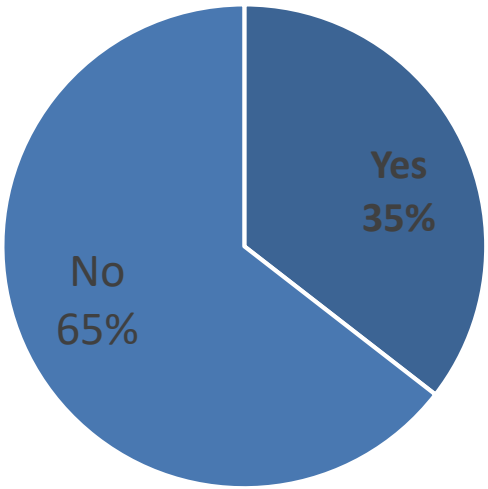
What data sources do respondents access for complementary feeding counseling coverage data?*

Data sources	Overall (N=121)	Single country focus (N=6)	Multi-country focus (N=54)
Household survey (eg. DHS/MICS/SMART/other household survey)	77.7	75.4	79.6
Health facility survey (e.g. SPA, other)	16.5	24.6	7.4
Surveillance System (e.g. DSS, Hot Spot monitoring, etc)	17.4	23.1	9.3
Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data)	37.2	38.5	35.2
Other	13.2	9.2	18.5

*Multiple responses possible, denominators reflect those who reported using complementary feeding counseling coverage data

How frequently do respondents want complementary feeding counselling data to be available

Is data on complementary feeding counseling available as frequently as you would like it to be?

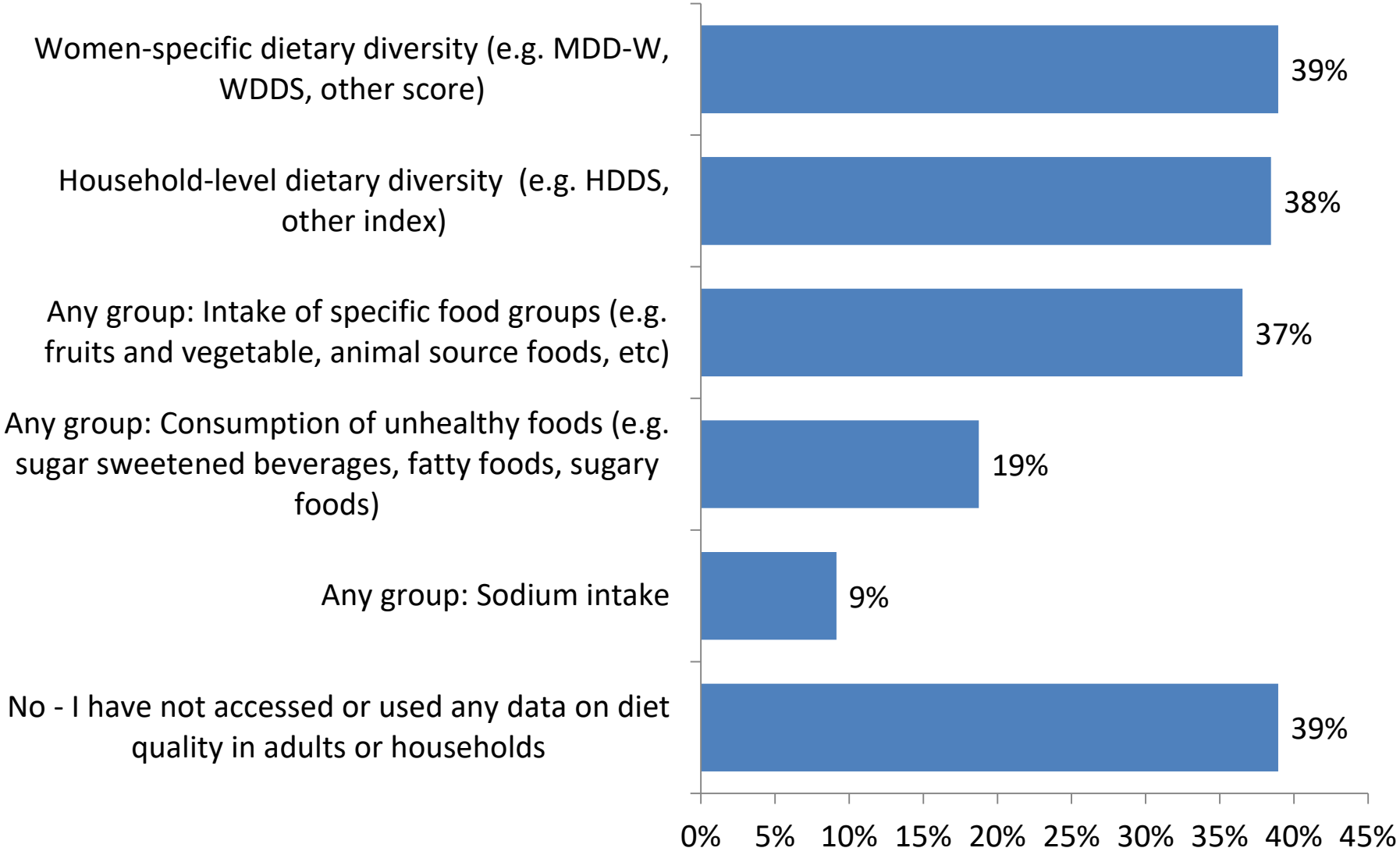


Note: no meaningful difference between single vs. multiple country focus

Preferred frequency of data availability			
	Single country focus (N=44)	Multi-country focus (N=35)	Overall (N=80)
Every 6-10 years	0.0	0.0	0.0
Every 2-5 years	11.4	22.9	16.3
Annual	**50.0**	**42.9**	**47.5**
Quarterly	13.6	22.9	17.5
Monthly	22.7	8.6	16.3
Other	2.3	2.9	2.5

Diet quality

Respondents who accessed diet quality data within the past year by indicator (N=208)



Percent of respondents who accessed diet quality indicators by working organization

	Overall	Government	UN/Multinational Orgs	NGO	Donor	Research	Private	Other
N	208	24	52	59	11	49	11	2
Women-specific dietary diversity (e.g. MDD-W, WDDS, other score)	38.9	41.7	32.7	47.5	45.5	34.7	36.4	0.0
Household-level dietary diversity (e.g. HDDS, other index)	38.5	41.7	40.4	40.7	36.4	34.7	36.4	0.0
Any group: Intake of specific food groups (e.g. fruits and vegetable, animal source foods, etc)	36.5	41.7	30.8	33.9	36.4	42.9	45.5	0.0
Any group: Consumption of unhealthy foods (e.g. sugar sweetened beverages, fatty foods, sugary foods)	18.8	16.7	13.5	13.6	0.0	28.6	27.3	50.0
Any group: Sodium intake	9.1	8.3	5.8	5.1	18.2	16.3	27.3	0.0
No - I have not accessed or used any data on diet quality in adults or households	38.9	33.3	46.2	40.7	36.4	30.6	45.5	50.0

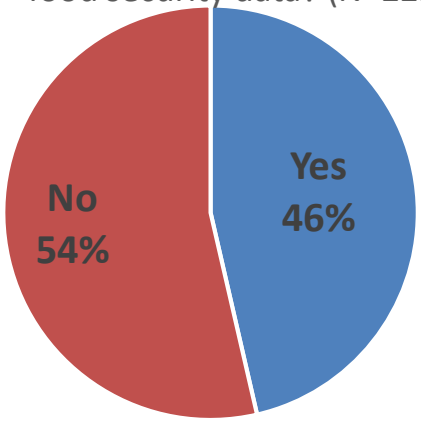
Percent of respondents working who accessed diet quality indicators by geographical scope of work

	Overall (N=208)	Single country focus (N=100)	Multi-country focus (N=107)
No - I have not accessed or used any data on diet quality in adults or households	38.9	42.0	36.4
Women-specific dietary diversity (e.g. MDD-W, WDDS, other score)	38.9	**34.0**	**43.0**
Household-level dietary diversity (e.g. HDDS, other index)	38.5	39.0	37.4
Any group: Intake of specific food groups (e.g. fruits and vegetable, animal source foods, etc)	36.5	33.0	39.3
Any group: Consumption of unhealthy foods (e.g. sugar sweetened beverages, fatty foods, sugary foods)	18.8	19.0	18.7
Any group: Sodium intake	9.1	14.0	4.7

Food security

Food security indicators accessed by geographical scope of work

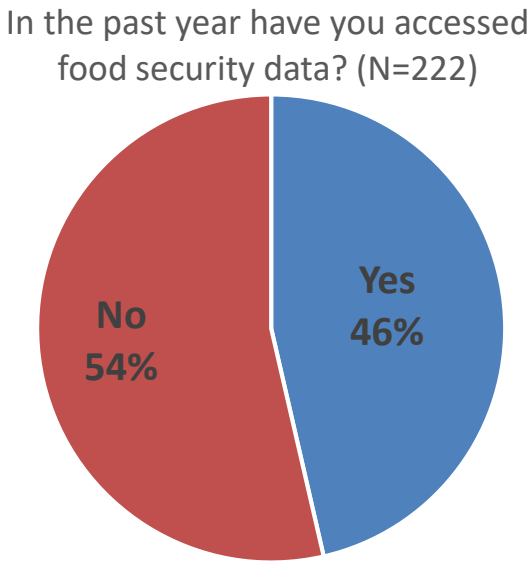
In the past year have you accessed food security data? (N=222)



In the past year have you accessed food security data?		
	Single country focus (N=107)	Multi-country focus (N=114)
Yes	40.2	51.8
No	59.8	48.2

Food security indicators accessed	Overall (N=91)	Single country focus (N=35)	Multi-country focus (N=55)
Food consumption Scores (FCS)	46.2	40.0	49.1
Household Food Insecurity and Access Scale (HFIAS)	45.1	45.7	45.5
Prevalence of undernourishment (FAO)	35.2	31.4	38.2
Coping Strategies Index (CSI)	29.7	31.4	29.1
Proportion of expenditure on food	26.4	22.9	27.3
Household Hunger Scale (HHS)	25.3	22.9	27.3
Other	14.3	14.3	14.5
Household Food Insecurity Experience Scale (HFIES- Gallup World Poll / FAO Voices of Hungry)	13.2	8.6	16.4

Food security indicators accessed by organization of work (1)



In the past year have you accessed food security data?							
	Government (N=25)	UN/Multinational Orgs (N=55)	NGO (N=64)	Donor (N=12)	Research/University (N=53)	Private (N=11)	Other (N=2)
Yes	60.0	50.9	48.4	58.3	34.0	27.3	50.0
No	40.0	49.1	51.6	41.7	66.0	72.7	50.0

What type of food security indicators have you accessed in the past year?*

	Overall	Government	UN/Multinational Orgs	NGO	Donor	Research/University	Private	Other
Food security indicators accessed (N)	**91**	**11**	**29**	**25**	**6**	**16**	**3**	**1**
Food consumption Scores (FCS)	29.7	18.2	31.0	28.0	50.0	18.8	54.5	0.0
Household Food Insecurity and Access Scale (HFIAS)	25.3	36.4	41.4	32.0	16.7	12.5	63.6	0.0
Prevalence of undernourishment (FAO)	13.2	45.5	27.6	24.0	0.0	18.8	45.5	50.0
Coping Strategies Index (CSI)	35.2	18.2	6.9	4.0	66.7	18.8	63.6	0.0
Proportion of expenditure on food	45.1	36.4	27.6	36.0	33.3	43.8	27.3	50.0
Household Hunger Scale (HHS)	46.2	45.0	27.6	56.0	50.0	56.3	45.5	50.0
Other	14.3	27.3	55.2	60.0	33.3	31.3	27.3	50.0
Household Food Insecurity Experience Scale (HFIES-Gallup World Poll / FAO Voices of Hungry)	0.0	9.1	10.3	16.0	0.0	18.8	54.5	0.0

*Among those who accessed any

Non-communicable diseases (diabetes, hypertension, overweight/obesity)

What data sources do respondents access for diabetes prevalence data?*

Data sources	Overall (N=23)	Single country focus (N=18)	Multi-country focus (N=13)
Household survey (eg. DHS/MICS/SMART/other household survey)	46.9	44.4	53.8
Health facility survey (e.g. SPA, other)	21.9	27.8	7.7
Surveillance System (e.g. DSS, Hot Spot monitoring, etc)	12.5	16.7	7.7
Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data)	28.1	38.9	15.4
Other	34.4	27.8	46.2

*Multiple responses possible, denominators reflect those who reported using diabetes prevalence data

How frequently do respondents want diabetes prevalence data to be available?

Is data available as frequently as you'd like it to be?		
	Single country focus (N=20)	Multi-country focus (N=14)
Yes	40.0	50.0
No	60.0	50.0

Preferred frequency of data availability			
	Overall (N=20)	**Single country focus (N=12)**	**Multi-country focus (N=7)**
Every 6-10 years	0.0	0.0	0.0
Every 2-5 years	30.0	25.0	28.6
Annual	**45.0**	**33.3**	**71.4**
Quarterly	5.0	8.3	0.0
Monthly	20.0	33.3	0.0
Other	0.0	0.0	0.0

What data sources do respondents access for hypertension prevalence data?*

Data sources	Overall (N=36)	Single country focus (N=22)	Multi-country focus (N=14)
Household survey (eg. DHS/MICS/SMART/other household survey)	50.0	54.5	42.9
Health facility survey (e.g. SPA, other)	27.8	40.9	7.1
Surveillance System (e.g. DSS, Hot Spot monitoring, etc)	27.8	31.8	21.4
Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data)	30.6	36.4	21.4
Other	33.3	22.7	50.0

*Multiple responses possible, denominators reflect those who reported using hypertension data

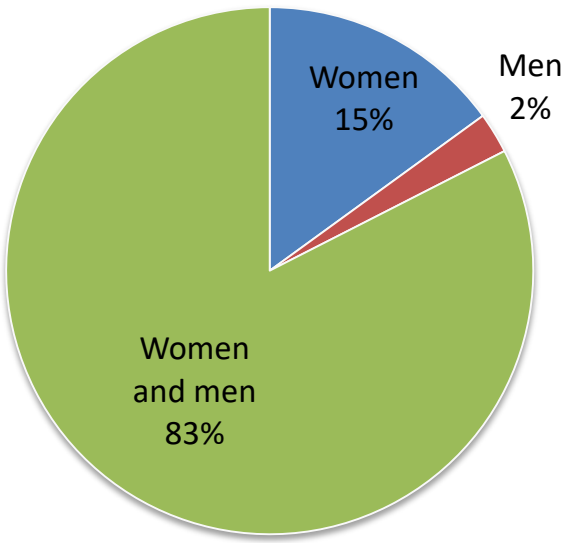
How frequently do respondents want hypertension prevalence data to be available?

Is data available as frequently as you'd like it to be?		
	Single country focus (N=24)	Multi-country focus (N=14)
Yes	**33.3**	**71.4**
No	66.7	28.6

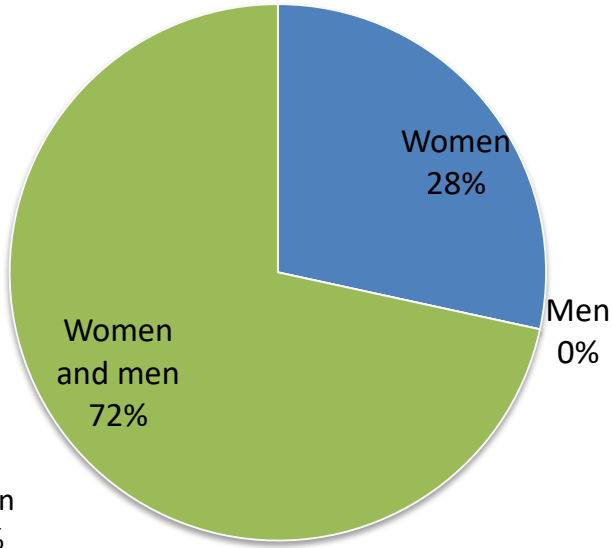
Preferred frequency of data availability			
	Overall (N=20)	**Single country focus (N=16)**	**Multi-country focus (N=4)**
Every 6-10 years	0.0	0.0	0.0
Every 2-5 years	15.0	12.5	25.0
Annual	**45.0**	**37.5**	**75.0**
Quarterly	20.0	25.0	0.0
Monthly	15.0	18.8	0.0
Other	5.0	6.3	0.0

NCD data on both genders is usually accessed

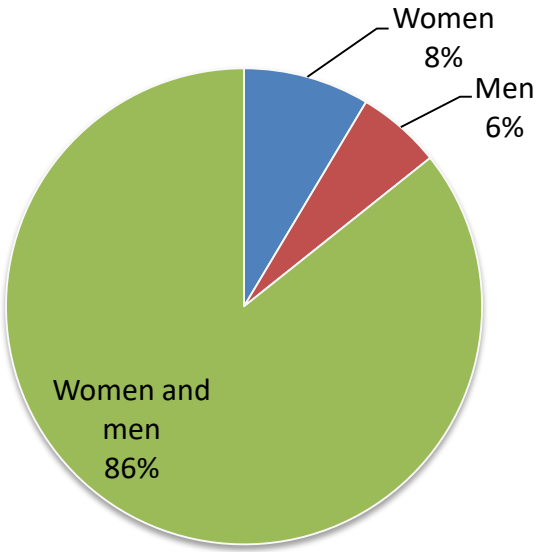
Hypertension (N=40)



Overweight/Obesity (N=88)

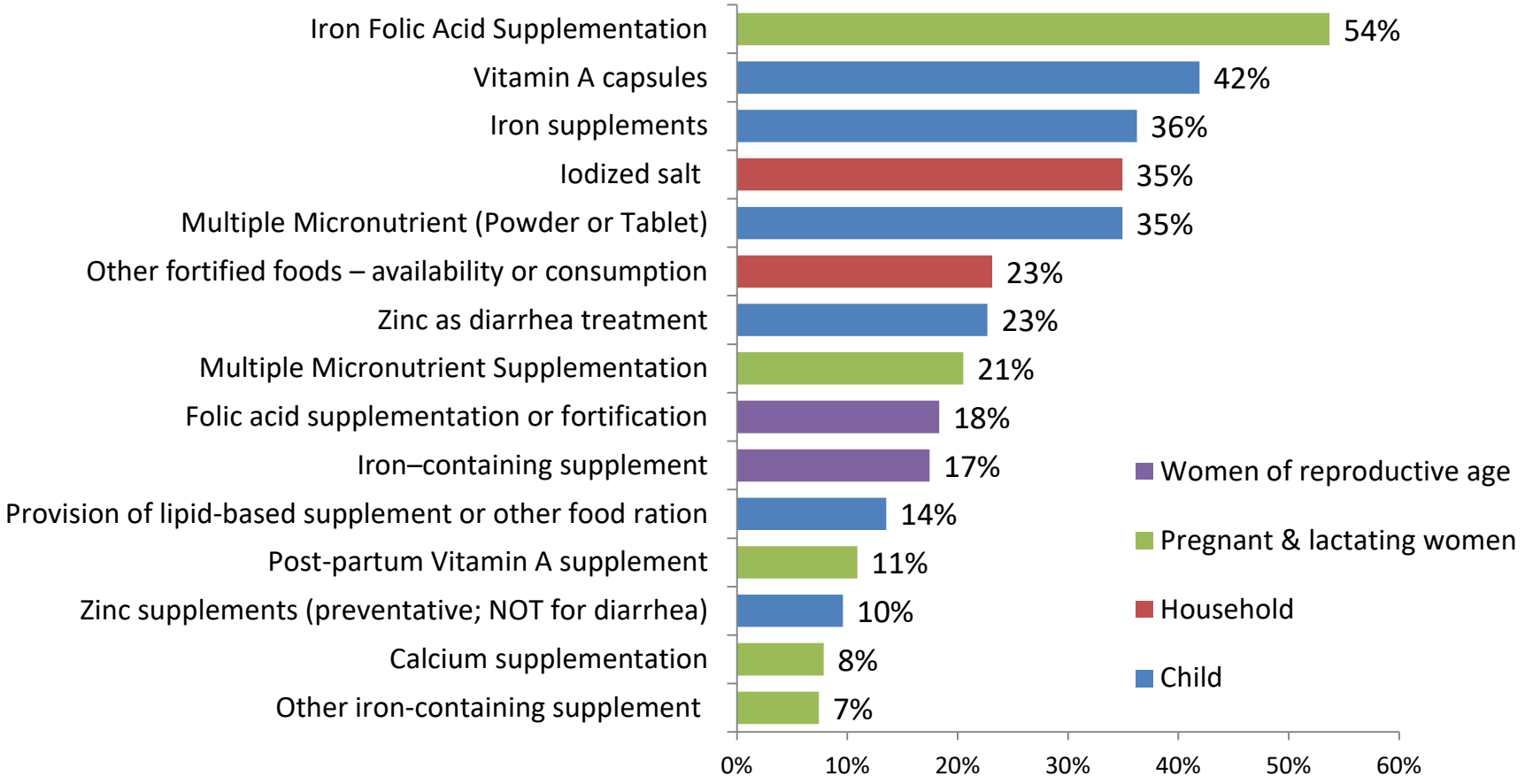


Diabetes (N=35)



Micronutrient coverage and utilization data

Respondents who accessed coverage or utilization data in last year by intervention (N=229)



Respondents who accessed coverage or utilization data in past year by institution type (N=229)

	Overall	Government	UN/Multinational Orgs	NGO	Donor	Research/University	Private	Other
N	229	26	56	69	13	51	12	2
PLW- Iron Folic Acid Supplementation	53.7	57.7	55.4	63.8	76.9	35.3	41.7	0
Child vitamin A capsules	41.9	53.8	62.5	37.7	61.5	19.6	16.7	50
Child iron supplements	36.2	50	44.6	31.9	53.8	25.5	25	0
Child- Multiple Micronutrient (Powder or Tablet)	34.9	50	50	21.7	53.8	29.4	16.7	0
Household-Iodized salt	34.9	53.8	51.8	24.6	23.1	25.5	33.3	0
Household- Other fortified foods – availability or consumption	23.1	42.3	16.1	18.8	30.8	21.6	41.7	0
Child- Zinc as diarrhea treatment	22.7	26.9	26.8	27.5	23.1	11.8	16.7	0
PLW- Multiple Micronutrient Supplementation	20.5	26.9	21.4	15.9	38.5	19.6	16.7	0
WRA-Folic acid supplementation or fortification	18.3	30.8	12.5	21.7	30.8	13.7	8.3	0
WRA- Iron–containing supplement	17.5	30.8	7.1	21.7	30.8	13.7	16.7	0
Child provision of lipid-based supplement or other food ration	13.5	19.2	7.1	10.1	30.8	15.7	25	0
PLW- Post-partum Vitamin A supplement	10.9	11.5	10.7	15.9	23.1	3.9	0	0
Child- Zinc supplements (preventative; NOT for diarrhea)	9.6	11.5	10.7	5.8	15.4	11.8	8.3	0
PLW-Calcium supplementation	7.9	11.5	1.8	11.6	23.1	5.9	0	0
PLW-Other iron-containing supplement	7.4	11.5	1.8	8.7	7.7	11.8	0	0

Respondents who accessed coverage or utilization data in the last year by geographic focus (N=112)*

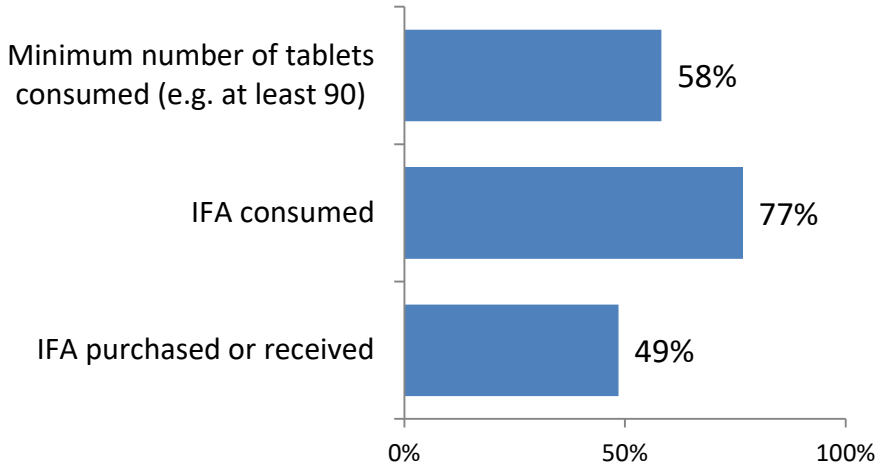
	Single country focus **(%)**
PLW- Iron Folic Acid Supplementation	55.4
Child iron supplements	38.4
Child vitamin A capsules	37.5
Household- Iodized salt	36.6
Child- Multiple Micronutrient (Powder or Tablet)	33.0
Household- Other fortified foods – availability or consumption	26.8
Child- Zinc as diarrhea treatment	22.3
WRA-Folic acid supplementation or fortification	19.6
PLW- Multiple Micronutrient Supplementation	17.9
Child provision of lipid-based supplement or other food ration	11.6
PLW- Post-partum Vitamin A supplement	10.7
PLW-Calcium supplementation	7.1
PLW-Other iron-containing supplement	7.1
Child- Zinc supplements (preventative; NOT for diarrhea)	6.3

*Multiple responses possible

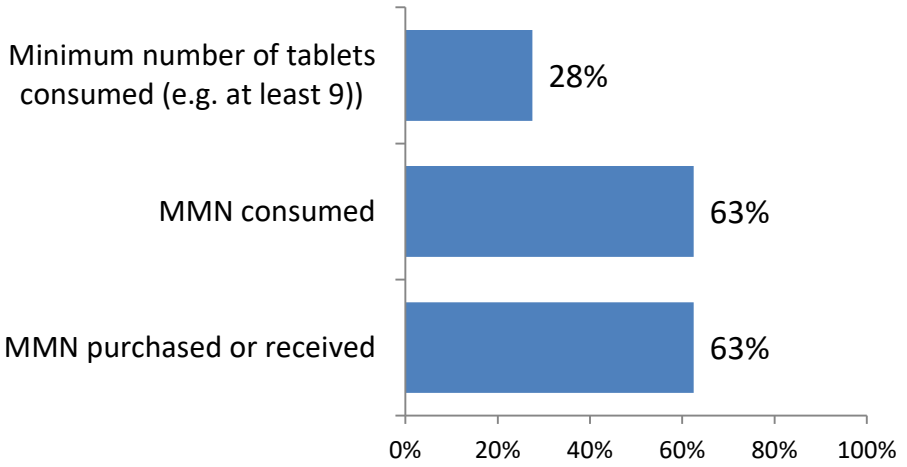
Additional Detail: IFA & Multiple Micronutrients (1)

Among those who accessed data in previous year, which specific information included?

Iron folic acid* (N=103)



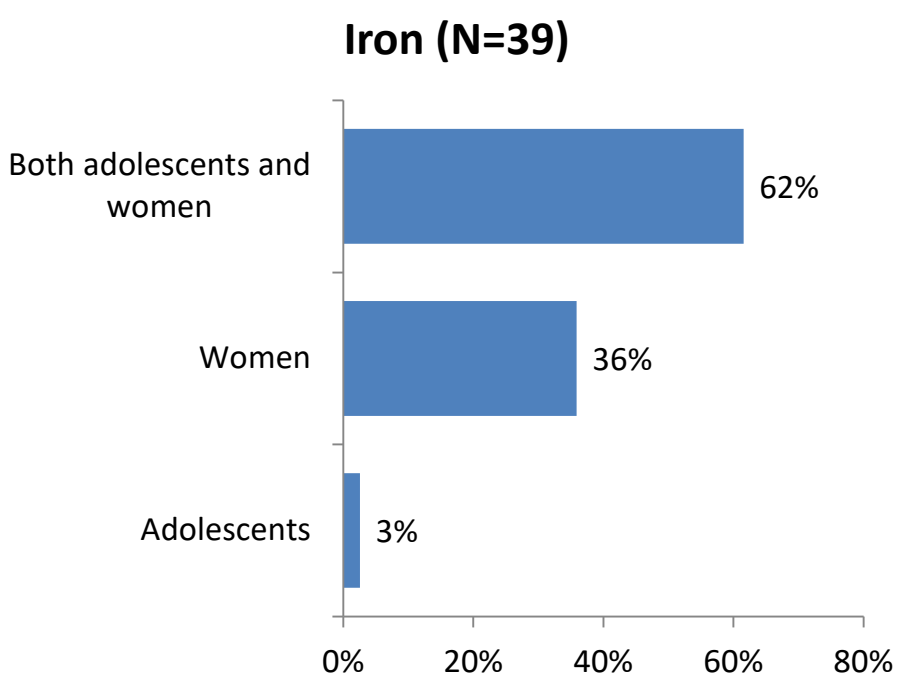
Multiple Micronutrient Supplementation (MMN) * (N=40)

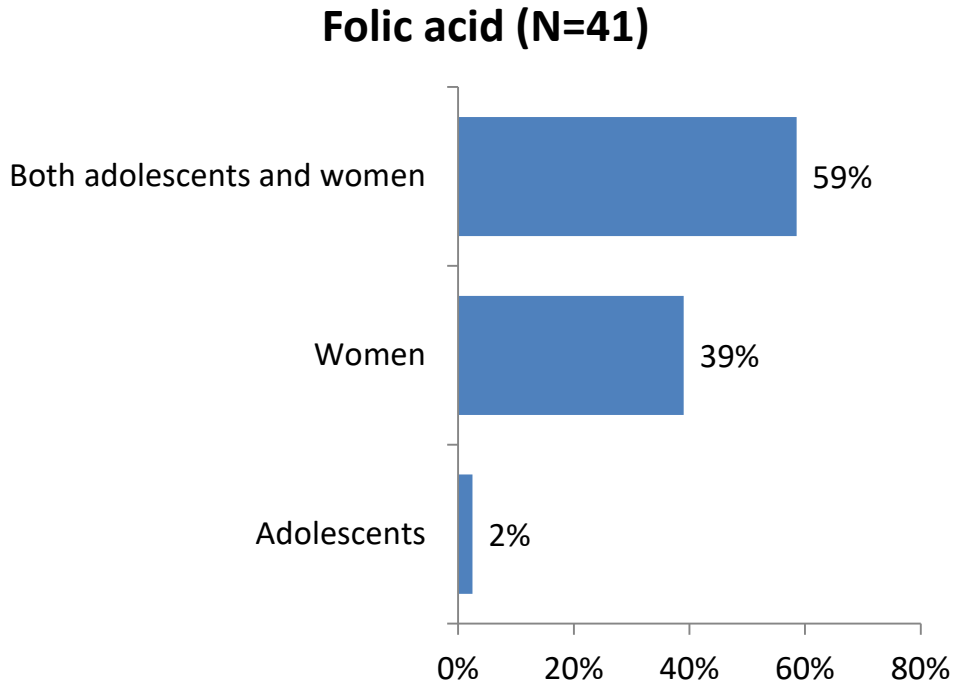


*Multiple responses possible

Additional Detail: IFA & Multiple Micronutrients (2)

Among those who accessed data in previous year, which populations were considered?





Additional Detail: iron-containing supplements

Who is accessing iron supplementation data? (n=229)

By geographic focus		Overall	Single country focus	Multi-country
	N	**229**	**112**	**115**
Child iron supplements		36.2	38.4	34.8
PLW- Iron Folic Acid Supplementation		53.7	55.4	53.0
PLW-Other iron-containing supplement		7.4	7.1	7.8
WRA Iron–containing supplement		17.5	18.8	16.5

By institution type	Overall	Government	UN/ Multinational Orgs	NGO	Donor	Research/ University	Private	Other
Individuals working within that organization (N)	**229**	**26**	**56**	**69**	**13**	**51**	**12**	**2**
Child iron supplements	36.2	88.5	44.6	31.9	53.8	25.5	25.0	0.0
PLW- Iron Folic Acid Supplementation	53.7	57.7	55.4	63.8	76.9	35.3	41.7	0.0
PLW-Other iron-containing supplement	7.4	11.5	1.8	8.7	7.7	11.8	0.0	0.0
WRA Iron–containing supplement	17.5	30.8	7.1	21.7	30.8	13.7	16.7	0.0

Additional Detail: Data on IFA for non-pregnant non-lactating

Among those who accessed data on IFA in non-pregnant non-lactating women in the previous year, data sources used* (N=23)	
Data sources	
Household survey (eg. DHS/MICS/SMART/other household survey)	91.3
Health facility survey (e.g. SPA, other)	17.4
Surveillance System (e.g. DSS, Hot Spot monitoring, etc)	17.4
Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data)	39.1
Other (please specify)	8.7

**Multiple responses possible*

Additional Detail: Vitamin A

*Among those who accessed or used vitamin A supplementation data in previous year, which data source did they access or use?**

Data sources	Overall (N=91)	Single country focus (N=40)	Multi-country focus (N=51)
Household survey (eg. DHS/MICS/SMART/other household survey)	71.4	62.5	78.4
Health facility survey (e.g. SPA, other)	18.7	37.5	3.9
Surveillance System (e.g. DSS, Hot Spot monitoring, etc)	15.4	22.5	9.8
Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data)	60.4	72.5	51.0
Other	6.6	5.0	7.8

*Multiple responses possible, denominators reflect those who reported using VAC supplementation data

Additional Detail: Vitamin A

How frequently do respondents want vitamin A coverage data to be available?

Is data available as frequently as you'd like it to be?		
	Single country focus (N=40)	Multi-country focus (N=47)
Yes	80.0	68.1
No	25.0	31.9

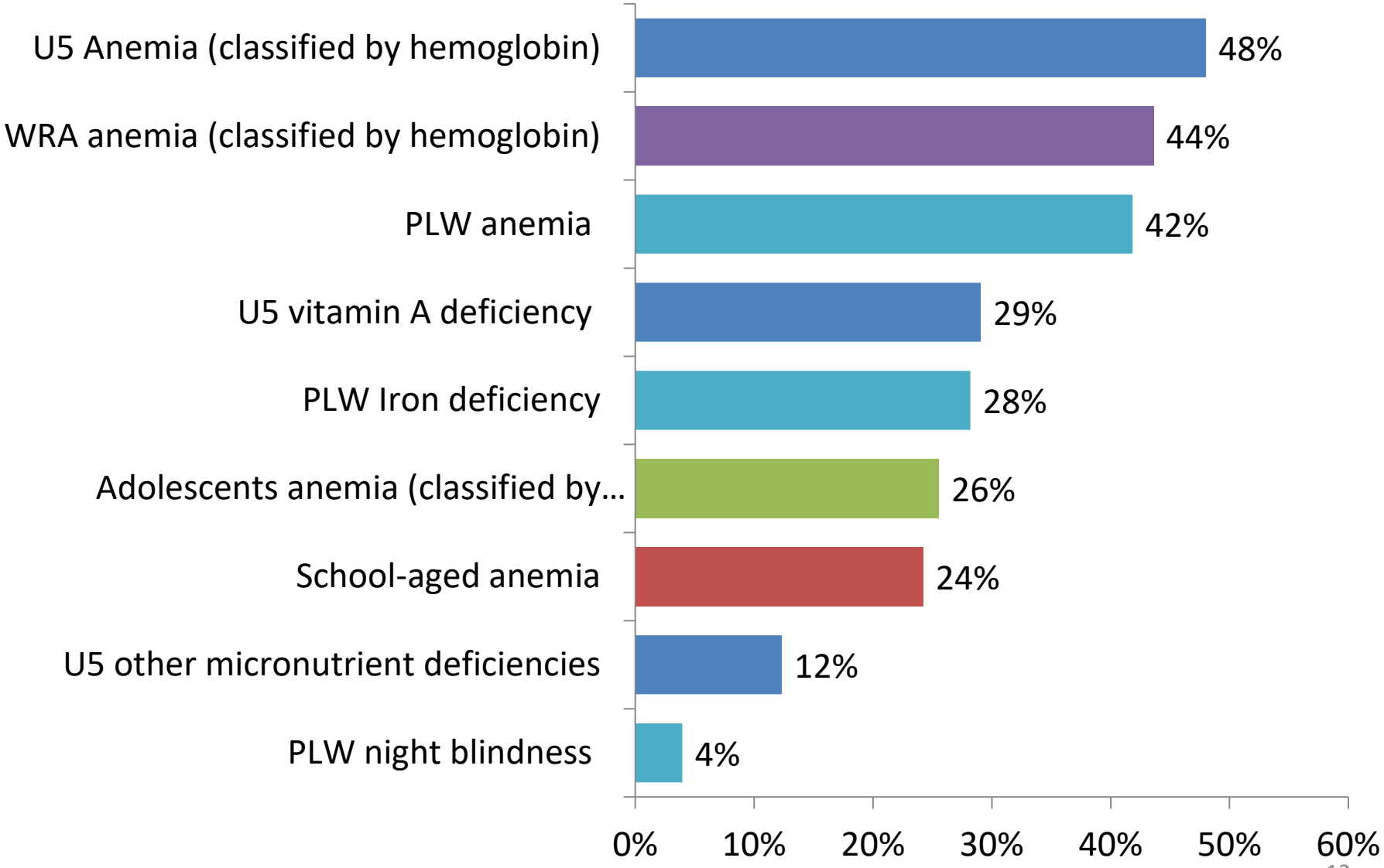
Preferred frequency of data availability			
	Overall (N=23)	**Single country focus (N=8)**	**Multi-country focus (N=15)**
Every 6-10 years	0.0	0.0	0.0
Every 2-5 years	16.3	0.0	13.3
Annual	47.5	37.5	40.0
Quarterly	17.5	25.0	26.7
Monthly	16.3	25.0	13.3
Other	2.5	12.5	6.7

Summary: current use & demand for indicator

- Indicators most often accessed or used in last year
  - iron folic acid in PLW (>50%)
  - micronutrients in children: vitamin A, iron and multi-micronutrient supplements/powders (all ≈30%)
- Vitamin A coverage/utilization data was accessed from different types of sources depending on whether user was focused on single vs. multiple countries
  - Administrative data used more by single country users (73%) than multi-country users (51%)
  - Survey data sources were more likely to used by multi-country users (78.4%) than single country (62.5%)
- For vitamin A coverage, >70% of respondents who had accessed data were satisfied with frequency of data availability

Micronutrient status

Respondents who accessed micronutrient status data by indicators in the previous 1 year (N=227)



Indicators of micronutrient status that were accessed in the past year by working organization

	Overall	Government	UN/ Multinational Orgs	NGO	Donor	Research/University	Private	Other
Individuals working within that organization (N)	**227**	**24**	**57**	**66**	**13**	**53**	**12**	**2**
U5 Anemia (classified by hemoglobin)	48.0	62.5	43.9	50.0	53.8	45.3	33.3	50.0
WRA Anemia (classified by hemoglobin)	43.6	54.2	31.6	47.0	69.2	41.5	41.7	50.0
PLW anemia	41.9	58.3	33.3	45.5	69.2	34.0	33.3	50.0
U5 vitamin A deficiency	29.1	33.3	33.3	34.8	30.8	18.9	16.7	0.0
PLW Iron deficiency	28.2	29.2	17.5	40.9	30.8	22.6	25.0	50.0
Adolescent Anemia (classified by hemoglobin)	25.6	20.8	17.5	31.8	53.8	24.5	8.3	50.0
School aged anemia	24.2	25.0	21.1	28.8	23.1	24.5	8.3	50.0
U5 other micronutrient deficiencies in under 5	12.3	12.5	7.0	15.2	15.4	17.0	0.0	0.0
PLW night blindness	4.0	12.5	1.8	3.0	7.7	1.9	8.3	0.0

Respondents who accessed nutritional status data disaggregated by geographical scope of work

	Single country focus (N=109)	Multi-country focus (N=116)
U5 Anemia (classified by hemoglobin)	43.1	52.6
WRA Anemia (classified by hemoglobin)	**35.8**	**51.7**
PLW anemia	34.9	47.4
U5 vitamin A deficiency	19.3	37.9
PLW Iron deficiency	26.6	29.3
Adolescent Anemia (classified by hemoglobin)	22.0	29.3
School aged anemia	25.7	22.4
U5 other micronutrient deficiencies in under 5	8.3	15.5
PLW night blindness	2.8	5.2

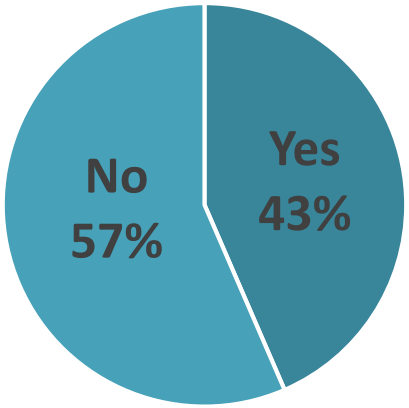
What data sources do respondents access for iron deficiency data on pregnant and lactating women?*

Data sources	Overall (N=59)	Single country focus (N=27)	Multi-country focus (N=31)
Household survey (eg. DHS/MICS/SMART/other household survey)	83.1	66.7	96.8
Health facility survey (e.g. SPA, other)	15.3	25.9	6.5
Surveillance System (e.g. DSS, Hot Spot monitoring, etc)	16.9	22.2	12.9
Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data)	33.9	51.9	19.4
Other	11.9	18.5	6.5

*Multiple responses possible, denominators reflect those who reported using iron deficiency data

How frequently do respondents want iron deficiency/status data on pregnant and lactating women?

Is the data available as frequently as you would like it to be?



Preferred frequency of data availability			
	Overall (N=35)	Single country focus (N=17)	Multi-country focus (N=18)
Every 6-10 years	2.9	5.9	0.0
Every 2-5 years	34.3	29.4	38.9
Annual	37.1	23.5	50.0
Quarterly	8.6	17.6	5.6
Monthly	8.6	11.8	5.6
Other	8.6	11.8	0.0

Note: no meaningful difference between single vs. multiple country focus

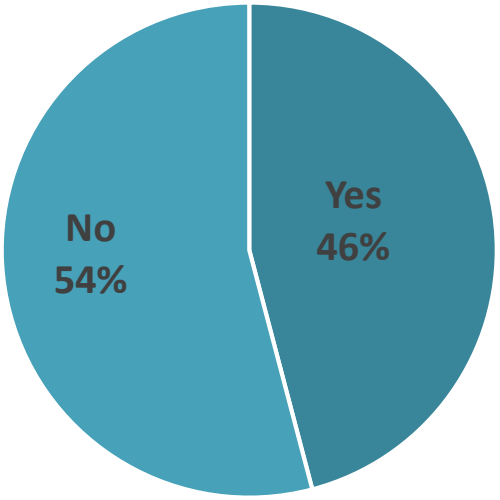
What data sources do respondents access for vitamin A in deficiency data for children under 5 years?*

Data sources	Overall (N=64)	Single country focus (N=21)	Multi-country focus (N=42)
Household survey (eg. DHS/MICS/SMART/other household survey)	84.4	76.2	88.1
Health facility survey (e.g. SPA, other)	10.9	28.6	2.4
Surveillance System (e.g. DSS, Hot Spot monitoring, etc)	14.1	23.8	9.5%
Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data)	23.4	33.3	19.0
Other	12.5	4.8	16.7

*Multiple responses possible, denominators reflect those who reported using vitamin A deficiency data

How frequently do respondents want vitamin A deficiency data for children under 5 years?

Is the data available as often as you would like it to be? (N=61)



Note: no meaningful difference between single vs. multiple country focus

Preferred frequency of data availability			
	Overall (N=32)	**Single country focus (N=11)**	**Multi-country focus (N=18)**
Every 6-10 years	6.3	9.1	5.6%
Every 2-5 years	34.4	27.3	44.4
Annual	37.5	36.4	44.4
Quarterly	12.5	18.2	11.1
Monthly	0.0	9.1	11.1
Other	9.4	0.0	0.0%

MIYCN counselling coverage or utilization

Are data on BF & CF Counselling coverage or utilization being accessed or used?

Respondents who reported accessing or using data in the last year (%)

By geographical scope of work			
	N	**BF counseling**	**CF counseling**
Single country	112	60.7	61.6
Multi country	115	56.5	50.4
Overall	229	56.3	58.5

By institutional affiliation			
	N	**BF counseling**	**CF counseling**
Government	26	61.5	61.5
UN/ Multilateral	56	64.3	62.5
NGO	69	68.1	62.3
Donor	13	76.9	69.2
Research/ University	51	37.3	39.2
Private	12	50.0	50.0
Other	2	0.0	0.0
Overall	229	56.3	58.5

BF Counseling: data sources

What data sources did respondents access for breastfeeding counseling coverage or utilization data in the previous year?*

Data sources	Overall (N=126)	Single country focus (N=61)	Multi-country focus (N=60)
Household survey (eg. DHS/MICS/SMART/other household survey)	73.8	70.5	81.7
Health facility survey (e.g. SPA, other)	23.0	37.7	10.0
Surveillance System (e.g. DSS, Hot Spot monitoring, etc)	12.7	18.0	6.7
Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data)	41.3	50.8	33.3
Other	15.1	11.5	20.0

**Multiple responses possible, denominators reflect those who reported using breastfeeding counselling data*

BF Counseling: Frequency of Data

Are data available as frequently as you'd like?		
	Single country focus (N=67)	Multi-country focus (N=60)
Yes	41.8	28.3
No	58.2	71.7

Preferred frequency of data among those who said it is no to previous questions			
	Single country focus (N=39)	**Multi-country focus (N=43)**	**Overall (N=82)**
Every 6-10 years	0.0	0.0	0.0
Every 2-5 years	12.8	14.0	13.4
Annual	48.7	51.2	50.0
Quarterly	12.8	23.3	18.3
Monthly	23.1	7.0	14.6
Other	2.6	4.7	3.7

CF Counseling: data sources

What data sources did respondents access for complementary feeding counseling coverage or utilization data in the previous year?*

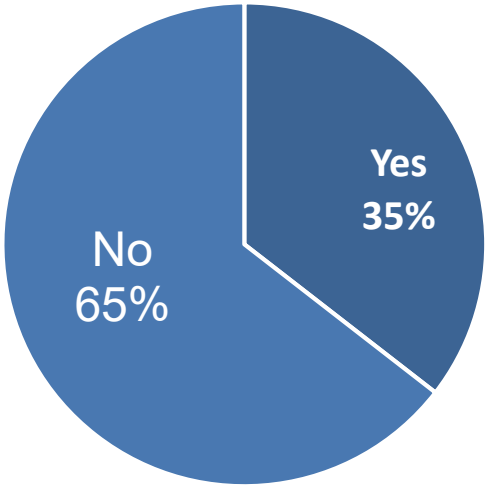
Data sources	Overall (N=121)	Single country focus (N=65)	Multi-country focus (N=54)
Household survey (eg. DHS/MICS/SMART/other household survey)	77.7	75.4	79.6
Health facility survey (e.g. SPA, other)	16.5	24.6	7.4
Surveillance System (e.g. DSS, Hot Spot monitoring, etc)	17.4	23.1	9.3
Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data)	37.2	38.5	35.2
Other	13.2	9.2	18.5

**Multiple responses possible, denominators reflect those who reported using complementary feeding counseling coverage data*

CF Counseling: Frequency of Data

How frequently do respondents want complementary feeding counselling data?

Is data on complementary feeding counseling available as frequently as you would like it to be?



Note: no meaningful difference between single vs. multiple country focus

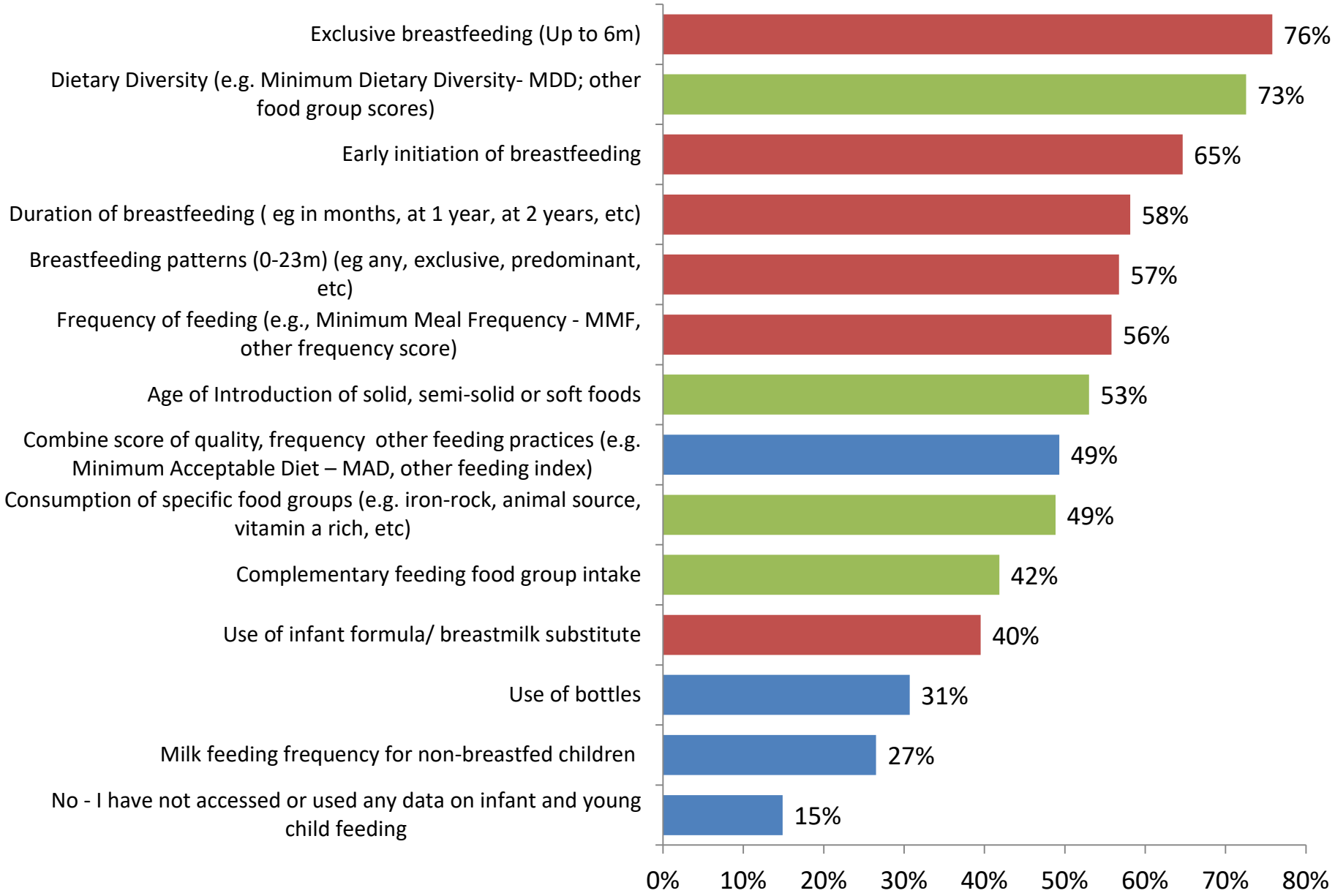
Preferred frequency of data among those who said it is no to previous question			
	Single country focus (N=44)	Multi-country focus (N=35)	Overall (N=80)
Every 6-10 years	0.0	0.0	0.0
Every 2-5 years	11.4	22.9	16.3
Annual	50.0	42.9	47.5
Quarterly	13.6	22.9	17.5
Monthly	22.7	8.6	16.3
Other	2.3	2.9	2.5

MIYCN counseling: quick overview

- Data on complementary feeding coverage or breastfeeding counseling were accessed by 58.5% and 56.3% of respondents respectively.
- Most common sources of breastfeeding counseling data include:
  - household surveys (74%)
  - administrative data (41%).
  - *Similar pattern for Complementary Feeding Counseling data*
- For BF counseling coverage:
  - Among single-country focus users, 51% accessed administrative data
  - Among multi-country focus users, 33% accessed administrative data
  - No difference by country focus for Complementary Feeding Counseling data (38.5% SC vs. 35.2% MC)
- Only 1/3 of respondents were satisfied with the frequency of breastfeeding or complementary feeding data
  - Single-country focus users were more satisfied with current frequency of BF data (42%) vs. multi-country focus users (28%).
  - Of those who were not satisfied, about half wanted BF counseling annually

IYCF Practices Data

Respondents (%) who accessed IYCF data within the past year by intervention (N=229)



Respondents (%) who accessed IYCF data within the past year by institution type

	Overall	Government	UN Multinational Orgs	NGO	Donor	Research/ University	Private	Other
N	**215**	**24**	**55**	**62**	**12**	**49**	**11**	**2**
Exclusive breastfeeding (Up to 6m)	75.8	75.0	81.8	82.3	75.0	65.3	72.7	0.0
Dietary Diversity (e.g. Minimum Dietary Diversity-MDD; other food group scores)	72.6	83.3	69.1	83.9	75.0	61.2	54.5	50.0
Early initiation of breastfeeding	64.7	58.3	72.7	74.2	75.0	49.0	54.5	0.0
Duration of breastfeeding (eg in months, at 1 year, at 2 years, etc)	58.1	50.0	58.2	71.0	50.0	51.0	54.5	0.0
Breastfeeding patterns (0-23m) (eg any, exclusive, predominant, etc)	56.7	50.0	60.0	64.5	50.0	49.0	63.6	0.0
Frequency of feeding (e.g., Minimum Meal Frequency - MMF, other frequency score)	55.8	70.8	52.7	69.4	41.7	40.8	45.5	50.0
Age of Introduction of solid, semi-solid or soft foods	53.0	62.5	56.4	62.9	33.3	36.7	63.6	0.0
Combine score of quality, frequency other feeding practices (e.g. Minimum Acceptable Diet – MAD, other feeding index)	49.3	58.3	52.7	56.5	50.0	36.7	27.3	50.0
Consumption of specific food groups (e.g. iron-rock, animal source, vitamin a rich, etc)	48.8	50.0	47.3	54.8	58.3	40.8	45.5	50.0
Complementary feeding food group intake	41.9	54.2	36.4	48.4	41.7	36.7	27.3	50.0
Use of infant formula/ breastmilk substitute	39.5	45.8	38.2	46.8	25.0	30.6	54.5	0.0
Use of bottles	30.7	41.7	34.5	38.7	16.7	16.3	27.3	0.0
Milk feeding frequency for non-breastfed children	26.5	37.5	32.7	25.8	8.3	24.5	0.0	50.0

Respondents (%) who accessed IYCF data within the past year by geographical scope of work

	Overall (N=215)	Single country focus (N=101)	Multi-country focus (N=112)
Exclusive breastfeeding (Up to 6m)	75.8	78.2	74.1
Dietary Diversity (e.g. Minimum Dietary Diversity- MDD; other food group scores)	72.6	70.3	75.0
Early initiation of breastfeeding	64.7	64.4	66.1
Duration of breastfeeding (eg in months, at 1 year, at 2 years, etc)	58.1	52.5	64.3
Breastfeeding patterns (0-23m) (eg any, exclusive, predominant, etc)	56.7	56.4	58.0
Frequency of feeding (e.g., Minimum Meal Frequency - MMF, other frequency score)	55.8	57.4	54.5
Age of Introduction of solid, semi-solid or soft foods	53.0	56.4	50.0
Combine score of quality, frequency other feeding practices (e.g. Minimum Acceptable Diet – MAD, other feeding index)	49.3	42.6	55.4
Consumption of specific food groups (e.g. iron-rock, animal source, vitamin a rich, etc)	48.8	44.6	52.7
Complementary feeding food group intake	41.9	47.5	36.6
Use of infant formula/ breastmilk substitute	39.5	38.6	41.1
Use of bottles	30.7	30.7	31.3
Milk feeding frequency for non-breastfed children	26.5	27.7	25.9
No - I have not accessed or used any data on infant and young child feeding	14.9	14.9	14.3

What data sources do respondents access for IYCF practices data?*

Data sources	Overall (N=173)	Single country focus (N=81)	Multi-country focus (N=91)
Household survey (eg. DHS/MICS/SMART/other household survey)	85.5	80.2	91.2
Health facility survey (e.g. SPA, other)	12.1	21.0	4.4
Surveillance System (e.g. DSS, Hot Spot monitoring, etc)	16.8	19.8	14.3
Administrative (routine) data source (e.g. DHIS-2, HMIS, other administrative data)	24.3	30.9	18.7
Other	17.9	13.6	22.0

*Multiple responses possible, denominators reflect those who reported using growth monitoring data

How frequently do respondents want IYCF practice data?

Preferred frequency of data availability			
	Overall (N=82)	Single country focus (N=38)	Multi-country focus (N=43)
Yes	38.6	42.9	35.2
No	60.2	57.1	64.8

Preferred frequency of data availability			
	Overall (N=48)	Single country focus (N=20)	Multi-country focus (N=25)
Every 6-10 years	0.0	0.0	0.0
Every 2-5 years	26.7	25.5	27.6
Annual	46.7	40.4	53.4
Quarterly	11.4	12.8	10.3
Monthly	10.5	17.0	5.2
Other	3.8	4.3	3.4

Q&A and Discussion for Plenary 1: DHS Results from a Nutrition Stakeholder Survey of Data Use and Data Needs, Andrew Thorne-Lyman, Johns Hopkins

Q: It's concerning that only 11% of responses came from actual government. Do you know why that is?

A: Yes, I agree. This was difficult. We did our best to reach out to government and ask them to weigh in. We do have the ability to go back to people and ask follow-up questions for interpretation purposes. We can do that with government people. I'm not sure why there weren't as many government respondents; perhaps it was internet access or just that they were too busy.

Q: Are you able to delve more deeply into where frequency and subnational data seem to relate to areas where we already have much of the data needs covered, versus, where (by the nature of those who responded) it was more about stretching into important new areas. Meaning, have we got the basics covered from the perspective of governments? And then, what are the areas where are stretching the boundaries into important but new areas of nutrition?

A: It's a great comment. For example, single country users do seem to be more satisfied with the frequency of data collection, and I'm not sure exactly what that means. Another piece I haven't mentioned, but is in the slides, is the use of information from surveys from administrative data. For certain things, for example, vitamin A capsule distribution. Surveys were used a lot, but administrative data was also used for assessing coverage. These questions would be useful to explore further.

Q: We manage the WHO Vitamin Mineral Nutrition Information System. I would be really interested to hear more about the micronutrient data [*inaudible*] markers and information that was provided on that. We hope to work with CDC to have a further evaluation of the system we just upgraded. We could probably take on some of the topics related to micronutrient status as well. I would be very interested to hear if people want the actual survey data or if they want estimated data (i.e. model data) and if there is any efforts to differentiate these kinds of data.

A: I didn't see too many picking up on this issue. It might be useful to look at the qualitative responses in the excel folder. In general, people tended to say, 'multiple micronutrient deficiency' and just be very vague with that.

Q: You showed that the most used indicators were 'coverage' data. But if DHS is the most used platform, how is this possible since DHS doesn't collect coverage data?

A: I expected this question. All we can surmise is that maybe when people say 'IYCF coverage', what they actually mean is the WHO indicators on practices, not coverage of the actual intervention.

Q: I'm thinking about supply and demand for indicators, and how much of the demand is driven by the fact that we are already familiar with certain indicators, so we think 'I wish I had this for other groups…, etc.' versus thinking 'Here is this problem that I want to solve, so what information do I need….'.

Also, you showed that roughly 25% of respondents thought that data quality was not reliable. Is it in fact unreliable? Or is it just a perception that it's unreliable? Do you have any thoughts on this?

A: I agree with you. I don't have any specific thoughts but they are good topics to follow up on.

Q: Are there any findings where people said they need LESS of something rather than more, i.e. we DON'T need this kind of information.

A: You mean information overload. I didn't see anything like that. We struggled to include a question about whether there is too much of any particular information. We should definitely follow-up on that.

Q: We are conducting the DHS in India. When I answered your on-line survey, I struggled with the questions related to the ideal frequency of data collection. In India, we have a massive survey infrastructure so it depends on what level of data collection. Frequency becomes a function or question of what *level* of government is requiring that data.

A: Perhaps the best approach is to disaggregate the responses to frequency questions by the 'type of user', since different users need different frequencies. That's a good point.

Q: I think it's a good step forward to start standardizing questions across regions and survey platforms. The goal of standardizing is to improve the quality, validity and interpretability of the data. In situations where surveys are giving us 60% coverage rates of Vitamin A, and administrative data is saying coverage is 110%, which do we believe? Policy and programmatic implications would be hugely different depending on which you believe. The question I urge the group to consider is: how do we check the quality of this data. In SMART, we put a lot of emphasis on checking the quality of anthropometry data, but we are frequently faced with questions about the quality of other types of nutrition and food security data, often from surveys in the same geographic areas. How do we check the quality of these various platforms? This should be discussed as well.

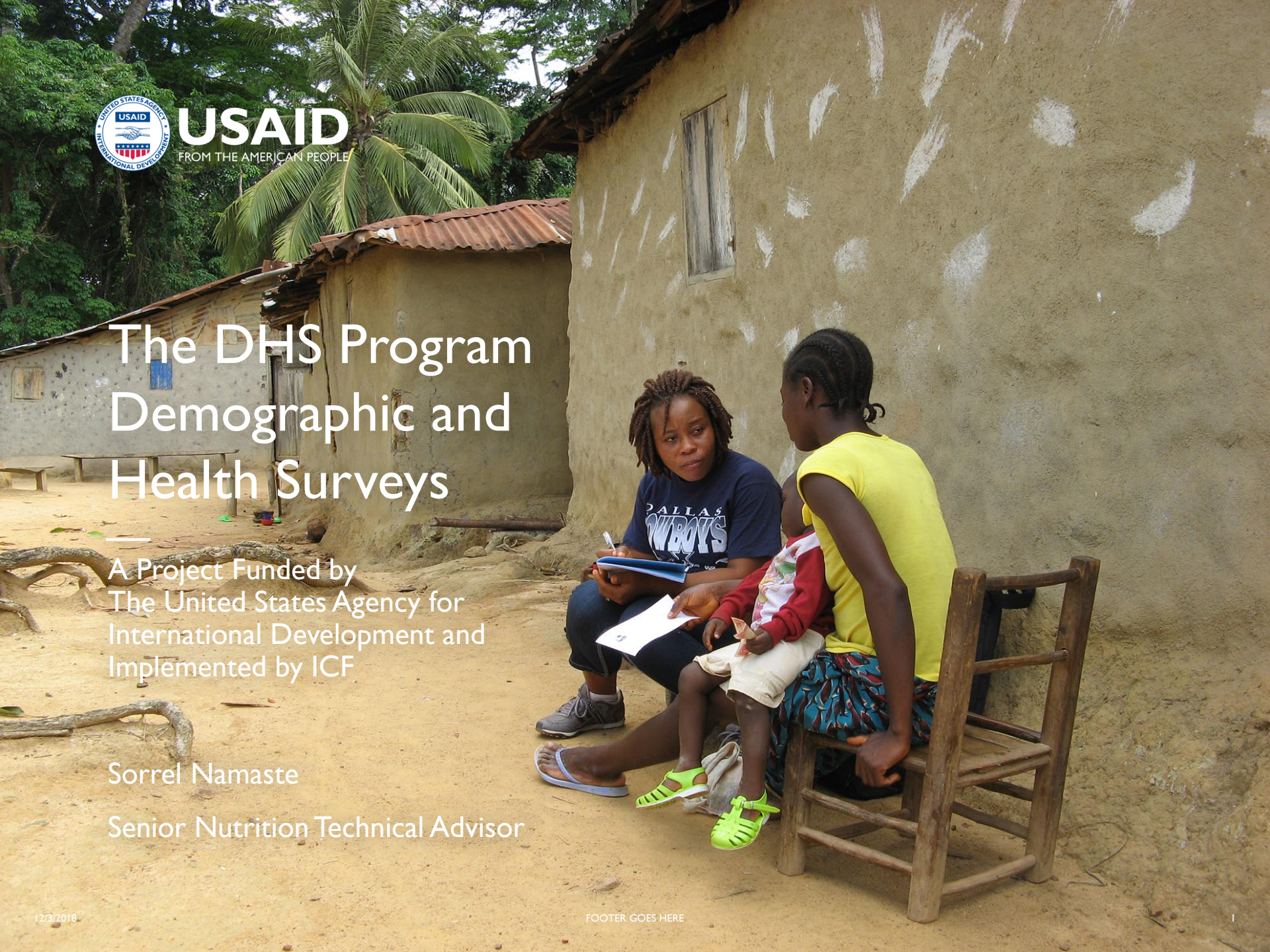
A: Good points.

Summary of Q&A, Rebecca Heidkamp, Johns Hopkins

An important point was raised: It's important to ask not only what data *is* being used, but also what data *is not* being used? And what are the various sources of data?

Do we pick from the menu of what's available to define our universe of information?
Or do we ask want we ideally need and want, and have *that* define our demand for data?

For a lot of groups, measurement is not the only thing they focus on in their jobs, so they rely on other people to tell them what are the most important data needs and requirements. We this group's expertise to tell us what the data priorities are, and therefore where we should invest, knowing that there are many different platforms that we can use.



The DHS Program Demographic and Health Surveys

A Project Funded by
The United States Agency for International Development and Implemented by ICF

Sorrel Namaste

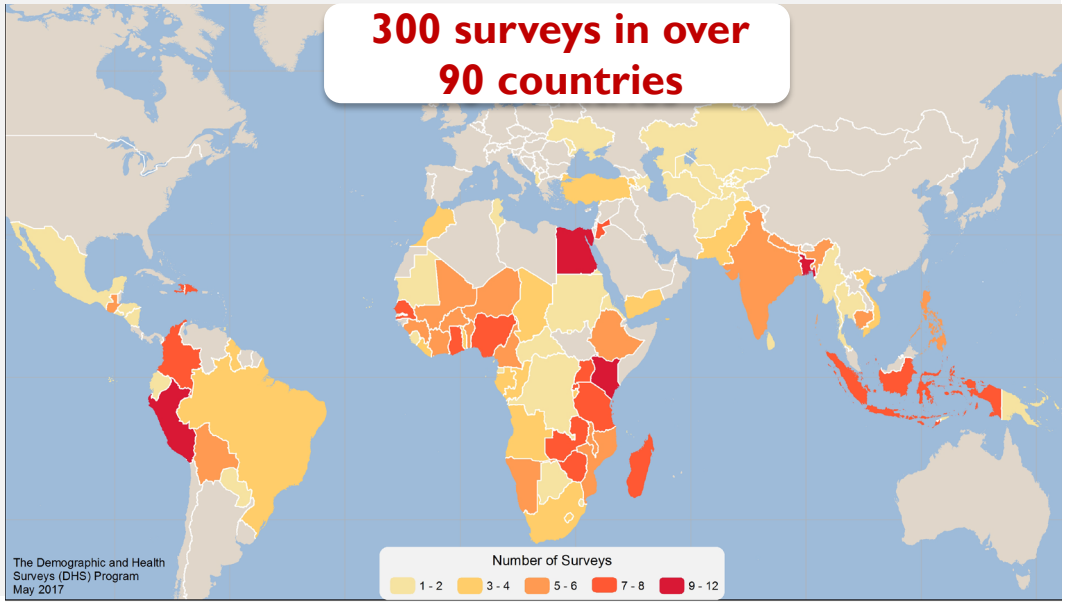
Senior Nutrition Technical Advisor

What is The DHS Program?

A USAID-funded project that provides technical assistance to:

- *improve* the collection, analysis and presentation of population, health, and nutrition data
- facilitate *use* of these data for planning, policy-making, and program management

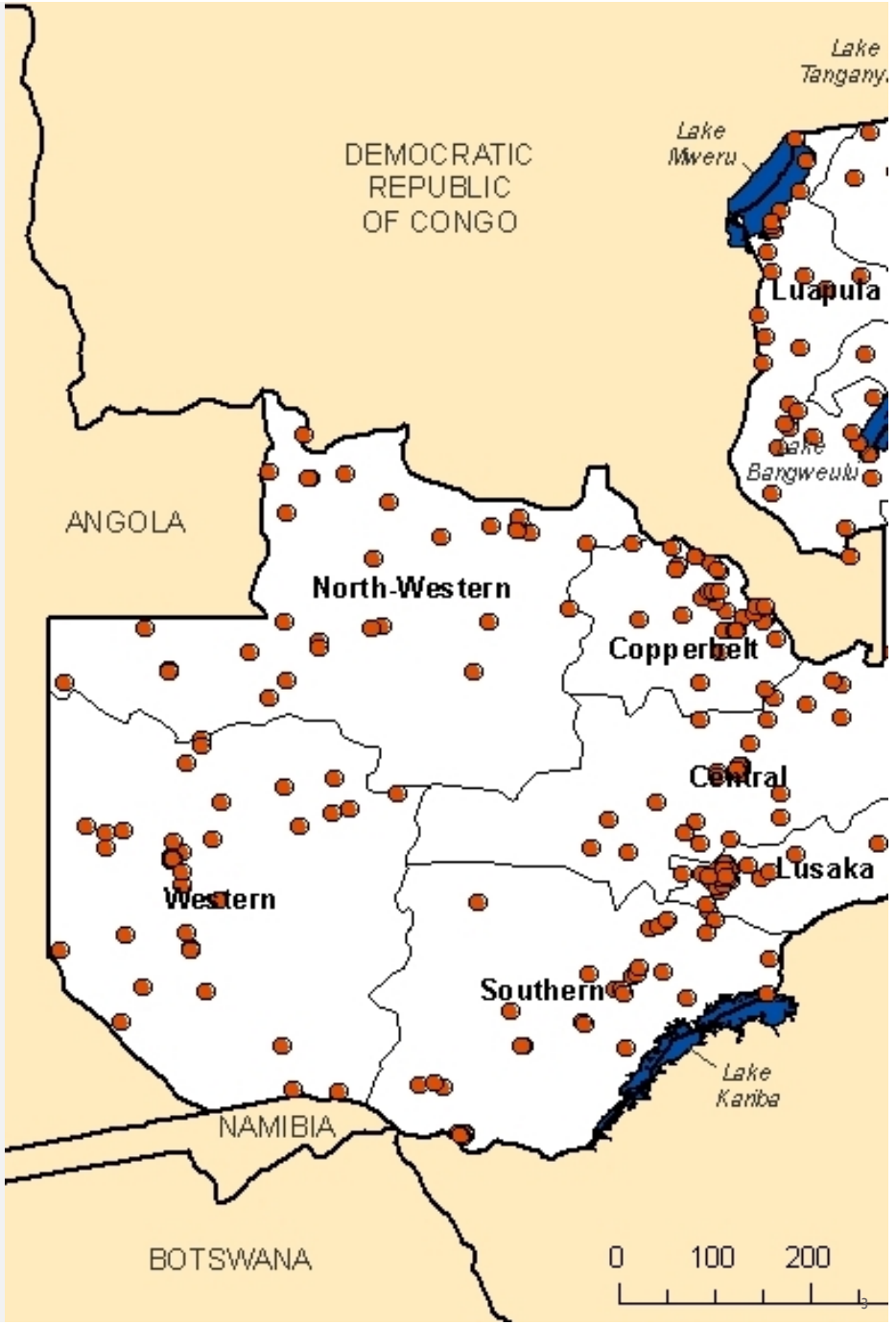
DHS-8 implemented by ICF with partners Johns Hopkins University, PATH, EnCompass, Avenir Health, Vysnova Partners, Blue Raster



DHS Sample

The DHS sample is typically representative at

- National level
- Urban and rural areas
- Regional level (sometimes groups of regions)
- Some surveys are representative at the state/provincial or district level



DHS Core Questionnaires

- Household questionnaire
- Woman's questionnaire
- Man's questionnaire
- Biomarker questionnaire
- Fieldworker questionnaire

DHS Modules

- Accident and Injury
- Adult and maternal mortality
- Disability
- Domestic violence
- Female genital cutting
- Fistula
- Male child circumcision
- Newborn care
- Non-communicable diseases
- Out-of-pocket health expenditures

Nutrition data

DHS

- Anemia
- Height and weight
- Breastfeeding/Complementary feeding
- Breastfeeding counselling
- Iodized salt in households
- Micronutrient supplementation

MIS survey

- Anemia

SPA survey

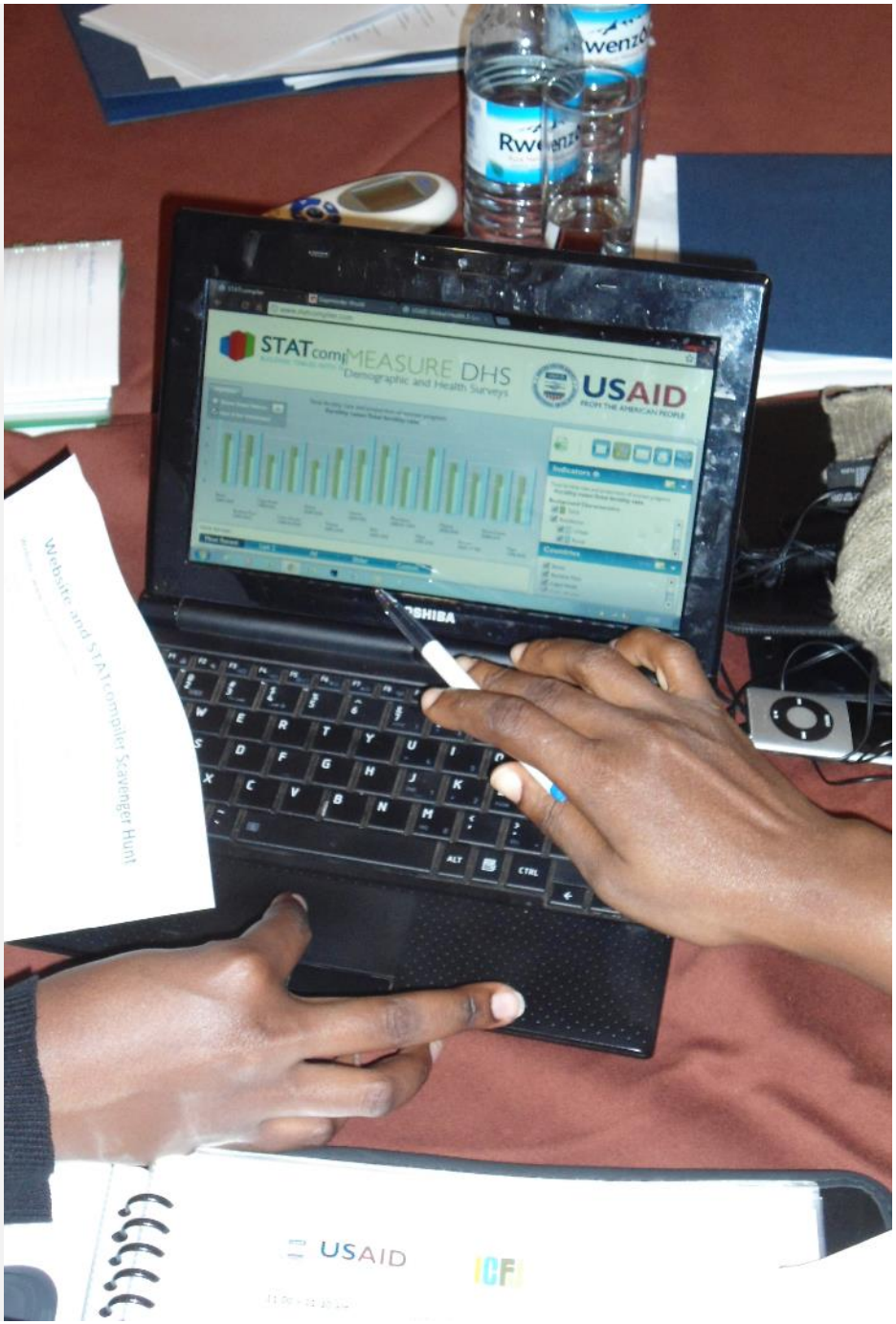
- Inventory of iron, zinc, vitamin A, scales
- Training IYCF and nutritional assessment during pregnancy
- Provision of nutrition counselling, IFA, growth monitoring, anemia assessment during pregnancy

Survey updates

- Major revisions to core questionnaire every 5 years
- Country needs met through country-specific questions
- Modules developed at any point in program cycle

DHS-7 process

- Sought public input through online platform
- DHS questionnaire design committee and content specific review groups
- Discussions with and final approval by USAID



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Plenary 2: Overview of major nutrition-related HH survey programs

Technical Consultation on Measuring Nutrition in Population-Based Household Surveys and Associated Facility Assessments

Washington DC, 19 September, 2018

Presented by:

Bo Robert Beshanski-Pedersen, Household Survey Consultant, UNICEF HQ MICS Team

MICS

Generating evidence to deliver for children

Overview

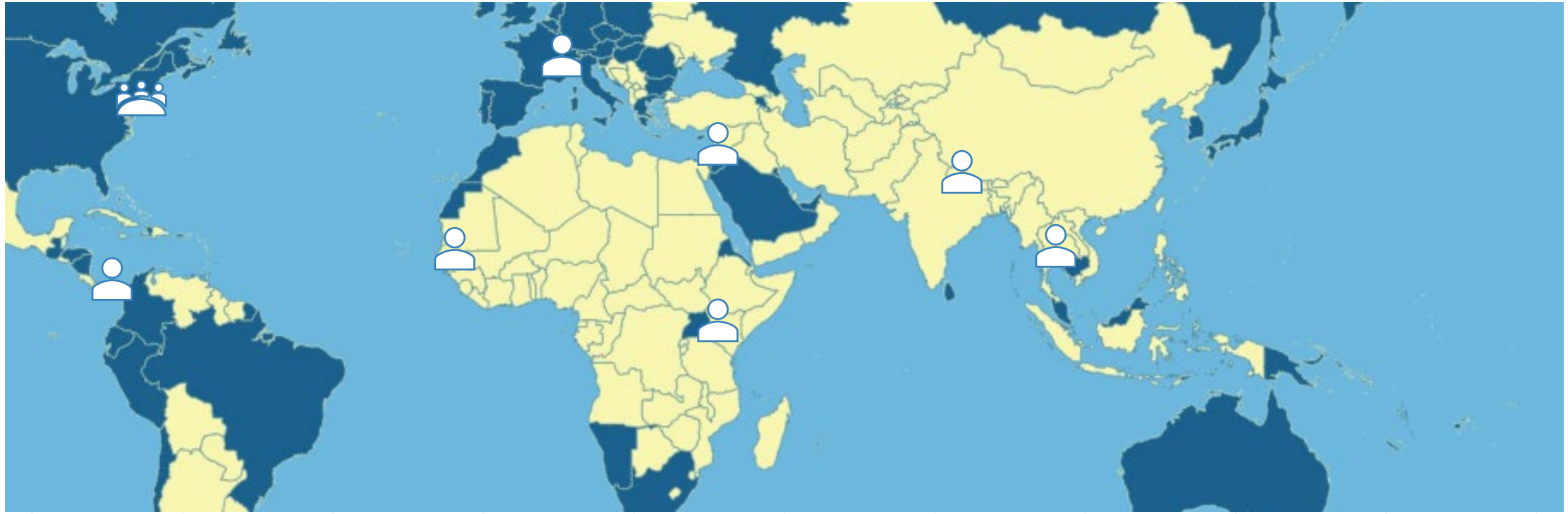
- Indicator-based survey
- Objective: A tool for countries to collect internationally comparable data on indicators of the situation of children, adolescents, women and households.
- Currently implementing a new overall management structure.
- Partnerships include
  - Groups: Intersecretariat Working Group on Household Surveys, International Household Survey Network and the DHS-MICS-LSMS Collaborative Group. The latter accompanied by (decades of) increasingly extensive informal communication.
  - Reference groups, often spearheaded by data focal points in UNICEF's Data & Analytics Section, developing "internationally agreed" indicators, supported or accompanied by MICS staff.
  - Globally, UN sister agencies are "partners": collaboration on indicators and modules suitable for MICS.
  - Locally and regionally, UN agencies partner on content, as do bilaterals and a variety of international organisations.

Geographical focus

22
Years

112
Countries

306
Surveys



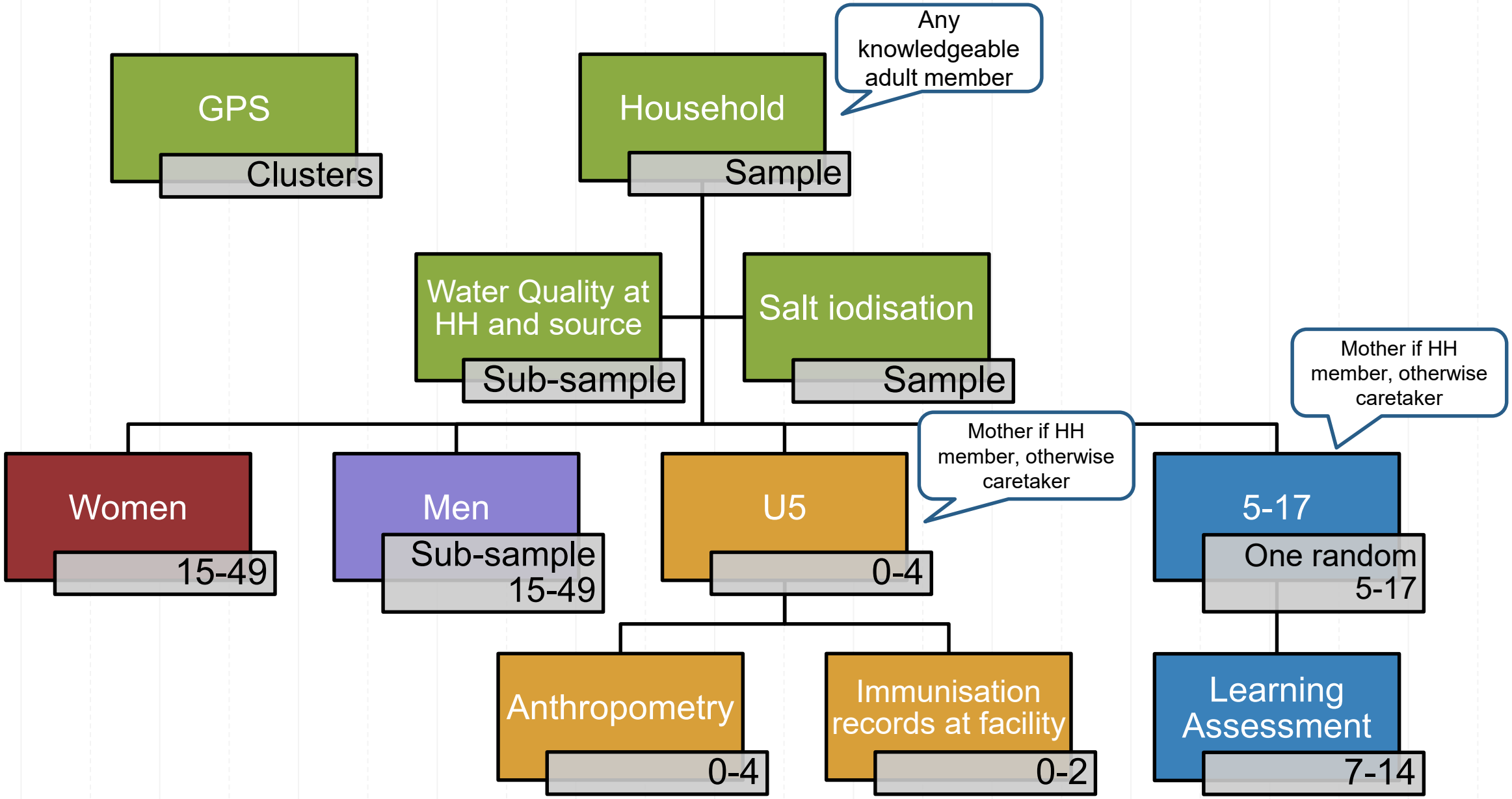
Historical emphasis

Round	Year/Period	Emphasis	# of Surveys
MICS1	1995	World Summit for Children Goals	63
MICS2	2000	World Summit for Children Goals	66
MICS3	2005-09	World Fit For Children Goals, MDGs, Other Global Monitoring Frameworks	53
MICS4	2009-13	MDGs, Other Global Monitoring Frameworks	60
MICS5	2013-16	Final MDG Assessment, A Promise Renewed, Other Global Monitoring Frameworks, baseline for post 2015 goals/targets	52
MICS6	2016-20	SDGs, other globally recommended indicators, new topics, emerging issues	60

Sampling Design

- Multi-stage, stratified cluster design, usually drawn on census with updated household listing
- National surveys, usually representative at 1st geographic division
- Frequent additional stratification with oversampling of target population: U5s, ethnic groups, geographic areas, women 15-24, and exclusive sub-national/population samples
- Median size currently at about 12,000, mean is increasing to above
- Foundation is key indicators, cost, feasibility

Survey Structure



Survey Structure

HOUSEHOLD

List of Household Members
Education [3+]
Household Characteristics
Social Transfers
Household Energy Use
Insecticide-Treated Nets
Water and Sanitation
Handwashing
Salt Iodisation

WATER QUALITY

GPS DATA COLLECTION

WOMEN AGE 15-49

Woman's Background
Mass Media and ICT
Fertility/Birth History
Desire for Last Birth
Maternal and Newborn Health
Post-natal Health Checks
Contraception
Unmet Need
Female Genital Mutilation
Attitudes toward Domestic Violence
Victimization
Marriage/Union
Adult Functioning [18-49]
Sexual Behaviour
HIV/AIDS
Maternal Mortality
Tobacco and Alcohol Use
Life Satisfaction

MEN AGE 15-49

Man's Background
Mass Media and ICT
Fertility
Attitudes toward Domestic Violence
Victimization
Marriage/Union
Adult Functioning [18-49]
Sexual Behaviour
HIV/AIDS
Circumcision
Tobacco and Alcohol Use
Life Satisfaction

CHILDREN AGE 5-17

Child's Background
Child Labour
Child Discipline [5-14]
Child Functioning
Parental Involvement [7-14]
Foundational Learning Skills [7-14]

CHILDREN UNDER 5

Under-Five's Background
Birth Registration
Early Childhood Development
Child Discipline [1-4 years]
Child Functioning [2-4 years]
Breastfeeding and Dietary Intake [0-2 years]
Immunisation [0-2 years] incl. Facility Form
Care of Illness
Anthropometry

Survey Structure

HOUSEHOLD

List of Household Members
Education [3+]
Household Characteristics
Social Transfers
Household Energy Use
Insecticide-Treated Nets
Water and Sanitation
Handwashing
Salt Iodisation

WATER QUALITY

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Immunisation [0-2 years] incl. Facility Form
Care of Illness
Anthropometry

Nutrition content

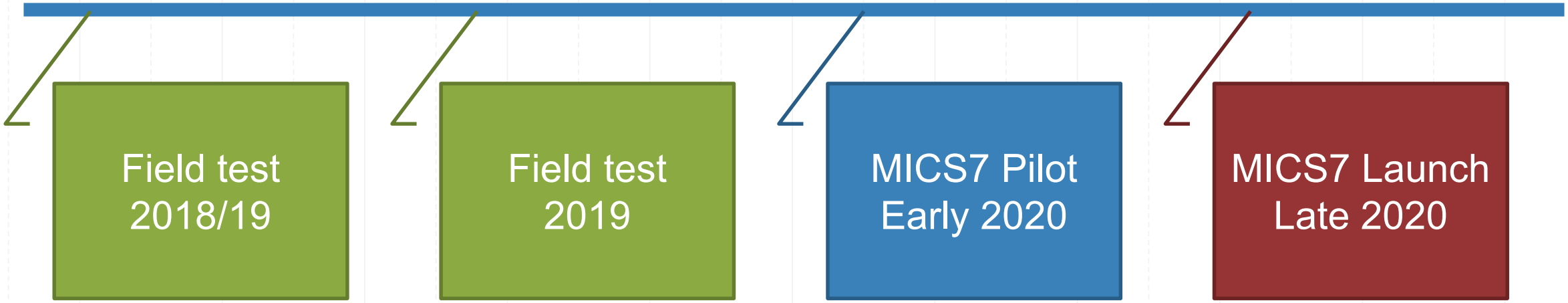
Salt
Iodized salt consumption

At birth
Children weighed at birth
Newborn feeding*
Post-natal signal care functions

IYCF	
Children ever breastfed	Introduction of solid, semi-solid or soft foods
Early initiation of breastfeeding	Minimum acceptable diet
Exclusive breastfeeding under 6 months	Milk feeding frequency for non-breastfed children
Predominant breastfeeding under 6 months	Minimum dietary diversity
Continued breastfeeding at 1 year	Minimum meal frequency
Continued breastfeeding at 2 years	Bottle feeding
Duration of breastfeeding	
Age-appropriate breastfeeding	

Anthropometry
Underweight prevalence
Stunting prevalence
Wasting prevalence
Overweight prevalence

Survey update timeline



- New or significantly changed content is typically individually tested, before inclusion in Field test, depending on source and history.
- MICS6 preceded by 1 Field test and Pilot (all rounds) in late 2015 and mid-2016, respectively. MICS6 launched late 2016
- Field test in 2017. Content for end-2018 Field test is currently in discussion and development.

Survey update process – MICS7

Already too big

Demand for new

Constant changes to old

CORE

CRITERIA CURRENTLY ALIGNING TOWARDS

- SDG indicator
- Universality

(demand/applicability)

- Child-specific
- Doable

(feasible, structurally appropriate, cost, burden, quality, utility, robust data)

+

THE REST:

Optional

(With criteria)

EVERYTHING NEW:

Validated

Tested by MICS

SMART SURVEYS PLATFORM

SMART

SMART OVERVIEW

- Global project convener Action Contre la Faim – Canada
- Partners
  - IASC Nutrition cluster and its members
  - Major international NGOs (ACF, Save the Children, World Vision, Concern, GOAL, etc.)
  - UN agencies (UNICEF, UNHCR, WFP)
  - Local partners -- governments (MoH, Statstics Committee), local NGOs
  - Donors – OFDA/USAID, ECHO, SIDA, etc
  - Technical support – Technical Advisory Group, CDC/CGH/ERRB
- Objective – to provide high quality, timely, representative anthropometry, mortality and other related data for public health policy and action
- Geographic focus:
  - Most surveys in Africa, Middle East, Asia
  - Emergency, post-emergency, refugee settings (initial focus)
  - Development settings

SMART SAMPLING DESIGN

1. Small-scale surveys
   - Level -- District, sub-district, camp etc.
   - Design – one-stratum two-stage cluster survey, sometimes simple random or exhaustive
   - Sampling – PPS first stage, enumeration and random selection of HH second stage
   - Sample size – usually 400-700 households
2. National nutrition surveys (NNS)
   - Level – National or sub-national
   - Design – multi-strata cluster survey, two-stage cluster design at stratum level, strata representative at admin 1 (province) or rarely at admin 2 (district) level depending on country needs and budgets
   - Sampling – PPS first stage, enumeration and random selection of HH second stage
   - Sample size – varies, around 500-700 per stratum*
   - Cost – varies, about 25-45 USD per HH, 15-23,000 USD per stratum*

* Burkina Faso and Tanzania taken as examples

SMART SURVEY STRUCTURE

- General SMART guidance principles regarding additional indicators:
  - SMART is not dictating what additional questions should be included, however
  - Keep additional variables and overall questionnaire length to a necessary minimum justified programmatically, long questionnaires affect quality of key variables; better measure few variables well than hundreds of variables badly
  - Standardize how additional variables are measured for comparability and quality of indicators (example – SENS by UNHCR)
- Examples of additional modules included in SMART questionnaires
  - Water, Sanitation and Hygiene (WASH)
  - Morbidity (e.g., diarrhea, ARI, malaria, etc)
  - Vaccination coverage
  - Mortality
  - Bed net coverage
  - Access to health services
  - Nutrition and food security indicators (see next slide)

SMART NUTRITION CONTENT

- MANDATORY -- Child anthropometry (0-59 or 6-59 months): weight, height, age, bilateral edema; MUAC optional
- OPTIONAL (examples of those used)
  - Coverage of vit A and deworming programs
  - Enrollment in nutrition treatment programs
  - Infant and Young Child Feeding (based on full or shortened WHO IYCF instrument)
  - Food security (HDDS, FCS, coping strategies, HHS, etc depending on the needs)
  - Women anthropometry (15-49 y) -- weight, height, MUAC
  - Pregnant/breastfeeding status of women
  - Iron/folate coverage during pregnancy
  - Child and/or women hemoglobin
  - Iodized salt in HH

SMART UPDATE PROCESS

1. Technical updates (data quality checks, automated analyses, sampling methods, etc)
   - Based on field practices, feedback of practitioners, research of technical partners
   - Ongoing process, current guidance at smartmethodology.org
2. Questionnaire content updates (standard questions, mandatory and optional modules, etc)
   - Up to agencies and countries (e.g., UNHCR, WFP, Kenya, South Sudan, etc.)
   - Ongoing guidance provided to limit content to a necessary minimum
   - Some indicators are slow changing and do not need to me measured annually
   - Advent of mobile data collection tools can facilitate standardization

Overview of LSMS Work Program

Mimi Siwatu

Technical Consultation on Measuring Nutrition in Population-Based Household Surveys and Associated Facility Assessments
September 19-20, 2018 – Washington, DC

LSMS: Overview

- Produce high-quality, multi-topic, nationally (& sub-nationally) representative **data** that allow for a richer understanding of **poverty**
  - Data Production (technical assistance)
  - Methodological & Policy Research
  - Training & Dissemination (Open Access Data)

- **Geographic focus:**
  - Developing countries around the world
  - LSMS-ISA countries in Africa

- **Partnerships:**
  - Local partners: National Statistics Offices, Research institutions (ISSER, EDI)
  - Development partners: BMGF, USAID, DHS+MICS+LSMS Collaborative Group, FAO, IFAD, UK Aid, WFP, USDA, UN Edge, CGIAR, Bank of Italy, Stanford, Skybox, Planet Labs, MIT, WAEMU, etc

LSMS
Living Standards Measurement Study

LSMS: Sampling Design and Survey Structure

- **Nationally and sub-nationally representative data**
  - Population based frame
  - Sample sizes typically range from ~3 to 10,000 HHs
- **Panel/longitudinal**
  - LSMS-ISA countries
- **Geo-referenced**
  - Create "geo-variables" to avoid dissemination of confidential data
- **Computer-assisted**
  - Using *Survey Solutions* CAPI platform

LSMS
Living Standards Measurement Study

LSMS: Sampling Design and Survey Structure

- **Welfare**: monetary & non-monetary measurement
  - Consumption & income
  - Allows for distributional analysis

- **Multi-purpose** (beyond indicators)
  - Tool to study behavior, understand phenomena & analyze linkages

- **Multi-level**: community, household, individual, plot data (Gender-disaggregation)
  - **Household level** modules – Respondent is household head or most knowledgeable member, e.g. consumption, household businesses (farm and nonfarm), non-food expenditure, etc.
  - **Individual level** modules – Each household member responds unless too young or unable to, e.g. education, labor, health, etc.
  - **Community level** - Respondents are usually a group of leaders in the community, e.g. access to services, infrastructure, etc

LSMS
Living Standards Measurement Study

LSMS: Nutrition Content

- **Household Consumption**
  - Quantity of food consumed within the household from purchases, own production and gifts
  - Food purchased or consumed for free outside the household
  - Guidelines endorsed by the UN statistical commission

- **Anthropometric measurement**
  - Children 0-59 months (adults in some countries)
  - Quality matches well with DHS data
  - Panels of children that allows (in some countries) to look at measures of linear growth and growth velocity

- **Food security**
  - FIES (FAO), Food Consumption Score (WFP)
  - Dietary diversity modules for women 15-49 years and children 0-59 months (LSMS-ISA+)

LSMS
Living Standards Measurement Study

LSMS: Survey Update Process

- **LSMS surveys** have been around since the 1980s
  - Over 150 LSMS Surveys listed on the WB Microdata Catalogue
  - **Data users' group** to learn country needs & customize to reflect policy priorities
  - Integrates into the country's system of surveys when possible
  - Ongoing updates to meet country needs (e.g. SDG indicators)

- Surveys are updated to meet **international standards** and **best practices** through our **methodological work**
  - Test (old & new) methods in tandem with a gold standard
  - Assess relative accuracy , cost effectiveness, scale-up feasibility
  - Document results, best practices & protocols for scale-up
  - Integrate validated & cost-effective methods into LSMS operations

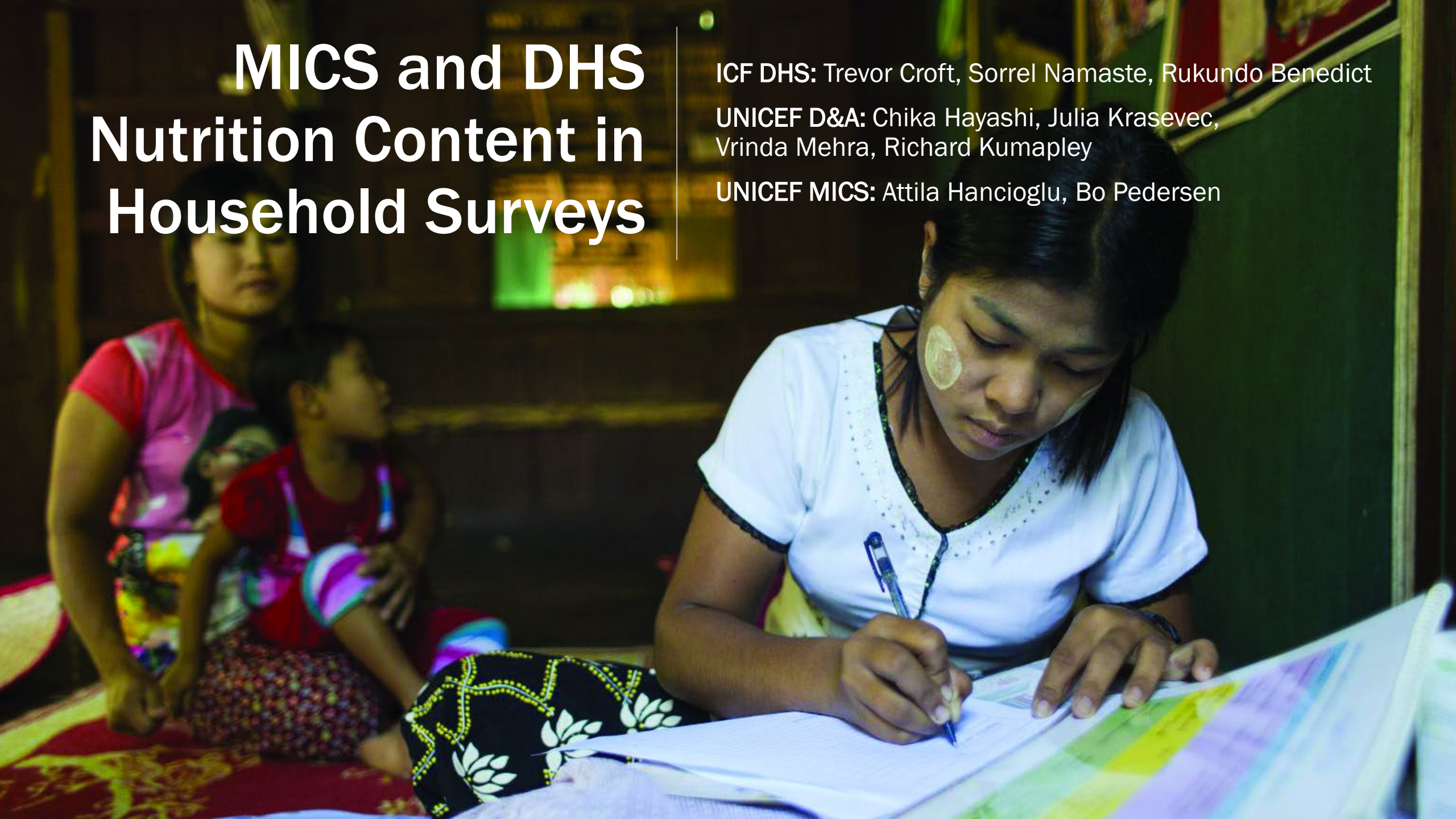
LSMS
Living Standards Measurement Study

MICS and DHS Nutrition Content in Household Surveys

ICF DHS: Trevor Croft, Sorrel Namaste, Rukundo Benedict

UNICEF D&A: Chika Hayashi, Julia Krasevec, Vrinda Mehra, Richard Kumapley

UNICEF MICS: Attila Hancioglu, Bo Pedersen



History of DHS and MICS Harmonization

- Over 20 years of harmonization
- Majority of content is harmonized

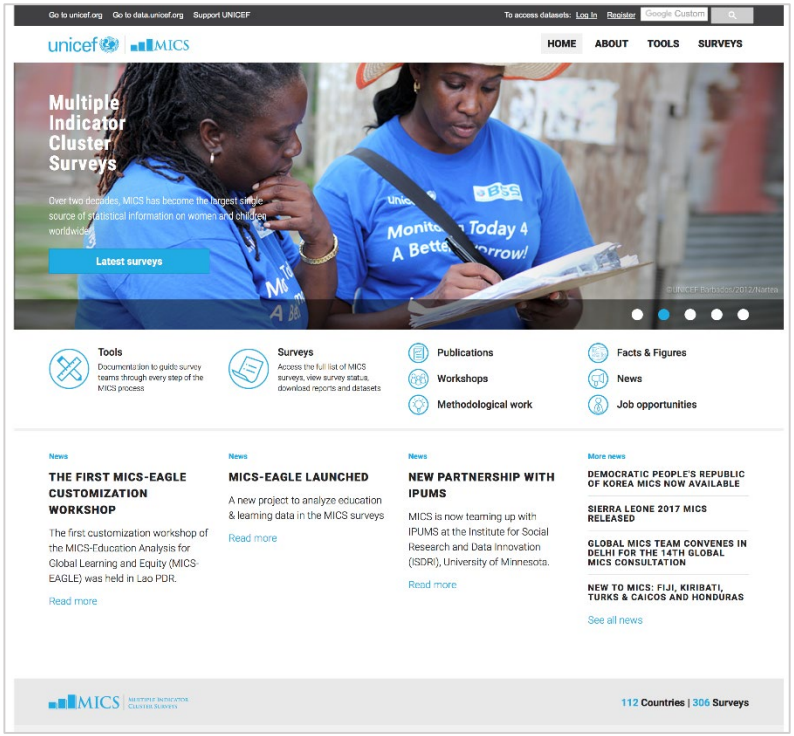
Two HH survey groups:

2015: Collaborative group established among DHS, MICS, and LSMS.

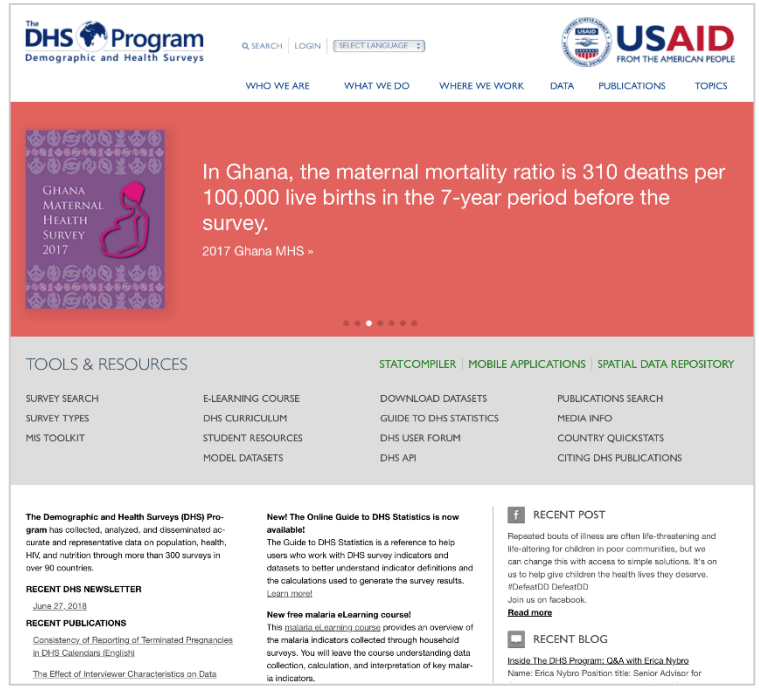
UN Inter-secretariat Working Group on Household Surveys.

Management Group (UN) and Technical Working Group chaired by: UNICEF. DHS on TWG

unicef | MICS



The DHS Program
Demographic and Health Surveys



Review of current core questionnaire

Reviewed nutrition questions and indicator calculations

- Anthropometry
- IYCF (Breastfeeding and Complementary Feeding)
- Low Birthweight
- Iodized Salt in Households

Collected in DHS, but not MICS, not reviewed:

- **Child U5:** VA<6m, Hb, receipt of iron in last 7 days, MMP, RUTF, RUSF
- **Adults:** Hb/anemia status and BMI, iron tablets in women 15+

Some overall differences

	DHS	MICS	Implications
Questionnaire	**Woman's Qrre**, only mothers asked about her children, and certain Qs not asked on all <2s	**Children U5 Qrre** to mother or primary caregiver when mother not living in household	DHS misses children whose mothers are dead, out of the country, or in an institution - orphaned children cared by others. Can impact countries with many children not living with their moms who may have different characteristics
Denominators			
Handling of missing and DK	Same in most cases (e.g. Missing/DK-> No)	Same in most cases (e.g. Missing/DK-> No)	Differences in how we handle missing data and "Don't Know"s can affect results for some indicators. Minor difference.
Population in indicators	De facto (stayed in HH night before)	De jure (usual residents)	When reviewed for anthropometry, no large difference in estimates. Impact does not seem to be substantial

Growth Monitoring and Promotion

No questions around growth monitoring and promotion interventions, but anthropometric measurement taken

Anthropometry – DHS and MICS are aligned

Household consumption of iodized salt

	The DHS Program Demographic and Health Surveys	unicef | MICS
NUMERATOR	Households with a positive test result	Households with a positive test result
DENOMINATOR	Tested households with salt	Tested households with salt + Households with no salt
	% of households using iodized salt among ***households with salt***	% of households using iodized salt among ***all households***

UNICEF calculates both version in database

IYCF Counselling

DHS

Table 9.13 Content of postnatal care for newborns

Among last births in the 2 years before the survey, percentage for whom selected functions were performed within 2 days after birth and percentage with at least two signal functions performed within 2 days after birth, according to background characteristics, Armenia 2015-16

Background characteristic	Among last births in the 2 years before the survey, percentage for whom the selected function was performed within 2 days after birth: Cord examined	Temperature measured	Counseling on danger signs	Counseling on breastfeeding	Observation of breastfeeding	Weighed[1]	Percentage with at least two signal functions performed during the 2 days after birth	Number of births

2 out of 6

MICS

Table TM.8.6: Content of postnatal care for newborns

Percentage of women age 15-49 years with a live birth in the last 2 years for whom, within 2 days of the most recent live birth, the umbilical cord was examined, the temperature of the newborn was assessed, breastfeeding counseling was done or breastfeeding observed, the newborn was weighed and counseling on danger signs for newborns was done, Survey name, Year

	Percentage of newborns receiving post-natal signal care function of:							Percentage of newborns who received a least 2 of the preceding post-natal signal care functions within 2 days of birth[1]	Number of women with a live birth in the last 2 years
	Cord examination	Temperature assessment	Breastfeeding: Counseling	Breastfeeding: Observation	Breastfeeding: Counseling or observation	Weight assessment	Receiving information on the symptoms requiring care-seeking		
								2 out of 5	

Infant & Young Child Feeding

Indicators

Data collected

- Mostly same
- Type of liquid *other than breastmilk* fed to child in first 3 days not asked in current DHS (was asked until DHS 7)

Data collection method

MICS: Foods consumed by child in last 24 hours collected based on *open recall*

DHS: Uses *list-based approach*

Reporting

MICS: reporting on new MDD indicator definition in ongoing round. MMF and MAD coming.

DHS: yet to operationalize

Questionnaire Source

Past breastfeeding

(Ever BF, EIBF, liquids first 3 days)

MICS and DHS aligned

- Woman's (15-49 years) questionnaire
- Last live birth in last 2 years

(DHS collects on last birth in past 5 years, but tabulates for the past 2 years. Ever BF asked for last and second to last birth also).

Current breastfeeding and complementary feeding *(EBF and Diet)*

MICS

- **Under 5 children's questionnaire,** *mother or caregiver*
- All living children under <3 years for still BF
- Diet questions, bottle-feeding asked to <2 years

DHS

- **Woman's (15-49 years) questionnaire,** *mother*
- Last born child in 5+ years for still BF
- Diet questions to youngest child living with the mother under 2+ years

Exclusive Breastfeeding (EBF)

Computation

Treatment of missing data and response "don't know" (DK) but analysis shows not much difference (1-2%) in rates

		Is child still being breastfed?	Has child had any liquids from list yesterday?	Has child had any food from list yesterday?
DHS: Exclusive Breastfeeding =	*Yes*	✓	✓	✓
	No	✗	✗	✗
	Don't know or missing	??	??	??
MICS: Exclusive Breastfeeding =	*Yes*	✓	✓	✓
	No	✗	✗	✗
	Don't know or missing	??	??	??

Child counted as EBF

Counting **DK/missing** as **not having received** a liquid or food → may overestimate

Analysis shows no large differences in rates!!

Overview

Topic	MICS	DHS	Additional Comments
IYCF counselling	Woman's	Woman's	No difference in reporting for IYCF counselling. DHS likely overestimates the PNC composite indicator as counselling and observation counted as 2 separate functions.
Ever BF Early Initiation of Breastfeeding	Woman's	Woman's	DHS collects information on last live birth (EIBF) and also next-to last live birth (ever BF) in past 5+ years. MICS collects it on last live birth in past 2 years. Both aligned with the global reporting on past 2 years. Age calculations may be a little different, but minor.
Liquids in the first 3 days	Woman's	Woman's	DHS asks only of ever breastfed kids, no details asked about the type of liquid. New proposed global indicator to capture liquids (+ foods) among all live births (breastfed or not) in last 2 years. MICS asks only about liquids to all live births.
Current Breastfeeding	Children Under 5	Woman's	MICS covers all children in a specific age-range based on indicator. DHS collects information on still breastfeeding for the last live birth. ORS/medicines asked as a separate category in MICS but not in DHS
Dietary Intake past 24hrs	Children Under 5	Woman's	Data collection method differs. MICS uses 24 hour open recall while DHS uses list-based approach. DHS collects data on food and liquids for youngest child alive living with the mother.
Birthweight	Woman's	Woman's	DHS data covers live births in last 5 years. MICS collects for last birth in 2 years.
Anthropometry	Children Under 5	Biomarkers	Completely aligned!!
Iodized Salt	Household	Household	DHS reports on iodized salt consumption only among households with salt available at the time of survey. MICS reports all surveyed households whether had salt or not, but UNICEF database covers both

Next steps

Short term

- Finish discussing differences
- Summary document for public?

Medium term

- Discuss common interests and potential areas of collaboration

Q&A and Discussion for Plenary 2: Overview of Major Nutrition-Related Household Survey Platforms – DHS, MICS, SMART & LSMS

Q: Does collaboration between the surveys include coordinating the timing of surveys in countries? In Bangladesh, the DHS ended data collection in April of this year, and the MICS is potentially next year. Who is it that decides when the surveys will be implemented?

DHS: It's somewhat informal. We try to not have them too close together, but it's the countries that are requesting the surveys, so it's really up to them.

MICS: The frequency of overlap that you describe has decreased due to improved collaboration. I would say the major culprit of any overlap, when it does happen, is the donors and surveys being owned by different departments within institutions. There might be a drive for data from the Census Department in one case, and the Department of Health in another, which might result in conflict.

Q: With regard to the HH consumption portion of the LSMS, there has been a lot of effort recently to work on the HH consumption module and this is excellent. Has there been any guidance or decisions made about minimum standards when adapting the list of foods per country in terms of number of foods or level of detail for those specific foods?

LSMS: As much as possible we do not want them to have long list. We tell them that if the survey is too time consuming, try to get the items that make up between 80-90% of their food expenditure. At a minimum you need enough to be able to give a welfare ranking of households. Usually, I say 100 items.

Q: I noticed that in the LSMS there is collection of dietary diversity for children of 2-5 years of age. The slide said 0 – 59 months. I know we have the standard IYCF indicator for 6 – 23 months. Can you comment on what metric was used to report dietary diversity among those older children under 5?

LSMS: We help them to collect this data using the Feed the Future model. We don't do the analysis, but we do help with data collection. It's a fairly new collaboration. Hopefully, in a couple years we'll have more results on this.

Q: On the MICS, in the nutrition community there is currently a lot more recognition of the need to collect more data on adolescents. We do collect the older adolescents in 'women of reproductive age' (15-19 years of age), but we really have no data on younger adolescents (10-14 years of age). Often times the challenge we hear about is that it's really hard to capture that demographic at home in a population-based survey. Since you do have this module that captures children 5-17, how has your response rate been?

MICS: This is a tough question. We had felt for many years that it's absurd to have a UNICEF led survey that does not have a child questionnaire (5-17 years of age). We all knew that the minute we developed such a questionnaire, there would be enormous pressure from all the different actors (e.g. child protection, etc.) to add indicators. The 5-17 age group questionnaire is not asked to the children; it's asked to the mothers.

We have recently introduced a learning assessment of children ages 7-14, which is a huge logistical field challenge, since you have to time your interviews carefully for when the children are finished school, and this may not necessarily be the right time to assess them since it's the end of a school day. We have about 15 surveys on this to date, and so far the response rates have been good.

Q: The example was given that in MICS 3, the family care behavior measures were added and in MICS 4 the Early Childhood Development indicators were added. And those are now being revised. They were

put in due to a major knowledge gap. We should be looking at it with this perspective, i.e. what's going to be needed in the future that's really going to make a difference. In relation to that, does anyone on the panel see demands for data coming from certain countries that we should know about as we go forward in this meeting?

DHS: As an example of data that countries are asking for, one country wanted micronutrient status data. A few countries wanted data on the MDDW. One country wanted data on counseling on nutrition, particularly around growth monitoring. South Africa wanted data on salt intake and fruit and vegetable consumption. We often have countries wanting information on quantities, consumption quantities and frequencies, and those are not feasible within the DHS context.

Comment: We talk about demand for data coming from the countries, but it's also important to acknowledge that there's a lot of demand from donors, and other global actors (e.g. UNICEF). It seems like the fundamental purpose of the surveys gets confused by the variety of people that are asking for indicators to be added to the survey.

Comment: On Monday there was a consultation on MYCIN and counseling indicators and what priorities we have. A big takeaway for me from that meeting was that the global nutrition community and country stakeholders need to agree on a core set of indicators simultaneously as we look at these platforms for providing data. One of the things that strikes me as a challenge is that we have potentially multiple global indicator frameworks for nutrition right now, i.e. a couple indicators in the SDG framework, 20 in the global nutrition monitoring framework, there's the SUN agreed framework.

Comment: I thought the exercise that was described regarding the DHS was helpful, where you look at the indicators then the availability of that data. I feel like we need a next level exercise though. As a community of people interested in nutrition, what are the core indicators, which global frameworks do they reside in, and then where in the measurement platforms do they come in? Some, of course, will be in local administrative systems, but some critical ones will come from these platforms. This is a question that this group should be addressing in the next couple days.

Q: On the topic of adding on modules to some of these surveys, how does the process work in country? Who makes the decision in country to add them on? How might we influence those people in countries? And if we were to put together a nutrition-oriented module, what confidence would we have that countries would actually adopt it?

DHS: Regarding the modules, my experience is that you can put something out that anyone can respond to over a long period of time. Or you can have something targeted that you know is going to get funded, but maybe in smaller amounts. I see the module as like this: most of the questions in the core questionnaire will get asked in every country, but the questions in the modules won't be because they are optional. But the benefit is that they are there as an option, so I do think having modules is important to use the module option.

Q: What is the dominant pressure that's been put on these surveys to expand? Is it UNICEF? Is it the global actors at this meeting? Is it the countries? What are the priorities? This may need to be discussed further.

DHS: The way the process works is that there is usually a survey design visit very early on. On that visit, a steering committee and a technical committee are established, and they look at the issue of what goes into the questionnaire. Funding always plays a role. If you do have funding for a topic, it's more likely to

get into the questionnaire. One thing that I've often heard is that the topic of nutrition gets handled by a higher-level MCH person, and that person is not necessarily a nutrition advocate/expert.

SMART: I'm less involved with the country level. SMART national nutrition surveys takes a maximum of 4-6 weeks, so you can tie it specifically to the seasonality questions. Also, preliminary anthropometry numbers are usually available within two weeks, so the turnaround is very fast, and the full report is available in a maximum of 2 months. This allows countries to use this information quickly, and it's especially helpful during emergencies.

SMART: In terms of what additional data should go in the questionnaire, unfortunately, technical staff in countries who participate in these discussions actually have limited capacity to articulate what they need and don't need. Unfortunately, we see a lot of instances where there's a nice report that just goes on the shelf in the ministry and is not used for any action. I don't know how we can engage countries in more meaningful discussions about the content, and encourage them to take more ownership of the data. At the moment, all the discussions are taking place between global actors, and when a ready-made questionnaire is given to the countries to use, there is not much 'wiggle room' to do what they want with it. The lack of ownership of the results, and lack of action taken from the results, might be due to this centralized approach.

LSMS: The LSMS situation might be different than the other survey platforms. The reason that some people say that it is challenging to do cross country comparisons between LSMS results is that we *do* actually customize the survey to the individual country. It involves sitting down in the technical working group in country, and focusing on what the country wants. In my experience, the country teams *knows* what they want. You do have to prioritize though. For example, in one LSMS round in Nigeria, they wanted us to collect information on women's breastfeeding, and they wanted to be able to link it with welfare indicators, which they hadn't been able to do with DHS or MICS. It was done, but in the next round, we told them it should not be done every time given that they have the DHS and MICS asking many of the same questions. There needs to be prioritization, so for example, every 4-6 years you could link women's breastfeeding to welfare, but not every year or 2 years. In the end though, it's the country team that makes the final decision on what will be included. Of course, donors have a big influence. In some cases a donor will add money to a survey in the interest of collecting certain information. The LSMS team sometimes acts as a facilitator between the government and the donors to make sure that the government needs are met.

MICS: Regarding the question on the demands from countries: In recent years there has been emphasis on the dual burden (the overweight phenomenon), and the desire to understand physical exercise. Also there's pressure to understand more about micronutrients, which we are already doing. People that understand the data that we collect, also understand that there are lots of problems with the data. The dietary intake module has massive implementation challenges. Data quality issues, training issues, monitoring issues, an enormous questionnaire. It's a huge challenge. We began not wanting to do the food list, then our arm was twisted and we were convinced to implement it. Then once we did it, we realized how poorly it worked in the field. So we made our own contributions to how it was implemented in the field, i.e. the recall method. I'm not saying it's perfect, but it is improved. We have to be serious about validation, and this group's help is needed on this.

MICS: I also want to comment on how content is determined at the country level. The first stage is usually that UNICEF country offices, with technical support of regional MICS people, do a data needs assessment, which used to be done using a list of indicators that MICS potentially collects. That list has been expanded to include many other indicators. But this is the foundation for advocating for a survey of

any kind. Many countries don't do a DHS or MICS survey, or haven't done one in 20 years. This is not acceptable in this day in age. It's our job to advocate that these countries have these surveys.

MICS: My last point is that we are all in this together to get the best possible data. We don't go out and tell countries that this is what we have, and you can't change the questionnaire. The UN represents the nations of the world. In countries, there are technical committees that represent the various stakeholders. These in-country committees have driven the SDG agenda, and we were not allowed to influence that. The indicators are actually decided in collaboration. I refuse the label of us forcing countries to do certain things.

Day 1 Working Groups

Introduction to WG Session 1-2

Aims of WG Sessions 1-2

- **GOAL:** To formulate & prioritize recommendations to improve the nutrition content of **population-based household survey (PBHS)** questionnaires
- **AIMS**

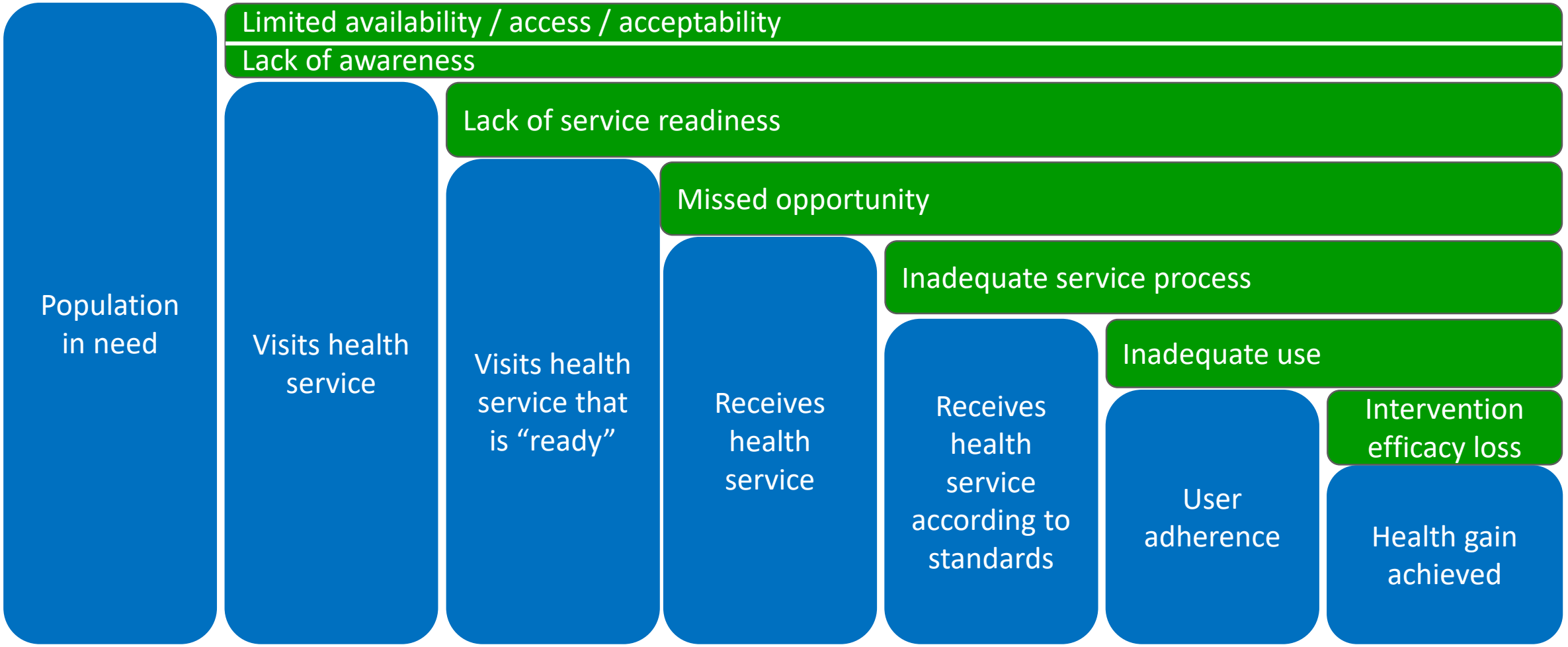
1. To identify gaps in nutrition coverage data that are amenable to PBHS & prioritized by nutrition stakeholders
2. For priority gaps, to review & recommend appropriate changes to most commonly used PBHS questionnaires
    - DHS & MICS
    - Other population-based HH survey platforms

What is coverage?

$$\% = \frac{\text{\# who do}}{\text{\# who should}}$$

- Can be for intervention (e.g. IFA) or practice (e.g. MDD)
- Indicator definition should be fit for purpose
  - Globally standardized coverage indicators (e.g. MDD)
  - Context-specific (e.g. IFA)

Continuum of coverage measures: building on Tanahashi (1978)



Slide from Agbessi Amouzou

3-part discussion

A. Identifying gaps in coverage data that are appropriate for measurement in PBHS

B. Proposed modifications to DHS*/MICS questionnaires (*core or modules)

C. Proposed inputs /modifications for other types of PBHS

Prioritization

Intervention	*DHS/MICS*	*Other PBHS*
A	• *Modify current question in DHS core*	• *NNS to include extended set*
B	• *Add new response option under current question in MICS* • *New optional module with questions at two additional time points*	• *NNS to include extended set*
C	• *N/A*	• *SMART to add question s about a, b, c,*

WG will use intervention/practice lists as starting point

WG	Intervention	Population
Micronutrient Interventions	Iron or IFA supplements	WRA; AD; PW; LW
	Folic acid supplementation	WRA; AD; PW
	Multiple micronutrient supplementation	WRA; AD; PW
	Calcium supplementation	PW
	Vitamin D	PW
	Postpartum Vitamin A supplementation (low-dose for high deficiency pop)	PLW
	Deworming	PW
	Pediatric iron supplements	Child<5y
	MMS - MNP or tablets	Child<5y
	SQ-LNS	Child<5y
	Vitamin A supplementation (high-dose)	Child<5y
	Zinc supplementation with ORS for children with diarrhea	Child<5y
	Salt (iodine; DFS)	HH; WRA; Child<5y
	Food fortification: wheat; maize; sugar; oil; bouillon; rice	HH; WRA; Child<5y
	Fortified Complementary Foods	Child<24m

See General → WG assignment Tab “Topic List” for all groups

A. Identifying gaps in coverage data that are appropriate for measurement in PBHS

1. Review intervention list for completeness
2. Identify priority coverage data gaps for interventions/practices on list:
   - *Is/are there indicator(s)?*
   - Are they already included in major surveys?
   - Is it used by nutrition stakeholders? Is there demand?
   - Consider WG knowledge & experience
3. Identify whether & which PBHS are appropriate to fill the gap:
   - DHS (core or module) / MICS
   - Other PBHS (e.g. NNS)

A. Identifying gaps in coverage data that are appropriate for measurement in PBHS

- Information / data gaps in PBHS can be due to
  - Missing questions
  - Incomplete questions
  - Inappropriate questions

- ”Appropriate” needs to reflect the survey design & intent:
  - DHS*/MICS have strict criteria & priorities
    - DHS modules* are more potentially more flexible
  - Consider recommending expanded questions for other survey types

B. Proposed modifications to DHS*/MICS questionnaires (*core or modules)

- **Key discussion points to document**

1. Rationale for new question or modification
   - population of interest
   - who will answer
   - recommended wording of question (to extent possible)
   - examples of use or supporting research
   - how to present data in report
   - *Prioritization:* Tier I, Tier II, or Tier III.
2. Are there any nutrition-related questions from current DHS/MICS core questionnaires that could be dropped?
   - Rationale?

*Focus on questionnaire content

Briefly note other issues (e.g. sampling, etc.)

C. Proposed inputs /modifications for other types of PBHS

- **Key discussion points to document**
- rationale for the new question or modification
  - the type(s) of PBHS recommended *(general or specific)*
  - population of interest
  - who will answer
  - recommended wording of question (to extent possible)
  - examples of use or supporting research
  - *Prioritization:* Tier I, Tier II, or Tier III.

*Focus on questionnaire content

Briefly note other issues (e.g. sampling, etc.)

Suggested prioritization levels

- **Tier I:** it is feasible to implement now (e.g. in survey in next year) & it should be prioritized
- **Tier II:** it is feasible to implement now (i.e in survey in next year) but it is not essential / no consensus
- Tier III: implementing possible in the next 2-5 years but requires additional research / development

Working Groups, Chairs, & Note Takers

WG	Color	Chair(s)	Note takers*
MICYN Counseling and Support Interventions	BLUE	Purnima Menon	Audrey Buckland
Micronutrient Interventions	RED	Lynette Neufeld	Tricia Aung Shannon King (Day 2)
Child Growth: Screening, Promotion, Treatment Interventions	YELLOW	Ed Frongillo	Quinn Marshall
IYCF practice, Diet Quality, Food Security	GREEN	Megan Deitchler Larry Grummer-Strawn	Swetha Manohar

**each group will have 2 voice recorders as well*

Plenary 4 will be WG report out – each WG needs to identify someone to compile ppt & load over afternoon coffee break. (Recommended template is in WG Guidance folder)

Working Group Resources (Dropbox)

- *Flash drives with folders will also be available for those who cannot access DB*
- Four Main Folders
  - Working Group Guidance
  - Results from data stakeholder survey (WG specific)
  - **Question Library (HH Survey → WG Specific)**
    - ***Hard copies of key documents (compiled questions & DHS/MICS core questionnaires)***
  - Other Resources

Question Library –WG PPT: Slide 2 is an overview of surveys with relevant question examples

Intervention	Population	Slide #	DHS*	MICS	PMA2020	NI Surveys	FTF	FACT	FFP	IFPRI	Ground Work	Other
WHO IYCF Indicators (see list in slide set)	Child<24m	**3**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	TZ SMART NNS
Diet assessment in children 2-5y	Child 24-59m	**47**									Yes	
MDD-W	WRA; PLW	**50**			Yes		Yes	Yes*	Yes	Yes		DHS Nepal
New indicators – "unhealthy" foods, diet quality	WRA; Child<5y	**61**			Yes					Yes	Yes	DHS South Africa
Food Security	HH	**69**			Yes		Yes	Yes	Yes	Yes		Nepal DHS

*DHS Core Questionnaires. If unique to DHS country survey listed in "Other."

DHS FQ 464-470

(Section 4: Pregnancy and Postnatal Care)

Notes about questions

NOTES

- Questions about breastfeeding in separate section from other liquids & solids (see next 2 slides)

Location in "source documents" folder

DHS Womans Questionnaire pgs. W30-31

464	Did you ever breastfeed (NAME)?	YES . . . . . 1 (SKIP TO 466) NO 2	YES . . . . . 1 NO 2
465	CHECK 404: IS CHILD LIVING?	LIVING ☐ (SKIP TO 470) DEAD ☐ (SKIP TO 471)	
466	How long after birth did you first put (NAME) to the breast? IF LESS THAN 1 HOUR, RECORD '00' HOURS; IF LESS THAN 24 HOURS, RECORD HOURS; OTHERWISE, RECORD DAYS.	IMMEDIATELY . . . . . 000 HOURS . . . . . 1 ☐☐ DAYS . . . . . 2 ☐☐	
467	In the first three days after delivery, was (NAME) given anything to drink other than breast milk?	YES . . . . . 1 NO 2	

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____
468	CHECK 404: IS CHILD LIVING?	LIVING ☐ DEAD ☐ (SKIP TO 471)	LIVING ☐ DEAD ☐ (SKIP TO 471)
469	Are you still breastfeeding (NAME)?	YES . . . . . 1 NO 2	
470	Did (NAME) drink anything from a bottle with a nipple yesterday or last night?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
471		GO BACK TO 405 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 501A.	GO BACK TO 405 IN NEXT-TO-LAST COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE BIRTHS, GO TO 501A.

Guiding Principles for WG

- WG Chair will keep group moving through topics
  - Identify & start with highest priority
    - reprioritize as you go
  - Capture current thinking for as many of the sub-questions as possible
  - If highly contentious – note & move on, revisit if time
- Divide into sub-working groups

WG Room Assignments

WG	Color	Room
MICYN Counseling and Support Interventions	BLUE	Connected - dining room
Micronutrient Interventions	RED	Across Hall
Child Growth: Screening, Promotion, Treatment Interventions	YELLOW	Plenary room – Left side
IYCF practice, Diet Quality, Food Security	GREEN	Plenary room – Right Side

Day 1
MIYCN Counseling and Support

Working Group Sessions 1-2 Report Out

Interventions

Intervention	Population

MIYCN counseling during pregnancy
- Multiple components of counselling during pregnancy
  - Diet
  - Physical activity
  - Consumption of supplements (IFA, Ca)
  - Breastfeeding
	PW

Support for early initiation of breastfeeding	PW
Breastfeeding counseling during PNC	2 days post delivery
Counseling / support for exclusive and continued breastfeeding (1m+ post partum)	Child<24m
Counseling for complementary feeding	Child<24m
Cross-cutting IYCF promotion via FLW, community platform and/or mass media	Child<24m

Other maternal support interventions (BFHI, maternity protection, etc)
- Multiple components
  - Rooming in
  - Support
  - No formula? Other?
	TBD

KEY POINT:

- Counseling central to several other interventions, including micronutrients, growth monitoring

IYCF counselling

- -Meeting on Sept 17 discussed key contact points, made questionnaire suggestions

Coverage data: Availability (MIYCN Counseling)

national surveys

Intervention	Population	DHS*	DHS Nepal	MICS	PMA2020	NI Surveys	IFPRI
MIYCN counseling during pregnancy	PW		X		X		X
Support for early initiation of breastfeeding	PW				X		
Breastfeeding counseling during PNC	2 days post delivery	X		X	X		X
Counseling / support for exclusive and continued breastfeeding (1m+ post partum)	Child<24m		X		X	X	X
Counseling for complementary feeding	Child<24m		X		X	X	X
Cross-cutting IYCF promotion via FLW, community platform and/or mass media	Child<24m		X			X	X
Other maternal support interventions (BFHI, maternity protection, etc)	TBD				X		

*DHS Core Questionnaires. DHS country-specific questions are listed in “Other.”

A. Summary: Data gaps that are amenable to population-based HH surveys (PBHS)

DHS (core/module) &/or MICS	Other PBHS

- *Almost all of the MIYCN counseling are amenable to inclusion in PBHS*
- *Some could be verified/examined in facility assessments too (e.g., content of ANC counseling)*

B. Summary: proposed modifications to DHS/MICS core questionnaires: IYCF counseling

- **Additions (new questions)**

4xx	**During this pregnancy, did a health care provider or community worker talk with you about breastfeeding?**	**YES** **NO** **DON'T KNOW**	
4xx	During the first month after (NAME)'s birth (but after first two days), did a health care provider or community worker talk with you about breastfeeding?	YES NO DON'T KNOW	
6xx	In the last six months, did a health care provider or community worker talk with you about how to feed your child?	YES NO DON'T KNOW	NO… 2 (SKIP TO 6xx)
6xx	What topics did he or she talk to you about?	1) BREASTFEEDING 2) NOT GIVING WATER IN THE FIRST SIX MONTHS OF LIFE 3) FEEDING OTHER FOODS STARTING AT 6 MONTHS OF AGE 4) FEEDING A VARIETY OF FOODS 5) FEEDING ANIMAL SOURCE FOODS 6) HANDWASHING BEFORE FEEDING 7) **TOPIC LIST CAN BE REDUCED OR EXPANDED**	

-

Potential modifications

457	**During the first two days after (NAME)'s birth, did any health care provider do the following:** **a) Examine the cord?** **b) Measure temperature?** **c) Counsel you on danger signs for newborns?** **d) Counsel you on breastfeeding?** **e) Observe breastfeeding?**	**YES** **NO** **DON'T KNOW**	

er

B. Summary: proposed modifications to DHS/MICS core questionnaires: Maternal nutrition counseling

- **Currently no questions**
- **Four areas of potential counseling support needed**
  - Maternal diet
  - Physical activity
  - Supplements
  - Breastfeeding
- **Additions (new questions) SIMILAR TO IYCF (for DIET) AS TIER 1. Potential questions on counseling on ifa. Calcium, physical activity/rest in longer/other surveys**

Tier 1 – maternal dietary counselling during pregnancy

6xx	**During this pregnancy, did a health care provider or community worker talk with you about what foods to eat?**	**YES** **NO** **DON'T KNOW**	**NO… 2 (SKIP TO 6xx)**
6xx	What topics did he or she talk to you about?	1) TOPIC LIST FOCUSED ON DIETARY ADVICE	

B. Summary: proposed modifications to DHS/MICS core questionnaires: BFHI

- **Indicator (from BFHI global guidance)**
  - % of mothers who received support with learning to breastfeed after delivery
  - % of mothers who report that they were informed where they can access breastfeeding support in their community (*after discharge*)
- **No existing questions on these**
- **Key component of BFHI that can be measured in a PBHS and a question(on support with learning to BF) has been tested in PMA2020 and is feasible to administer. No question exists on referral and access to BF support currently.**
- **Question (potential)**
  - *WHEN YOU DELIVERED [NAME], did a health worker help you put the baby to your breast?*

B. Summary: proposed modifications to DHS/MICS core questionnaires: community platforms/mass media

- **Why?**
  - Enabling environment for BF/IYCF
- **No existing questions on these**
- **Possible solutions**
  - IYCF question (6 mo recall) could cover community worker/platforms
  - Male questionnaire (India is testing inclusion of ANC questions in male questionnaire)
  - Need to develop on mass media (A&T experience but can be context/campaign specific)
- **Potential for male questionnaire:**
  - In the last six months, did a health care provider or community worker talk with you about how to feed your child?

C. Summary: Data gaps better addressed in other types of PBHS

- **Additions (new questions)**
  - [X]
  - [X]
  - [X]….
- **Modifications (of existing questions)**
  - [X]
  - [X]
  - [X]….

Day 2
[INSERT GROUP NAME]

Working Group Session 3&4 Report Out

3A. Summary: Data gaps that are amenable to facility-based surveys

- *X*
- *X*

NOTE TO GROUP
- Keep phrasing on slide simple – presenter can expand in presentation

3B. Proposed modifications to SPA core questionnaires

- [X]
- [X]
- [X]
- [X]
- [X]

NOTE TO GROUP

- For sake of time in plenary report out suggest keeping focus on:
  - Tier 1 changes & rationale
  - Points you'd like to get input on from wider audience
- Keep phrasing on slide simple – presenter can expand in presentation
- Add slides as helpful

4B. Specifying Research Agenda (Tier III)

NOTE TO GROUP

- For sake of time in plenary report out suggest keeping focus on:
  - Priority research areas & rationale
  - Points you'd like to get input on from wider audience
- Keep phrasing on slide simple – presenter can expand in presentation
- Add slides as helpful

Day 1
[Micronutrients]

Working Group Sessions 1-2 Report Out

A. Several overview comments related to Micronutrients

1. Coverage data on micronutrient interventions will be much more meaningful for program decision making if linked with micronutrient status data
2. Our wish would be to have a comprehensive overview of supplement/ fortification nutrient sources for each of our priority groups
3. Age groups in surveys not always aligned with WHO guidelines– so can't make conclusions about coverage on WHO recommendation by WHO age group
4. The group highlighted that with micronutrients there is an additional challenge in terms of understanding what we want to know
   - Coverage of ANY product regardless of origin
   - Coverage of public health programs that distribute those products
5. Adolescents are becoming higher priority among donors – definitely girls but increasingly boys
6. The group noted the gap in data on status and programs etc. for the elderly

A. Summary: Pregnant and lactating women (From the list: IFA, Fe, MMN)

DHS (core/module) &/or MICS

- *Focus is on iron containing supplements as now. Current level of detail appropriate – best you can get in this type of survey– very important given strength of WHO recommendation*
  - *Contact coverage:*
    - *Adapt wording slightly*
  - *Link to facilities survey*
  - *Include source (new)*
  - *Proxy for effective coverage using current question (acknowledging that it is indicative of direction of program not an accurate estimate of intake)*

Other PBHS

- *Women:*
  - *Include details of types of supplements (i.e., and MMN not captured)*
  - *Quantity consumed – better estimates of partial and effective*

A. Summary: Pregnant Ca (tier 3 only)

DHS (core/module) &/or MICS

- *Best case scenario – is like with iron*
  - *Contact coverage*
  - *Source*
  - *Proxy for effective coverage*

Other PBHS

- *Complex given complex guideline*
  - *Linked with low population based data on low Ca intake (existing data or dietary survey)*
  - *Quantity consumed –estimates of partial and effective – developed based on recommendations*

A. Summary: Postpartum VAS, Vit D, deworming

DHS (core/module) &/or MICS	Other PBHS
• *Not recommended to include because not recommended by WHO and not frequently implemented*	• *Exploratory if countries are still implementing to understand why etc etc. But not proposing standard indicators – would depend on local context*

A. Summary: WRA (FA and Fe containing)

DHS (core/module) &/or MICS

- *Add same Q-s as for pregnant women in past 6 m (contact, proxy for effective coverage and source)*
  - *Fe containing*
  - *FA containing*
  - *Include source (new)*

Other PBHS

- *Women:*
  - *Include details of types of supplements (i.e., and MMN not captured)*
  - *Quantity consumed – better estimates of partial and effective*

Food fortification

- Application: Countries with mandate
- Population of interest: Household
- Who: Household questionnaire respondent
- Source of questions: PMA2020 versions + DHS for salt

1. Consumption of food vehicle (salt, staple)
2. Consumption of food vehicle in a fortifiable form
3. Consumption of fortified food vehicle (only salt – rapid test)

B. Summary: proposed modifications to DHS/MICS core questionnaires

- **Food Fortification - For foods that are fortified as a national program:**

1. Did you or anyone else in your household eat foods with X in the past week?
2. If YES, the last time your household got X, where did you get it from? Categories of responses (countries would select appropriate options):
   - Purchased
   - Made at home or in the community
   - Social program

- Opportunity to align fortified food list with LSMS questions
- Want to know the content of the rejected food fortification module from DHS/MICS

B. Summary: proposed modifications to DHS/MICS core questionnaires

- **Iodized salt**

1. Did you use bullion cubes in the last week?
2. If respondent responds to DHS HQ 145 (“I would like to check whether the salt used in your household is iodized. May I have a sample of the salt used to cook meals in your household?”) “NO SALT IN HOUSEHOLD,” ask:
    - Did you use salt in the household in the last week?
    - If YES, where did you get the salt from?

- Recommend not using a rapid test to get a sense of PPM levels. This should be done with a special study.
- For both fortified foods and iodized salt, need to conduct a complementary study linked to biomarkers to measure fortifiable levels (outside DHS/MICS).

Under 5 child micronutrient “product” indicators

- Pediatric iron supplements
- MMS MNP or tablets
- SQ-LNS
- Vitamin A supplementation (high dose)
- Zinc supplementation with ORS for children
- **Basic principle**: If it’s part of national program implemented at large scale ask about it, if not, no point.

B. Child micronutrient interventions

- **Modifications (of existing questions)**
  - Vitamin A past 6 months: Already global guidance for reporting international indicator.
  - We feel there is value in keeping survey indicators given weaknesses of administrative data. Might be ways of improving the question.
  - Iron syrup, MNP, deworming. Currently DHS has 2 questions about consumption of iron/sprinkles 7 day recall. To align with international guidance would change recall to 6 period. Separate iron from MNP.
  - Ideally would want to also have recall about amount received, whether kid actually consumed it and differentiate prevention from treatment.
  - SQLNS: no programs at scale but work on indicators so that ready once guidelines come out. Will likely be targeted..?
  - Keep zinc for diarrhea…

Q&A and Discussion for Working Group Day 1 Report Out

1. **MYCIN WG**
2. **IYCF, Diet Quality and Food Security WG**
3. **Child Growth WG**
4. **Micronutrient WG**

MYCIN WG

Q: For counseling, in the core questionnaire, is it enough to just ask 'did they talk to you about this topic?', or is it actually necessary (as part of the core questionnaire) to ask about specific content/messages of that talk? For example, the current post-natal care question is 'Did they talk to you about breastfeeding?'. There is nothing about specific messages.

A: Yes, we did talk about this in our WG. Almost all of the interventions needed accompanying counseling and support, and we talked about the Alive and Thrive experience where with IFA, there is critical counseling on side effects, since that's what helps women to get through adherence. Should we ask about that in the core counseling section? Or should that be integrated in the context of longer PBHS, not necessarily DHS? The same applies to growth monitoring and promotion. Those content elements are really tied to that intervention. Whether you get information on growth or specific information on IFA supplementation, we felt that it belonged better in a deeper kind of a survey. We ended up focusing on what was a *completely* missing gap, which was dietary counseling for breastfeeding, complementary feeding and maternal nutrition.

A: This question also came up in the micronutrients WG, i.e. whether the link to all of the other things that happen aligned with micronutrient interventions needs to be covered by us or will be covered elsewhere. We therefore renamed ourselves 'the product group' because we weren't sure what was happening in the other groups, and this is something that we need to come back to in the future. We felt that IFA shouldn't be just a 'product', and instead there should be a whole structure of things that we need to know *around* IFA.

A: Going back to the issue of counseling paired with the supplement: We had a discussion in our group about SPAs where they do observations of ANC. This could be a good opportunity for looking at how IFA is given to mothers and whether counseling is accompanying the IFA distribution during ANC as a deeper way of looking at how counseling is paired with supplements during ANC.

Q: The messages that moms get around infant feeding are not necessarily always positive messages. Did your group have any discussions about exposure to marketing of breast milk substitutes?

A: No, we didn't get to that topic.

IYCF, Diet Quality and Food Security WG

Clarification from group: When we talk about the IYCF indicators going from 15 to 17, the biggest change is the addition of indicators on unhealthy eating (sugar/sweets). And now we're discussing how this can be addressed for other age groups too.

Q: Are these questions ready yet? Or still under development?

A: For IYCF, by the end of the year, we'll have clear recommendations so they will be ready for the next DHS and MICS cycles.

Q: In the food groups, is it possible to add information that provides examples of Vitamin A rich foods? At the moment, we keep getting responses like 'oranges'.

A: In the IYCF Measurement Guide, Annex 2 provides a list of sample foods. So this is a good reference to look at and you can adapt your questionnaire based on this.

Child Growth WG

Q: Did you discuss the idea that the seven day recall for food supplements needs to be country-specific or meaningful to a common reference period? We previously talked about either a three month or six month reference period for several of these interventions, for ease of training, etc.

A: I like the approach of PMA2020 for food supplementation, but I think there are still things we need to work out. There is the idea of asking if they are 'enrolled' in a program that provides food versus just asking 'did you receive food'. There are too many things for the respondent to think through when asking about 'enrollment'. It might be easier to just ask if the received X food. The India DHS has asked about foods from the ICDS, but that's very context-specific, and with a 12-month recall. But that data has been phenomenally useful for looking at the scaling up of the program. I think the 12 month recall is too long, and the seven day is too short, so we'll need to land on something in the middle that's meaningful, perhaps two or three months.

A: None of us knew why it said seven days. If you go back and look at the DHS questionnaire, it's imbedded within a set of questions related to immunization and related topics, and we don't know why seven was chosen. We agree that we would want to pick the past month or last three months, etc.

On the other issues, we agree that the question needs to get more to the heart of the matter as the 'program' or 'enrollment' is to ambiguous. Since we have Dr. Singh from India here, perhaps we could learn more about how they've adapted India's DHS.

Q: The number of pregnant women in the DHS is very small. It's less than 10% for each survey. We need to think about what we are after when developing these questions. The best is 'current status', so we're addressing women who are currently pregnant and asking them if they are enrolled, what kind of food they received, etc. The number of cases, however, will be very small. But if we want more cases, we can then go and do recall, and ask them about their last child or for all her children.

A: This links to one of the interventions in the Micronutrient WG, which is the fortified complementary foods. So we should probably bring these discussions together. Mexico has spent the last 20 years understanding the consumption and coverage of the fortified complementary foods that are provided under the conditional cash transfer program, and there are great questions in those national surveys. These might offer some good examples. Mexico representatives were actually invited here but couldn't make it.

A: It's important to note that if we lose the DHS question that is there, we lose the micronutrient powders so at a minimum we would need to add that back in here.

A: With regards to why seven days was selected as the recall period, at the time the questions were developed, there was no evidence or guidance. At the time, a seven day period was common, so that's what was chosen.

Q: I think it's really important to wait on developing indicators (and deciding on the tier) until there is actually program guidance. I don't think it makes sense to start thinking about the indicators until the guidance is clear.

A: I agree with that but we have to be realistic of windows of opportunity to include things and get information in a way that matches the timeline for the guidance development. What do others think? Do we wait for guidance to come out before we start recommending indicators?

A: If we think of this as a linear process, then the time from evidence to guidance is not just 2-3 years, but actually more like 7-10 years. So if we wait and say we won't measure anything unless there is guidance available for a survey, we'll be getting data on things 15 years after we know they should be done. I do appreciate that guidance is really important, but I don't think we can make a blanket statement saying no measurement unless there is guidance available.

A: I think there's a difference between indicators that we are proposing for collection across many countries, and providing countries with guidance on how to develop indicators that are specific to their programs. I think it's important for a country to be able to tailor an indicator to their program, and giving them guidance on how to do that, rather than just giving them a generic indicator for the last seven days because we don't know what else to do and that's applied across a huge set of countries and is potentially not very meaningful. So I think there's a place for guidance on how to develop indicators for your country-specific program, versus asking what are the indicators we think should be collected across the board.

A: I agree that we should give priority to measuring things for which there are guidance, and then we should use common sense for these other things. Your point is well taken about the universality of certain topics.

Micronutrient WG

Q: Regarding the recommendation to extend the recall period from seven days to six months. I wonder if this would result in less useful information given that the dose for these supplements is a *daily* dose.

A: Yes, it's taken as a daily does, but we were thinking more about the distribution of the supplements, since they would probably receive it on a monthly basis. That receipt would relate more to the indicator. Perhaps a second question would be related to 'how many of the 30 (or 90) doses did you take?

A: We know that the number of sachets that are distributed and the frequency of distribution is extremely heterogeneous. The intake regimen (daily, or less frequent) can vary dramatically as well. So we decided to go to a higher level of coverage, e.g. six months. This is coverage, not intake.

Q: Regarding the food fortification module, do we know who will be answering the HH questionnaire? And are we comfortable with a male answering these questions? In the PMA2020 experience, we informally switched to the woman when the man could not answer.

A: Since the salt question is located at the HH level, we felt that these questions should also be applied at that level. However, we don't have good data to support using a male head of HH. It's perhaps a question to test, and to look at who the respondent tends to be on these questions.

A: It might be worth considering moving the salt question to another respondent (i.e. not the head of HH).

Q: Regarding food fortification, why are we asking about the source of the food? In India, respondents are getting food from the Integrated Child Development Services (ICDS) scheme via take home rations. This is not more than $5 per month. Only 54% of women are utilizing ICDS services. In India, 93% of HHs are using iodized salt, so what is the need for adding this question.

A: The origin of this question is that not all food is fortifiable. Sometimes people home-produce their food, or they buy it from a local mill. Even with salt, it's sometimes bought from a local producer and not being iodized or fortified. So the point of the question is to separate out the portion of salt users whose salt is iodized from the total number of salt users, to assess the amount that can still be iodized. This ultimately gives us our denominator, i.e. what *can* be fortified.

Q: Often Vitamin A supplements are distributed via multiple rounds of child health days. Did you have any discussion about how to extend that to try and capture coverage over the last six and last 12 months to see how many children get a full year of coverage?

A: Yes, we discussed this. One of the limitations of DHS data was the timing of data collection. So if the round of DHS is in March versus July versus December, you might get different results on this question. And then you might have all kinds of distribution mechanisms. It's a complicated issue. Ideally, if you are trying to measure coverage, you would do it two months after a campaign and have a campaign-based approach, which has been done in some places. In Bangladesh, we could collected for a full year after campaigns and we had a good result. Given all of this, we still felt that it was worth keeping the six month recall as part of the DHS. Perhaps research could be done in the future to assess the validity of using longer recall and campaign based questions.

Q: In relation to the fortification module, did you discuss *bio*fortification and how that comes into play?

A: Yes, this was discussed. We agreed that it was important to consider, but we tabled the topic for future discussions as we know that Harvest Plus is working on ways of assessing coverage, so we included it as a topic for further research. We also acknowledged the difficulties in identifying whether foods are biofortified or not.

Plenary 4: Meeting Country Data Needs – Detailed Notes

The panelists were asked to describe some of the most pressing nutrition-related data needs from their country-specific perspectives, as well as their greatest challenges with data collection and use.

Anamika Singh (NITI Aayog, India)

The Ministry for Women and Child Development has been implementing child development programming for the past six decades. The program is known as Integrated Child Development Services (ICDS). Several of the sample questions in our data sets today come from that program. It's a huge program with more than 70+ million children, a work force of 3.5 million field workers, etc. India's new National Nutrition Mission aims to improve child nutrition by facilitating the collaboration of key ministries, such as the Ministry of Health, the Ministry of Women and Child Development and the Ministry of Drinking Water and Sanitation, so that there is long-lasting change.

The Mission has ambitious targets, including reducing stunting rates, reducing anemia among pregnant women, etc. The life-cycle approach (i.e. the first 1,000 days) is used as opposed to individual, Ministry-specific approaches. The Mission has an abundance of data, both from programmatic monitoring and from periodic surveys. In fact, the current thinking is that there is *too much* data, and it's coming from too many sources, which has become quite overwhelming.

For periodic surveys, India relies on the National Family Health Survey (NFHS), which just completed its fourth round last year. These surveys were previously conducted once per decade, but it was recently decided that this was too long to wait for such critical data, so going forward it will be conducted every three years. The next round will be completed in 2020.

UNICEF and the Ministry of Health take the lead in the Comprehensive National Nutrition Survey (CNNS). It's almost complete and by early next month (October 2018) there will be results from the 15 larger states. A unique feature of the CNNS is that it captures anthropometry and biochemical details, and it targets children 0-19 years, so adolescents are included. CNNS will capture micronutrient deficiencies, noncommunicable disease (NCD) risk factors among children, Vitamin E, etc. as well as all of the issues that were either not covered, or not adequately covered, under the NFHS.

There is a plethora of programmatic data. The Ministry of Health has its own portal, with more than 200 indicators captured periodically. The Ministry of Women and Child Development also has more than 800 data sets, organized in eight modules, that the field workers are responsible for completing. There are, of course, issues of data credibility here, especially since the field staff that are doing the work are also capturing the data.

One challenge is that both ministries are collecting data (for their respective programs) from the exact same beneficiaries (women or children). Ideally, we should find a way for the ministries to collaborate in data collection but until now, this has been difficult. There is a new model and software that will be piloted in the near future.

Finally, it's worth noting that the current, very centralized process is disempowering to field- and district-level staff who collect the data. They are neither involved in indicator selection nor utilization of the data, so they have no investment in ensuring that it's accurate. The Mission is grappling with how to increase/change their involvement to help them understand the data's value and the need for accuracy and reliability.

Ibrahim Kana (Federal Ministry of Health, Nigeria)

Historically, nutrition investments in Nigeria have been made without looking at the performance and outcomes of those investments. Therefore, working with the World Bank to manage a more performance based program has been a huge challenge. The first question was: What data would be used? And second: How will the monitoring be done? There are clear indicators, both qualitative and quantitative. For quantitative, it was decided that the DHS, MICS and SMART indicators would be used. For this reason, this morning's sessions were extremely helpful. For the qualitative aspects, we look at the quality of care using the National Health Facility Survey. The first National Health Facility Survey was conducted in 2015 and was used that as our baseline.

There was a lot of discussion and disagreement, but eventually an agreed set of indicators was arrived at, including Vitamin A, HIV, Malaria, contraceptive prevalence rate, etc. The SMART survey questionnaire was used for the baseline effort, and then in 2016, the MICS was used and this was used to measure change from the 2015 SMART. This analysis was used to determine which states in Nigeria would get money for programming. If a state showed improvement between these two surveys, they would receive further funding; and if not, funding was cut.

This was a dramatic shift since it was the first time states were being held accountable for the results of their programs. Funding and jobs were in jeopardy, and state-level staff pushed back saying that it was not appropriate to compare SMART data to MICS data (nor MICS data to DHS data), and therefore funding decisions should not be made on this basis.

This scenario emphasizes the need for harmonization between the survey platforms, and this meeting is helping towards that goal. In particular, it's helpful to see how specific questions are asked within each of the platforms, and understand how that affects the results.

By next year, Nigeria will have another round of National Health Facility Surveys, and following that a performance budget review (PBR) will once again look at improvement between survey years to determine future budgets.

Masresha Anegago (Ethiopian Public Health Institute, Ethiopia)

Ethiopia is one of the countries that are contributing to the Global Burden of Undernutrition. Related to this, the Government developed its first national nutrition strategy in 2008. It was very challenging to raise awareness about nutrition, particularly at very high levels of the government, mostly because these actors were not able to see the nutrition problem as a 'developmental' problem. After much advocacy work, the government began to understand that nutrition is an economic and a development problem. Since then, the Ethiopian Public Health Institute (EPHI) was mandated to conduct the national nutrition survey, which would serve as a nutrition baseline.

EPHI produced several national surveys, primarily to provide the government with evidence for improving both programs and policy. Thus far, the national nutrition surveys have been conducted periodically, as well as the national food consumption and national micronutrient survey. EPHI provides technical support for the health and nutrition components.

There are several challenges related to data: The most significant is human resources, though in recent years the number of nutrition graduates has definitely increased. Funding for surveys is also a significant challenge. For example, the first micronutrient survey was conducted in 2005, so the second one should be in 2010, five years later. Due to a lack of funding, it will instead take place 10 years later. Finally, utilization of data is a significant challenge; EPHI is constantly trying to narrow the gap between the researcher/technical people and the policy maker.

Q & A and Discussion for Plenary 3: Meeting Country Data Needs

Q: It was stated that in India, there is an abundance of data. Does this provide you with all of the information that you need? Or are there critical areas that still lack data?

Anamika Singh (India): We still don't have a lot of information on micronutrients and fortification. We are taking baby steps in that direction but it's still relatively new. We are also talking about the dual burden – NCDs and overnutrition. The new CNNS will take place in October (UNICEF- and Ministry of Health-led), so at least for the age-groups of children and adolescents, some of these questions will be addressed in a very comprehensive manner.

Q: You talked about the National Nutrition Mission in India. How are you ensuring that your data collection is aligned with national nutrition policies and the National Nutrition Plan? I believe that all of the countries now have an endorsed policy and plan. How do you link these two? How do you ensure that the demand for data is actually emerging from your national policy and plan?

Anamika Singh: What I didn't mention earlier is that we have launched an intensive scheme that focuses on high-burden districts of India, where the burdens of stunting are about 45%. For programmatic interventions in those districts, we have agencies that will do a review every quarter using 31 indicators that are very program driven. These will go into the planning and course correction for the Mission. The NFHS will also come on line next year will be a good baseline for the Mission.

Q: Is there one piece of advice you can provide to people like us so that when we come into your countries to talk about data, we are actually helping and being supportive?

Anamika Singh: Perhaps simplifying things for everyone would be helpful. Also, integration at the highest levels, so that data sets talk to one another and there is less confusion between them.

Masresha Anegago (Ethiopia): Data quality is extremely important. We should have tools to standardize and validate the data. We also need to improve dissemination of the data. Finally, there needs to be a coordination mechanism between the various data platforms (DHS, MICS and SMART) in each country. I suggest that these platforms always build the capacity of the local government and local organizations so that we can manage these platforms well in country.

Ibrahim Kana (Nigeria): I have several suggestions I'd like to share: Not only should DHS, MICS and SMART being talking to one another and coordinating with one another, but other areas such as HIV, Malaria, family planning, etc. need to be part of the discussions so that all of the surveys are better coordinated.

Often, there is funding and capacity to collect and analyze the data, but we need additional funding to do further analysis of data that has already been collected. Nigeria has dedicated significant funding to nutrition and other surveys, and as a result we have been able to attract complementary funding, such as BMGF monies, USAID and other major donors. This kind of diversified funding is an approach that allows for regular surveys.

There is need for better alignment between the WHO supported National Health Facility Surveys and the three platforms we've been speaking of (DHS, MICS and SMART). Even though one is qualitative, and the others are quantitative, they should still be aligned so that they can be interpreted together.

Technical Expert Advisory group on nutrition Monitoring (TEAM): Working Group on Anthropometry Data Quality (ADQ)

Recommendations on Anthropometry Data Quality

Rafael Flores-Ayala

Technical Consultation on Measuring Nutrition in Population-Based Household Surveys and Associated Facility Assessments

Washington DC September 19-20, 2018

World Health Organization

unicef

TEAM Background

- In 2014, Member States approved the Global Nutrition Monitoring Framework (GNMF) on Maternal, Infant and Young Child Nutrition and requested to establish an *independent technical group to advise on the definition and operationalization of GNMF indicators*
- In 2015, a Technical Expert Advisory Group on Nutrition Monitoring (TEAM) was jointly convened by WHO and UNICEF
- The *TEAM supports and advises WHO and UNICEF in their priorities on global nutrition monitoring*
- WHO-UNICEF act as a joint Secretariat

http://www.who.int/nutrition/team/en/

Anthropometry Data Quality Background

- Significant differences in results have been observed across survey systems (DHS, MICS, SMART, others) conducted in similar geographic locations and at close time points, leading to confusion at country and global levels.
- USAID's Nutrition Division hosted a technical meeting in July 2015 to develop a shared understanding of the purposes, strengths, and challenges of these survey methodologies and provide recommendations.
- USAID's Nutrition Division viewed the TEAM as the entity to provide leadership and global guidance on these issues

https://www.fantaproject.org/monitoring-and-evaluation/anthropometric-data-population-based-surveys-meeting-report/

TEAM workplan 2018-2019

1. GNMF indicators
   - IFA supplementation – validation
   - Breastfeeding counselling – development and validation
   - Extended set of indicators
2. Revision of IYCF indicators guidelines (WHO 2008 & 2010)
   - Diet quality indicators
3. Technical Report on improving anthropometry data quality
4. Manual on nutrition surveillance and monitoring
5. An agenda for TEAM research priorities
6. Communication with other groups
7. Others
   - Quality-adjusted coverage indicators
   - School-age/adolescents Nutrition
   - TEAM participation in Joint Malnutrition Estimates (JME) and UNICEF IYCF database

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Technical Report on Anthropometric Data Quality: Key Milestones

- Nov 2017-Feb 2018: Review of the 1st draft by WG and reviewers
- February 2018: 2nd draft. Webinar to specify focus of the document and data quality criteria
- June 2018: 3rd draft. Identification of outstanding issues.
- 14-15 June 2018: Face-to-face meeting in Atlanta

Recommendations on Anthropometry Data Quality

Pages	Chapters	Sections
1-3	Introduction	
4-10	Chapter 1- Organization and survey design	Planning
11-19		Sampling
20-27		Training and Standardization
28-35	Chapter 2 – Field work procedures	Measurements and equipment
35-39		Data collection
39-42		Quality assurance methods during data collection

Guidance on Anthropometry Data Quality

Pages	Chapters	Sections
43-45	**Chapter 3 – Data processing, analysis, reporting and assessment of data quality**	Data entry/capture
46-54		Data quality assessment
55-61		Data analysis-the standard approach
62-64		Data interpretation. Consequences of poor data quality
65-67		Harmonized reporting and data release
68-87	**Annexes**	

Areas for further research (1)

- **Thresholds for indicators of data quality:** what are the values that indicate quality problems?
- **WHO flags**: revisit whether the WHO flags are consistent with implausibility.
- **Distributions of anthropometric indicators:** revisit whether we can expect a normal distribution for the different indicators and a standard deviation around 1.
- **Validation of event calendars to estimate age in children having a unknown date of birth.** What is the accuracy of this methodology?

Areas for further research (2)

- **Technical Error of Measurement (TEM) and cut-offs to assess anthropometrists' performance:** which cut-offs to consider in field conditions?
- **Taking more than one measurement:** which will be the gain of doing this?
- **Random re-measurements during survey implementation:** how useful is this procedure to estimate precision and accuracy?
- **Fieldwork load**: what is a "reasonable" workload for anthropometrists as overworking will decrease data quality?

Next steps

- Revision of section on Sampling
- Review of cut-off for TEM in the standardization of anthropometrists
- Re-drafting the section on quality assurance during data collection
- Review of the section on data quality assessment
- Preparation of the 4th draft
- Review by TEAM
- Clearance

Questions?

Current TEAM members

Name	Affiliation
Mary Arimond	FHI 360
Jennifer Coates	Tufts University
Trevor Croft	ICF
Omar Dary	USAID
Rafael Flores-Ayala	US Centers for Disease Control and Prevention (CDC)
Edward Frongillo	University of South Carolina
Rebecca Heidkamp	School of Public Health, Johns Hopkins University
Purnima Menon	International Food Policy Research Institute (IFPRI)
Lynette Neufeld	Global Alliance for Improved Nutrition (GAIN)
Faith Thuita	School of Public Health, University of Nairobi
Wenhua Zhao	National Institute for Nutrition and Health

TEAM Secretariat

WHO

- Elaine Borghi
- Francesco Branca
- Mercedes de Onis
- Elisa Dominguez
- Larry Grummer-Strawn
- Kuntal Saha

UNICEF

- Chika Hayashi
- Julia Krasevec
- Vrinda Mehra

TEAM workplan: achievements during 2016-2017

1. Operational guidance for the GNMF indicators
   - Minimum Acceptable Diet (MAD)
   - Iron and Folic Acid Supplementation
   - Breastfeeding counselling
   - Trained nutrition professionals

   Achieved
2. Rules for tracking WHA Global Nutrition Targets
3. Prevalence thresholds for malnutrition (stunting, wasting and overweight)
4. Improving anthropometric data quality

   Ongoing
5. Modelling exclusive breastfeeding
6. An agenda for TEAM research priorities

   Included in 2018-19 workplan
7. Communication with other groups
8. Mapping of ongoing nutrition monitoring activities

   Dropped

Brief Summary

Technical Meeting on Assessments of Micronutrient Biomarkers in Population-Based Surveys

USAID

September 18, 2018

Discuss **rationale** and **lessons learned** about **assessments of micronutrient biomarkers** in low and middle-income countries (LMICs) through **population-based surveys**

Overview of Micronutrient Biomarkers

- Justifying micronutrient assessments and the importance of the quality of the sample: Omar Dary, USAID/GH/MCHN
  - Optimal nutrition depends on food, health, care, + environment
    - MN intervention impact depends on additional MN intake plus many other factors
  - E.g., anemia apparently simple but influenced by many factors in environment
    - Sample collection is key
    - Move toward pooled capillary samples, opens possibility of more easily assessing other MN biomarkers

- Overview of biomarkers in the micronutrient field: Daniel Raiten, HHS/NIH
  - Food ≠ Nutrition
  - Context matters – nutrition is an input and outcome of health
  - BOND – priority micronutrients indicators

Overview of Micronutrient Biomarkers

- Initiatives about novel tools for determining biomarkers: Ken Brown , BMGF
  - Lack of data is critical problem, assessment is challenging but doable
  - Exciting work on improvements to specimen collection, cold chain, and lab analysis
  - Key priority - keep doing, but more of it

- Importance of biomarker results for global reporting and monitoring of the world nutritional status: Lisa Rogers, WHO
  - Vitamin and Mineral Information System
  - Global reporting for global nutrition targets and burden of disease
  - Population based micronutrient status surveys are a critical need
    - Especially emerging priorities, such as adolescents

Lessons Learned on Coordination Between Micronutrient Surveys and other Population Surveys in LMICs

- Uganda/National Panel Survey: Maria Elena Jefferds, CDC
  - Integrated into main data collection and collected among full sample of the Uganda National Panel Survey
- Malawi/DHS: Parminder Suchdev, Emory/CDC
  - Linked and collected among sub-sample of the 2015/2016 DHS
- The Gambia/MICS: James Wirth, GroundWork
  - “Lightly” linked and collected among subsample of the 2018 MICS
- Panel: Bo Pederson, MICS; Joanna Lowell, ICF; Sorrel Namaste, ICF

Lessons Learned on Coordination Between Micronutrient Surveys and other Population Surveys in LMICs

- Various models possible of coordination – it does work!
  - Differences in modality and intensity of co-collection
    - Integration, piggyback, “light” linking
    - Both survey organization and micronutrient assessment expertise
  - Burden to the survey organization
    - Requires more resources and impacts other components, especially when not adequately funded
- Short term - lack of “standard” approach, requires both survey organization and micronutrient assessment expertise

Lessons Learned on Coordination Between Micronutrient Surveys and other Population Surveys in LMICs

- Required, starting at the beginning
  - Adequate planning time
  - Adequate financial and human resources (budget appropriately)
  - Good coordination and communication

- Micronutrient module is possible
  - Need, indicators, and methods exist
  - Next steps → technical discussions needed
    - Support specific recommendations for standardizing and piloting

Q&A and Discussion for Plenary 5: Report Out from Anthropometry Data Quality & Micronutrient Status Measurement Meetings

Q: In Africa, many of the key indicators, e.g. stunting, are actually improving. However, the prevalence of anemia has increased. Is there any investigation or plans to look at why this is happening? Are the biomarkers problematic? Could the prevailing assumption that anemia is caused by iron deficiency be incorrect? Also, is there a lower cost way of looking at zinc and other biomarkers?

A: This is a critical question/dilemma and has caused a lot of confusion. WHO is evaluating hemoglobin as an indicator, and looking at methods of assessment, etc. Other agencies, including the CDC, is examining how we collect data on anemia going forward. We know it varies by blood source, analytical methods, and other factors. I think that there will eventually be new guidance, and at some point the costs will come down. The Micronutrient Forum is also focusing energy on biomarkers, their collection, analysis and interpretation. There are already many biomarkers available, but there's a long way to go in terms of reducing their cost. Many countries (e.g. Nepal and Malawi) are doing work on etiology, and this is particularly important where there's malaria. If we assume that 40-50% of anemia is due to iron deficiencies, then that means there are a lot of other causes as well.

Q: In countries where female educational attainment is not very impressive, how do we maintain data quality? In the Indian DHS, only 6/36 states have 50% or more women with 10 or more years of schooling. Adding more MNs is better, but as a survey implementer, how do we maintain data quality, getting precise responses? The *survey teams* are not a problem; they receive comprehensive training. But the respondents are not educated enough to conceptualize and give accurate responses.

A: Yes, quality is extremely important. Appropriate field teams and sufficient supervision of field teams is critical. I see your point with respondent education.

HEALTH DATA COLLABORATIVE

DATA FOR HEALTH AND SUSTAINABLE DEVELOPMENT

The harmonized approach to

Health facility surveys (HFS)

Amani SIYAM (PhD, MSc, CStat)
WHO HQ (Health Metrics and Measurement)

Outline

- Brief background on the HDC (with focus on its objectives 2 and 3)
- The harmonized approach to HFS modules - purpose and methods
- Nutrition content in HFS
- Forward development of the nutrition content in the harmonized HFS

Health Data Collaborative:
Vision and scope

Improving country data systems and capacity to track progress toward the health-related SDGs and UHC

What are the problems we are trying to address?

34 % of health worker time spent on recording data

120+ Digital health systems in Tanzania

200 Supply chain indicators for donor reporting

9 Facility survey tools

HEALTH DATA COLLABORATIVE

DATA FOR HEALTH AND SUSTAINABLE DEVELOPMENT

50 % deaths globally reported with cause of death

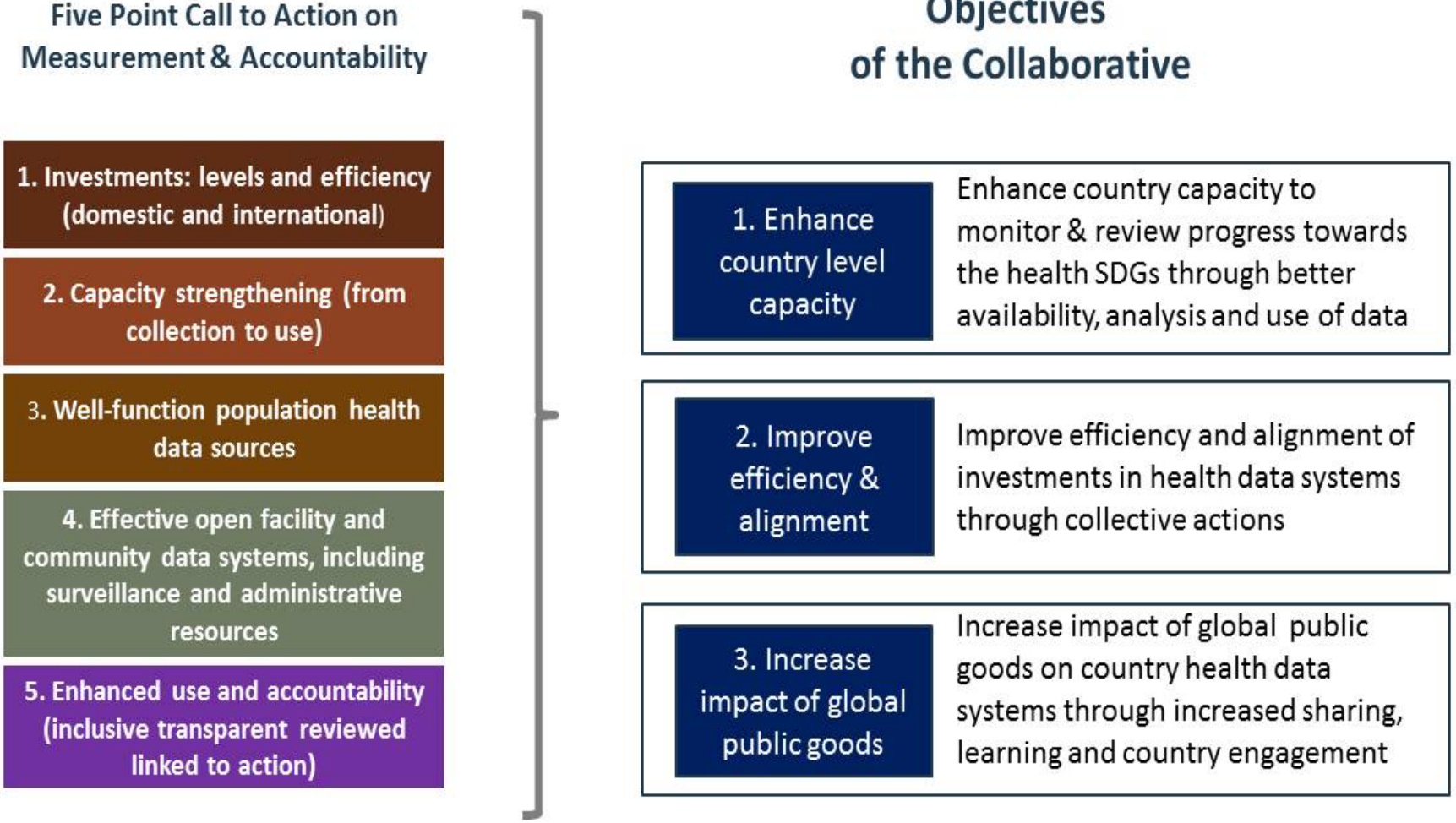
1.5 Billion USD (est.) spent on health data per year

42 Partners signed up to the HDC

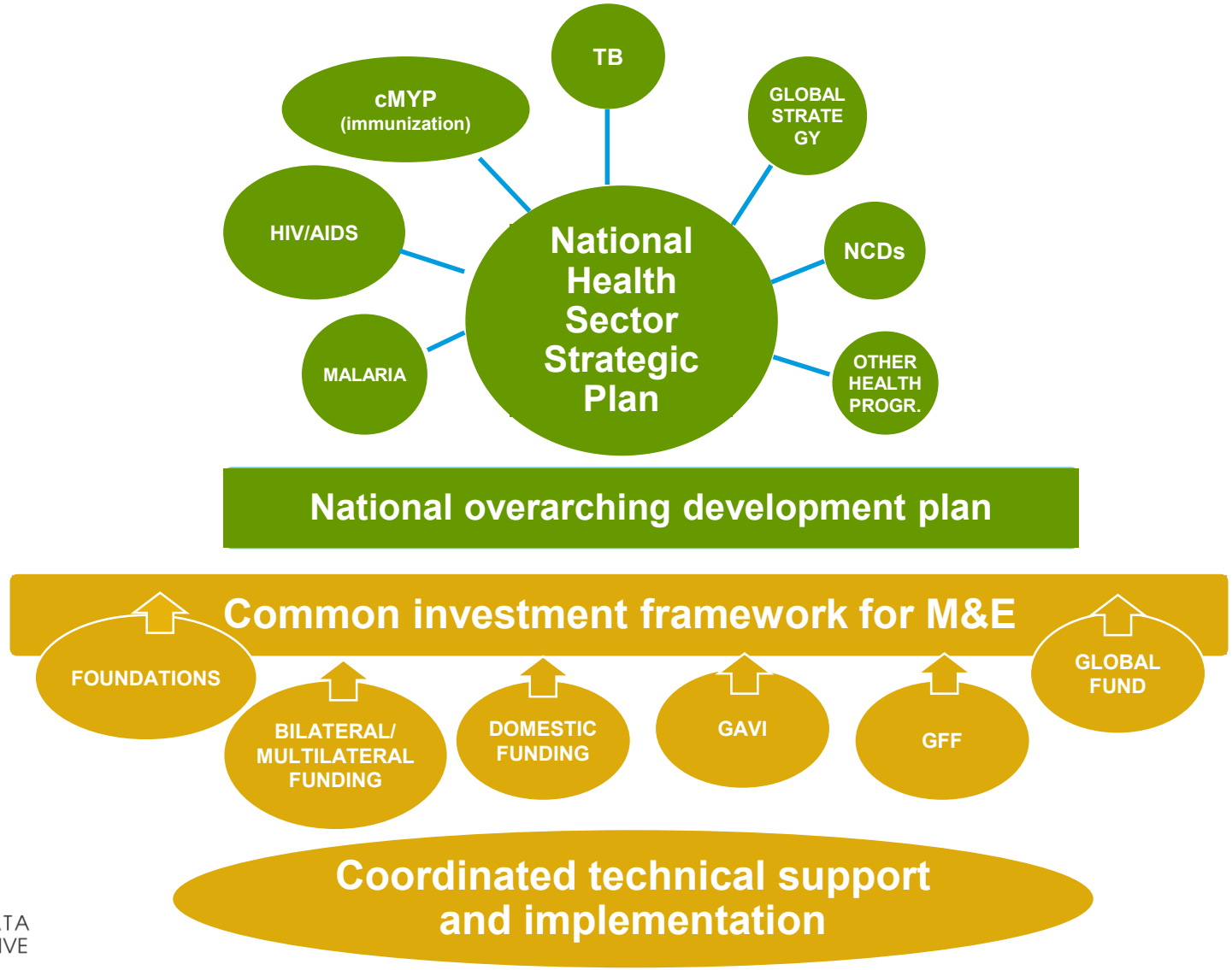
1 Common data approach

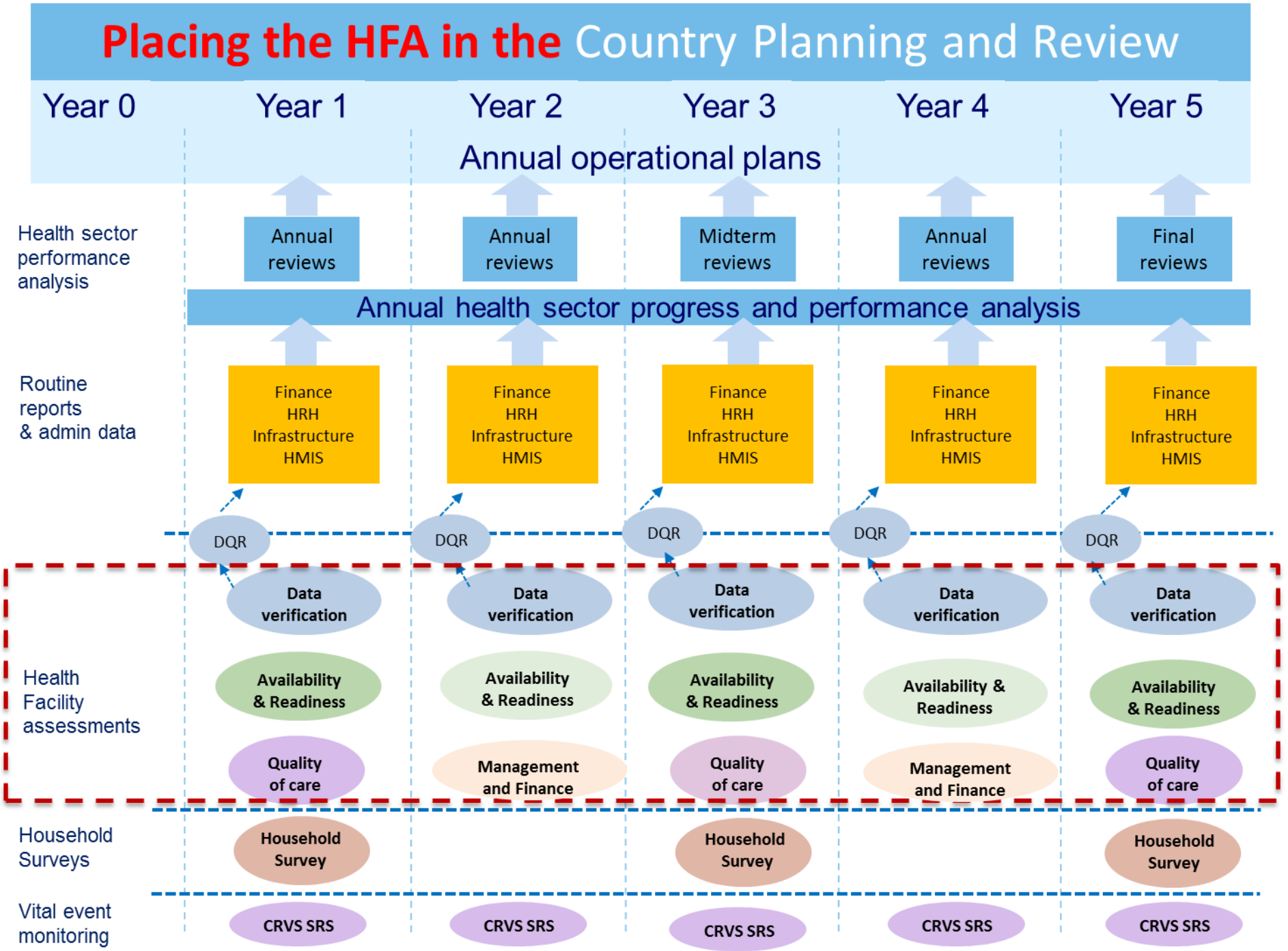
Health Data Collaborative

What are the objectives?



HDC Objective 2. Improve efficiency & aligning investment and support to countries




Placing the HFA in the Country Planning and Review
Year 0
Year 1
Year 2
Year 3
Year 4
Year 5
Annual operational plans
Health sector performance analysis
Annual reviews
Annual reviews
Midterm reviews
Annual reviews
Final reviews
Annual health sector progress and performance analysis
Routine reports & admin data
Finance HRH Infrastructure HMIS
Finance HRH Infrastructure HMIS
Finance HRH Infrastructure HMIS
Finance HRH Infrastructure HMIS
Finance HRH Infrastructure HMIS
DQR
DQR
DQR
DQR
DQR
Health Facility assessments
Data verification
Data verification
Data verification
Data verification
Data verification
Availability & Readiness
Availability & Readiness
Availability & Readiness
Availability & Readiness
Availability & Readiness
Quality of care
Management and Finance
Quality of care
Management and Finance
Quality of care
Household Surveys
Household Survey
Household Survey
Household Survey
Vital event monitoring
CRVS SRS
CRVS SRS
CRVS SRS
CRVS SRS
CRVS SRS

HDC Objective 3. Increasing the impact of global public goods

- **Harmonize existing tools:**
  - **Multiple data quality & facility survey tools**
  - Uncoordinated household survey modules
  - Surveillance tools & standards
  - Digital tools lacking interoperability
- Address duplication/fragmentation of systems:
  - Parallel facility reporting systems
  - Multiple indicators, data collection forms
- Address critical gaps/needs:
  - Poor reporting of births, deaths & causes of death
  - Lack of sound measurement methods for quality of care indicators
  - Weak analytical capacity and poor use of data for action

Time-limited technical working groups focusing on specific deliverables to address these challenges

The Harmonized health facility survey modules

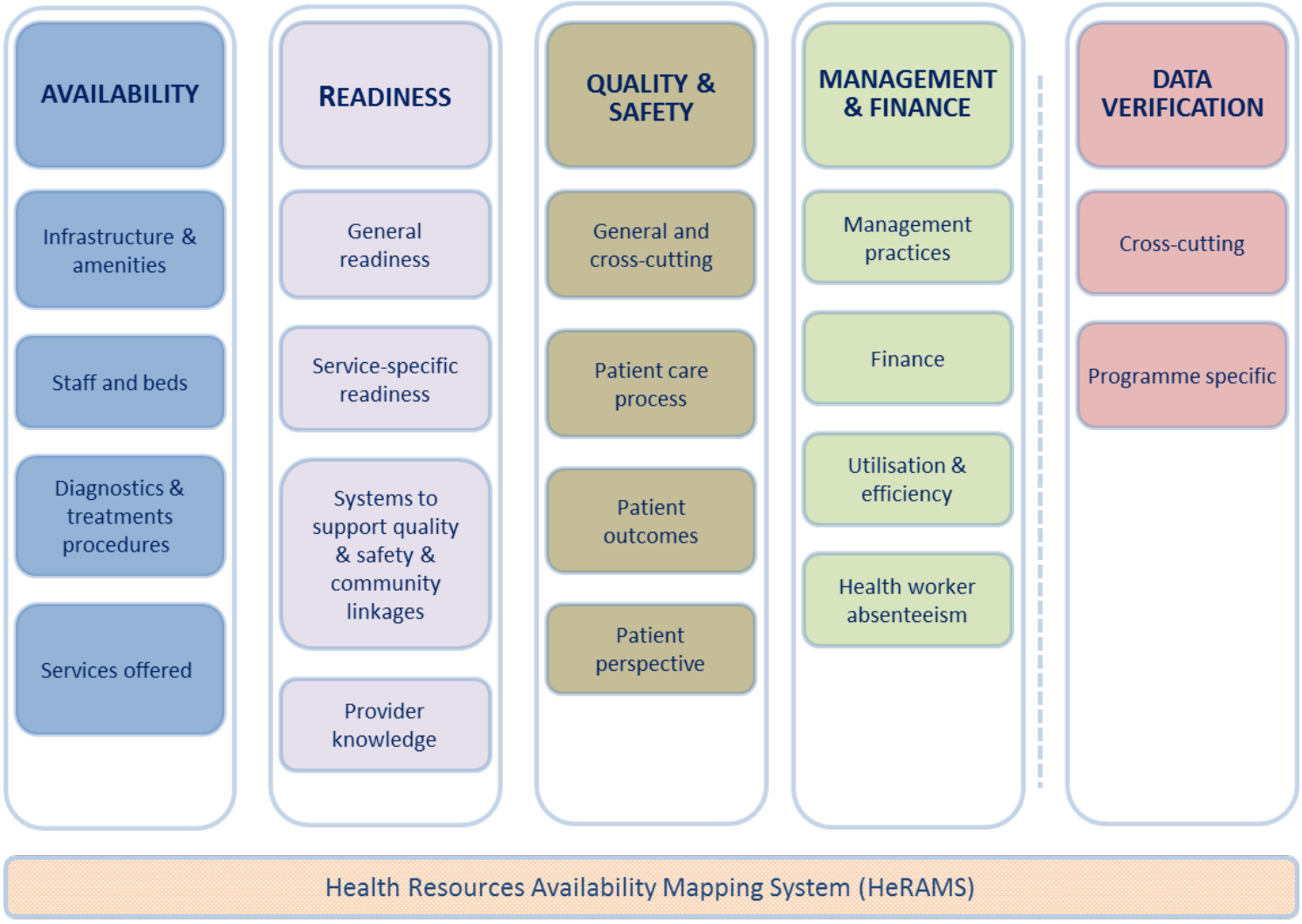
- Brought about by the **HDC "Health Facility Survey"** working group of technical experts from partners, countries, academia, civil society **as a deliverable** of the HDC operational work-plan 2016-2017

- Two main objectives:

  - **Review and harmonize facility survey modules**, including ***standard indicators*** and **measurement methods**, instruments and analyses;

  - **Catalyze a joint/aligned support for ONE country system of facility surveys**, based **on a modular approach**

The Harmonized health facility survey modules



HFS Measurement methods

Facility audit

The data collector walks through the facility and collects information **by interviewing the most knowledgeable person available** on the day of the survey for the subject. Reported information on availability of equipment, commodities, documents, and systems are validated by observation of the items in the vicinity where they are needed to reasonably assume usage for the service in question

Provider interview

A **sample of rostered providers** is interviewed on their knowledge on clinical practices in specific service areas through a checklist or vignettes (can include one or more providers)

Record review

The data collector draws **a sample from registers/records** for eligible patients and then reviews registers and records for documentation of specific elements in the patient care process. If records are not maintained at the facility, the sample may be persons who received services the day of the survey whose patient card is reviewed on exit.

Client exit interview

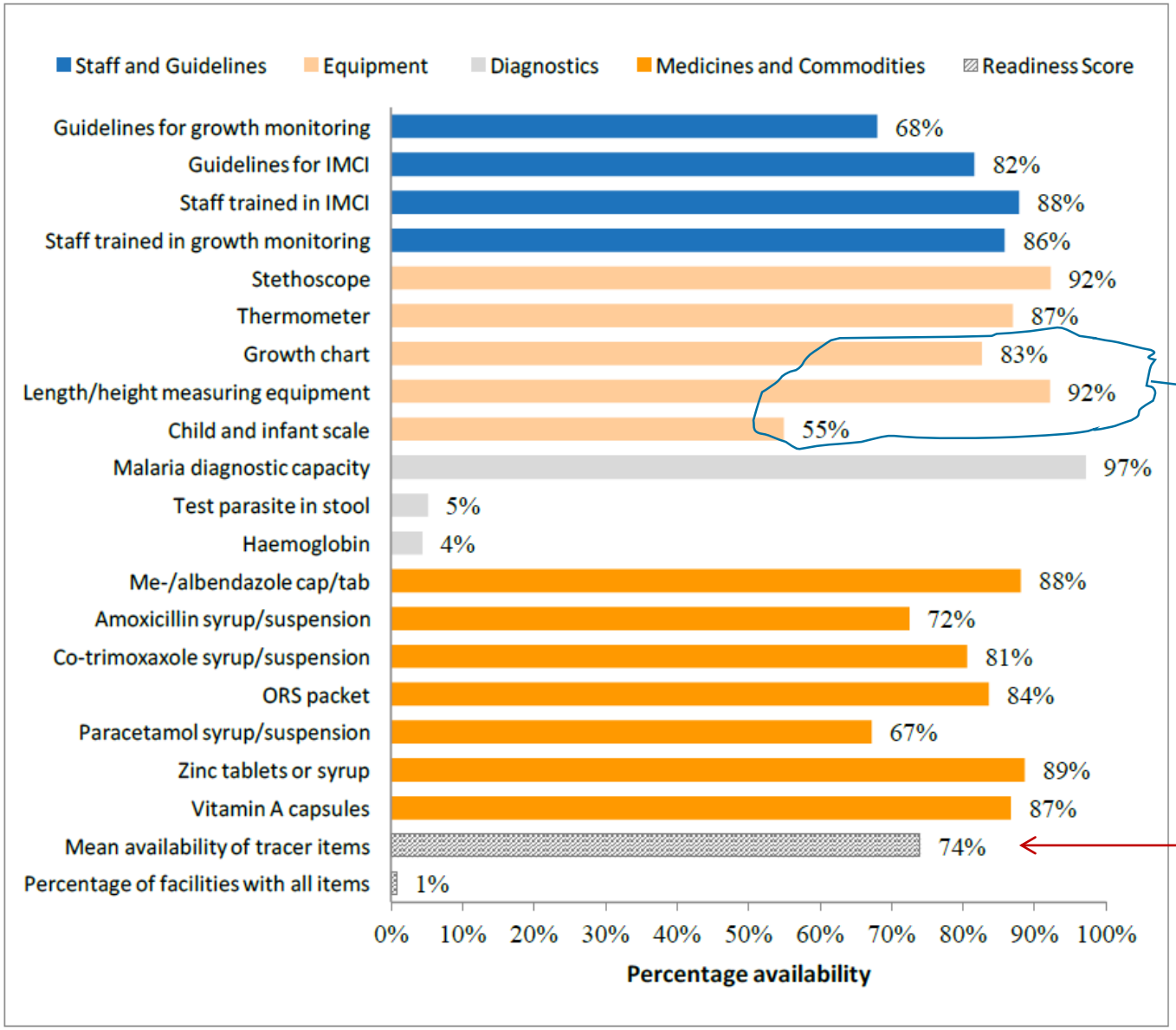
The data collectors draws **a sample from clients** who received care in the facility on the day of the survey when they are leaving the facility. Items assessed may include client opinion, knowledge, or to review their health card. This may be service specific or general.

Observation of client-provider interaction

A checklist is used to record topics on which information is shared, examinations that are performed, and diagnoses and treatments for a sample of patients receiving services the day of the survey.

Example of Nutrition – tracer items (Sierra Leone SARAPlus 2017)

Figure 41: Percentage of facilities with tracer items for offering child health services (N=1253)



- Tracer items availability may be high but not necessarily and indicator of correct and timely use

Anthropometric assessment readiness score = (83+92+55)/3 =77%

Overall readiness score =74%

Example of Nutrition – tracer items (Tanzania SDI 2014)

Methodological Note

The equipment indicator focuses on the availability (observed and functioning by the enumerator) of minimum equipment expected at a facility. The pieces of equipment expected in all facilities are: a weighing scale (adult, child or infant), a stethoscope, a sphygmomanometer and a thermometer. In addition, it is expected that the following pieces of equipment be available at health centers and hospitals: sterilizing equipment and a refrigerator.

Table 21. Availability of equipment items in the equipment indicator

% facilities	Tanzania	Public	Private (non-profit)	Private (for-profit)	Rural	Urban
Any scale	97.9	97.8	98.1	98.6	98.0	97.6
Thermometer	91.5	89.0	98.1	99.8	87.1	99.9
Stethoscope	97.8	97.4	98.1	100	96.6	100
Sphygmomanometer	95.3	94.9	95.7	97.3	94.0	96.8
Refrigerator (HCs and first-level hospitals only)	99.0	98.8	100	100	99.6	98.3
Sterilization (HCs and first-level hospitals only)	85.5	81.6	97.3	96	83.6	90.4

Source: Author's calculations using Tanzania 2014 SDI data

Table 22: Availability of selected medical supplies

% facilities	Tanzania	Public	Private (non-profit)	Private (for-profit)
Bag and mask[a]	57.8	62.3	54.9	32
Clear airways	45.8	47.1	50.8	31
Female condoms	14.1	15.8	7.4	11
Malaria RDT	81.4	82.1	81.3	77
HIV kit test	84.0	86.2	80.7	74
Glucometer	38.1	25.7	62.6	90
TB kit test	19.5	17.1	26.9	26
ITN	42.0	39.8	58.4	36
Tape measure	78.6	82.6	80.9	50
Length board	46.0	46.3	51.5	37

Source: Author's calculations using Tanzania 2014 SDI data

Forward *(suggested)* development of the nutrition content in the harmonized HFS modules

By the Facility audit

- Availability and Readiness (equipment, guidelines, growth monitoring charts, standardized child records, registers….etc)

By the provider interview…currently there is

- Provider competency in diagnosing and treating malaria with anaemia
- Provider competency in diagnosing and treating TB in adults and children

Record reviews……example extract from Malaria curative care record reviews

	QUESTON	SAMPLE PATIENT 1	SAMPLE PATIENT 2	SAMPLE PATIENT 3	SAMPLE PATIENT 4	SAMPLE PATIENT 5
PLEASE ANSWER THE FOLLOWING QUESTIONS FOR EACH PATIENT (USING INFORMATION FROM THE REGISTER(S) AND/OR PATIENT CARD/DATABASE)						
1102_01	Is the individual patient chart available?	YES NO	YES NO	YES NO	YES NO	YES NO
1102_03	What was the temperature of the patient?	__ . _ DON'T KNOW	__ . _ DON'T KNOW	__ . _ DON'T KNOW	__ . _ DON'T KNOW	__ . _ DON'T KNOW
1102_05	Was the patient anaemic?	YES NO DON'T KNOW	YES NO DON'T KNOW	YES NO DON'T KNOW	YES NO DON'T KNOW	YES NO DON'T KNOW
1102_06	Did the patient have symptoms of tiredness/ fatigue/ listlessness?	YES NO DON'T KNOW	YES NO DON'T KNOW	YES NO DON'T KNOW	YES NO DON'T KNOW	YES NO DON'T KNOW
1102_07	Did the patient have symptoms of fever?	YES NO DON'T KNOW	YES NO DON'T KNOW	YES NO DON'T KNOW	YES NO DON'T KNOW	YES NO DON'T KNOW

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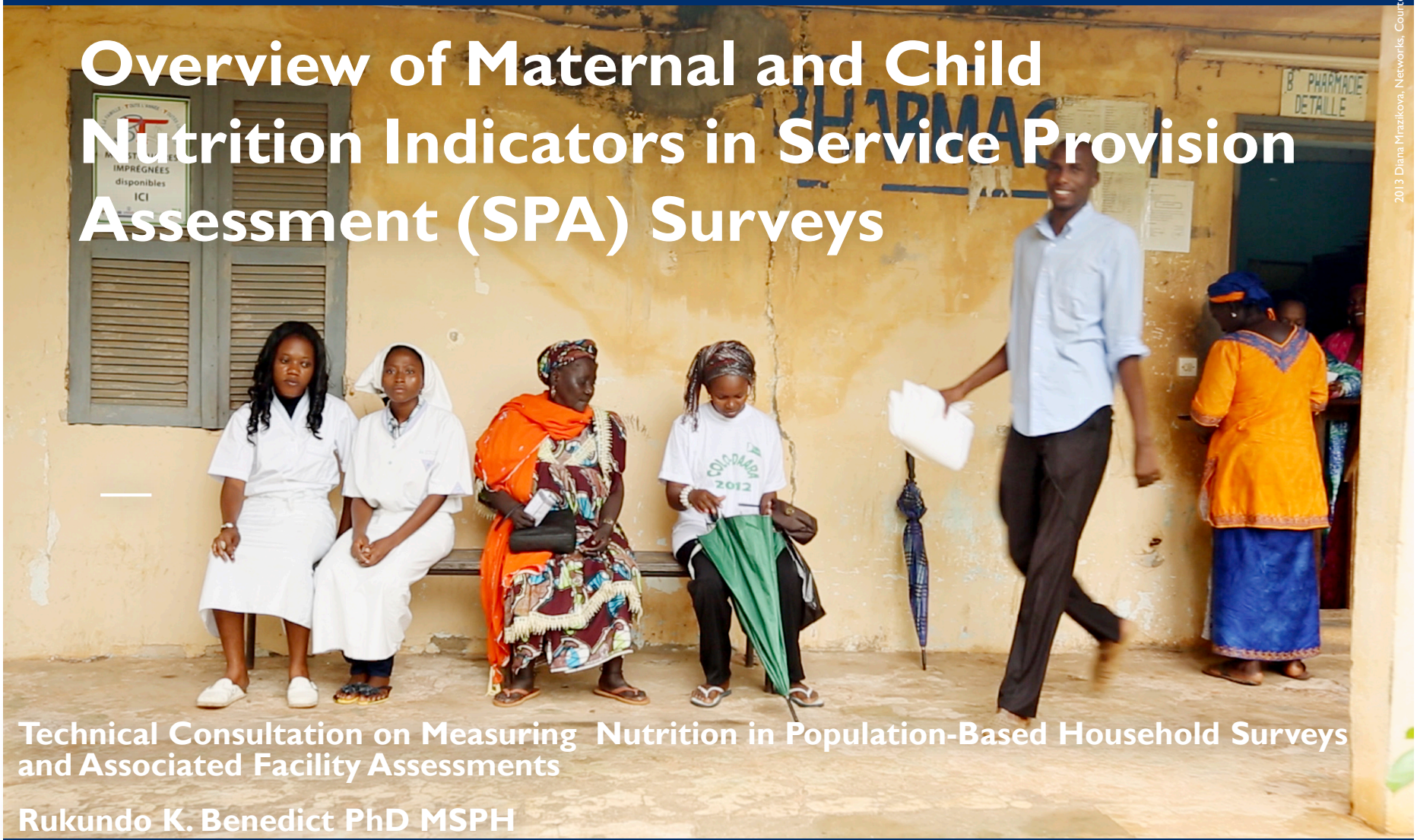
Overview of Maternal and Child Nutrition Indicators in Service Provision Assessment (SPA) Surveys



Technical Consultation on Measuring Nutrition in Population-Based Household Surveys and Associated Facility Assessments

Rukundo K. Benedict PhD MSPH

September 20, 2018

What is the SPA?

- Nationally representative sample survey or a census of health facilities
  - Formal sector health facilities
- Describes the service environment, facility preparedness and other components of health care
  - **Service Availability**
  - **Service Readiness**
  - **Service Delivery**

Four data collection questionnaires

Facility inventory/audit

Service availability e.g. antenatal care, family planning, sick child
General service readiness
Service-specific readiness

Provider interview

Provider qualification, in-service training
Supervision
Perception of the work environment

Client observation

Checklists cover basic elements of service delivery

Client exit interview

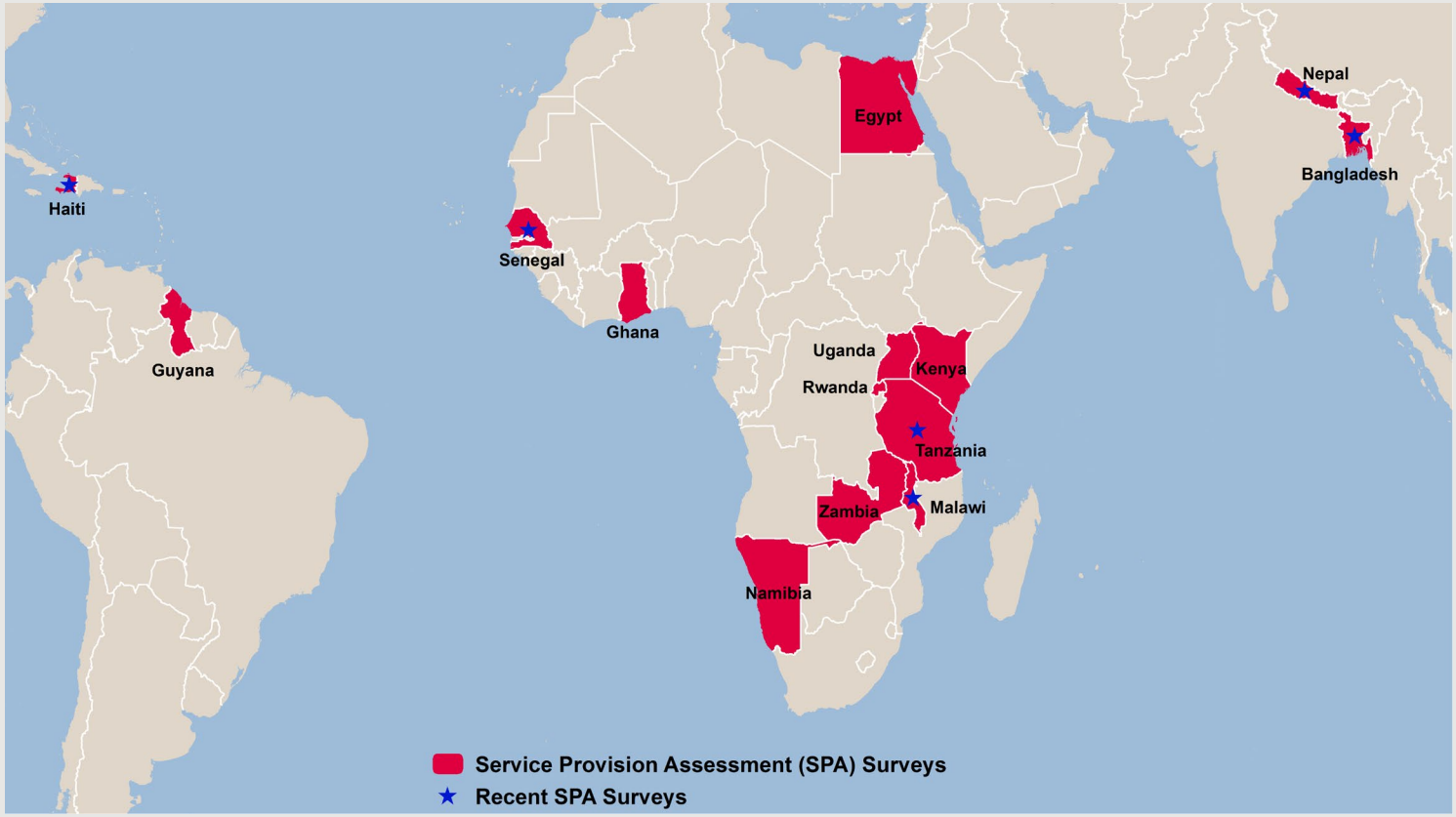
Client understanding and satisfaction

Icons created by Rauan, Wilson Joseph, Alax Kwa, and TukTuk Design from Noun Project

Maternal and child nutrition indicators in the SPA

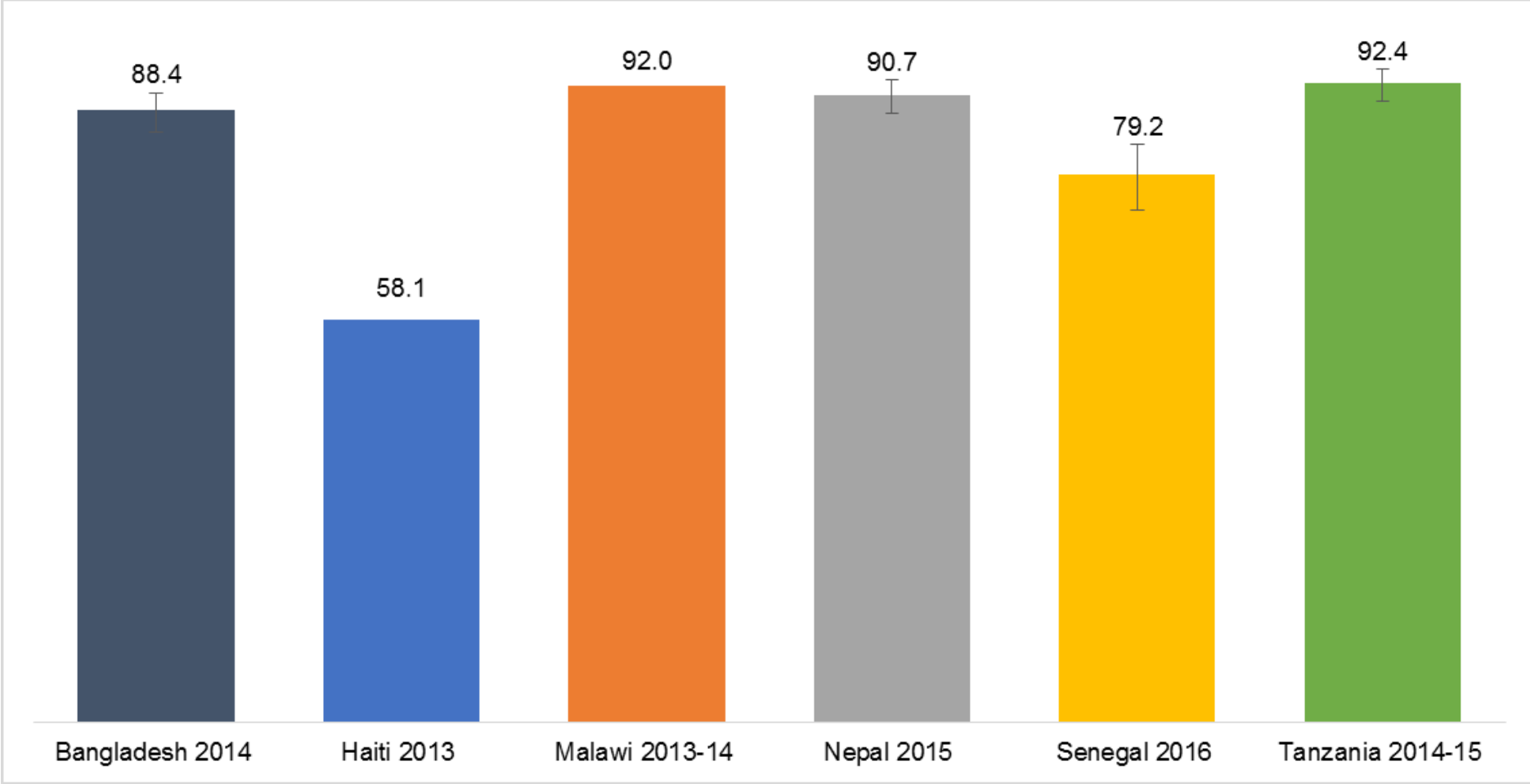
Antenatal care services	Sick child care services
IFA supplementation	Micronutrient supplementation
Pregnancy growth monitoring	Growth monitoring
Maternal nutrition counseling	
Anemia testing	
Breastfeeding counseling	Infant and young child feeding counseling

Countries with SPA surveys

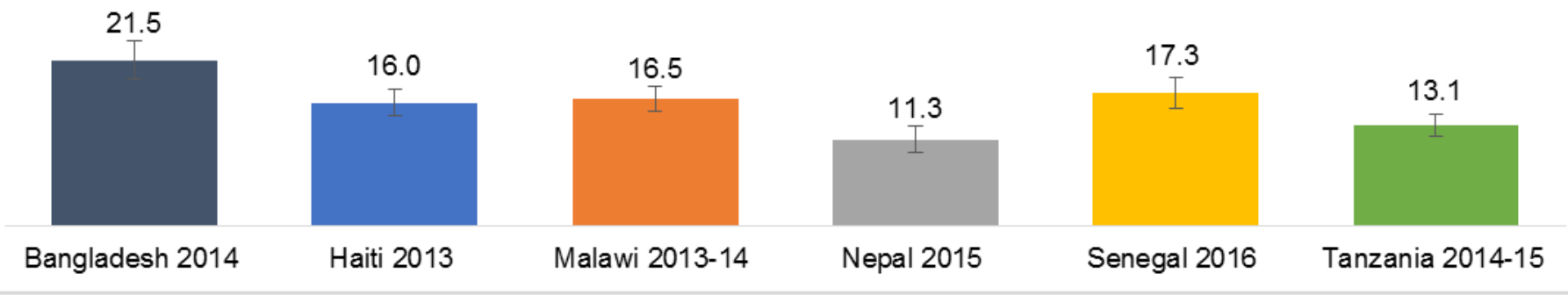


A typical SPA survey uses a sample size between 500 and 1000 health facilities, depending on the total number of health facilities and the number of regions in the country.

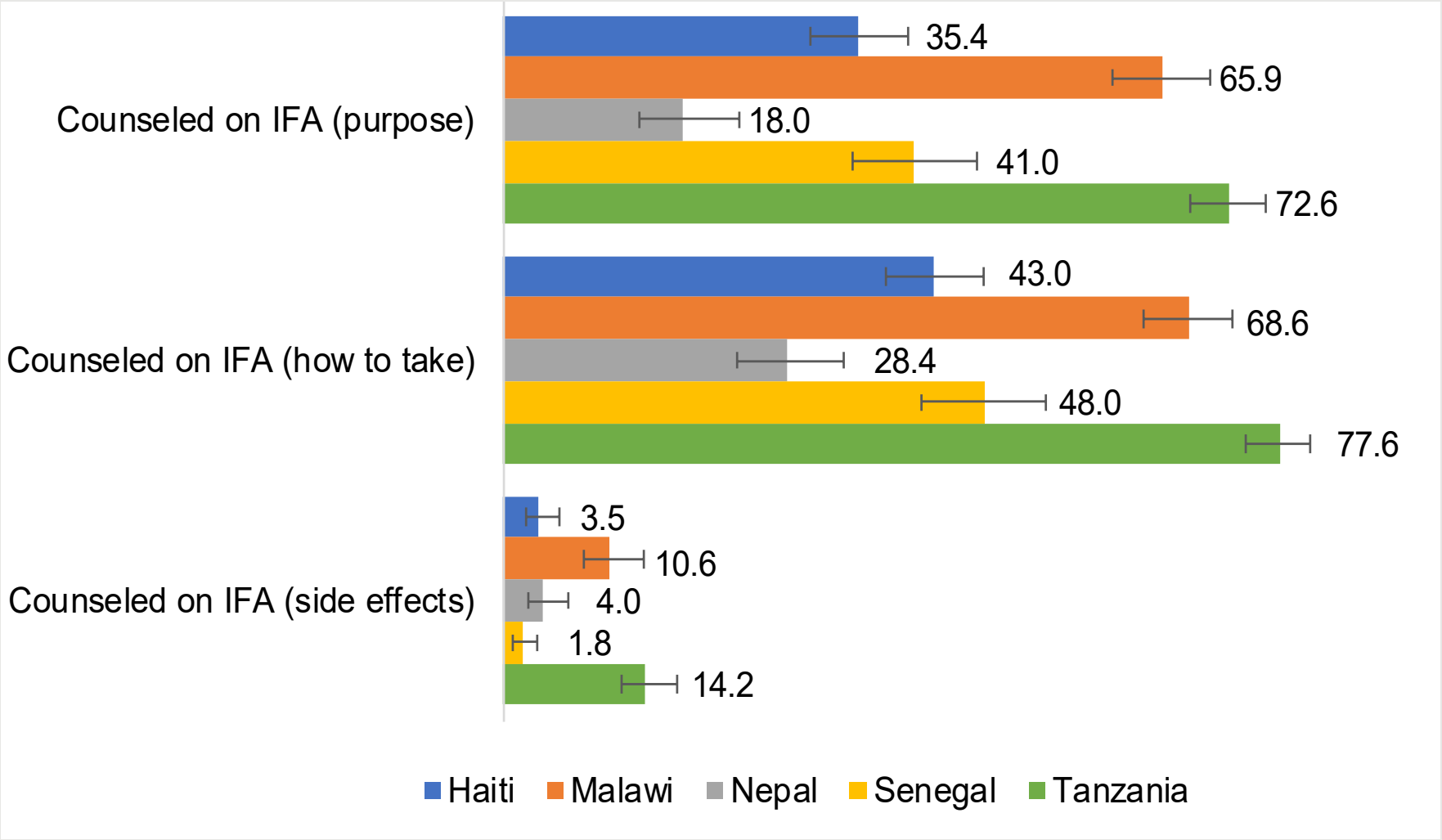
Service readiness: percent of facilities with IFA supplements (SPA-data)



Service readiness: percent health providers with training on nutritional assessment during pregnancy (SPA data)

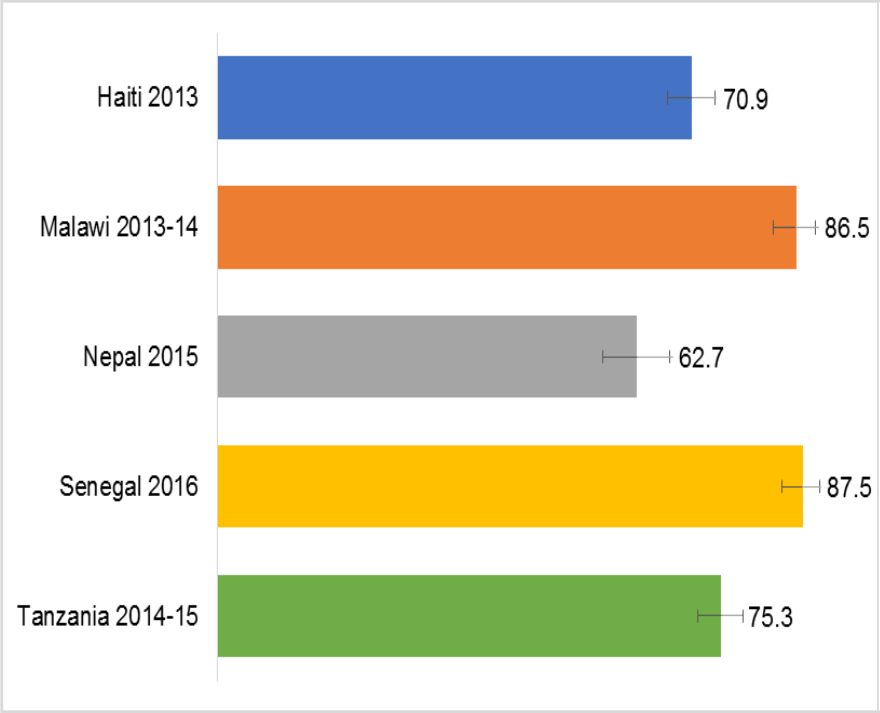


Service delivery: counseling on IFA supplements (SPA data)

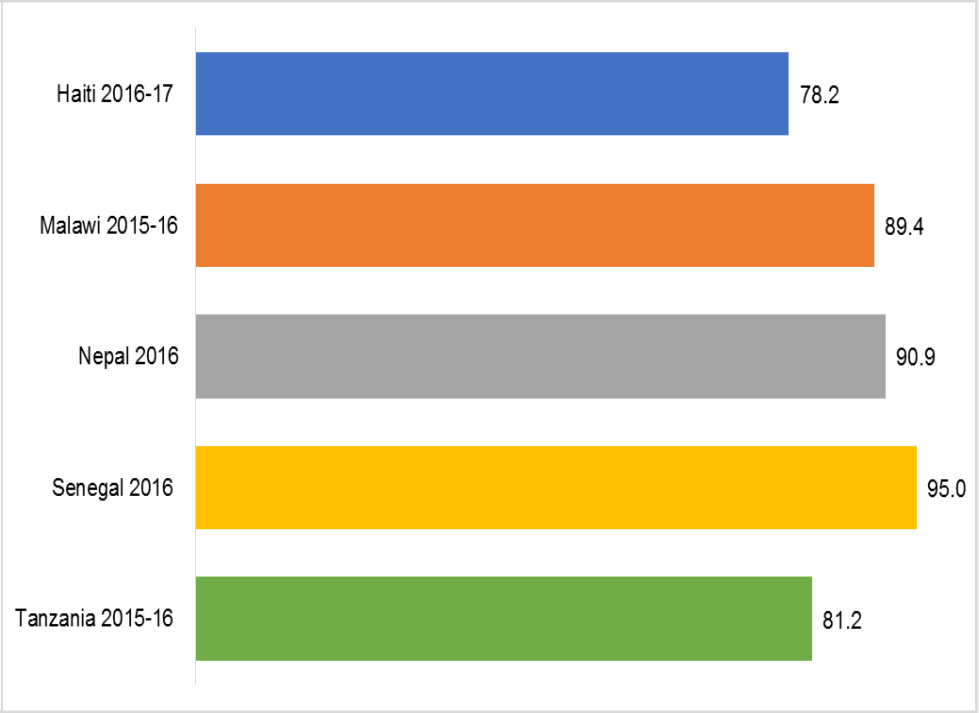


Service delivery IFA supplements (SPA data) and iron consumption (DHS data)

Percent of women provided or prescribed IFA supplements (SPA data)

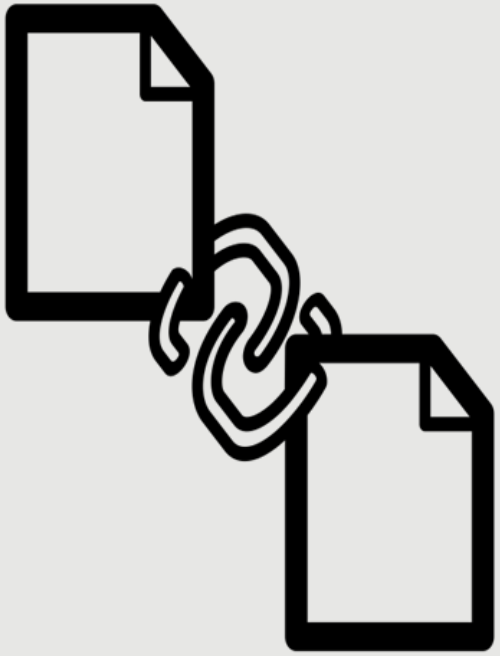


Percent of women with a birth in the past five years who took any iron tablets or syrup (DHS data)



Linking SPA and DHS surveys

- Linking is not 1:1
  - Household sample versus facility sample
  - Geographical linking
    - household survey data in a region are linked to facility data aggregated to the same region level
- Can link SPA and DHS data to assess relationships between service provision and utilization, behavior, or coverage BUT there are important considerations when linking



Icon created by H Alberto Gongora from Noun Project

Considerations when linking SPA to DHS surveys

1. Census SPA versus sample SPA
2. SPA/DHS survey dates
3. Indicator reference period
4. DHS cluster displacement
5. Health system

Summary

- 40 nutrition-related indicators in SPA surveys.
- SPA surveys can be used to describe information on nutrition intervention readiness and related service delivery.
- Can link SPA to DHS surveys to examine relationships between the service environment and nutrition outcomes.
- There several important considerations when linking SPA and DHS data

2013 Diana Mrazikova Network, Courtesy of Photoshare

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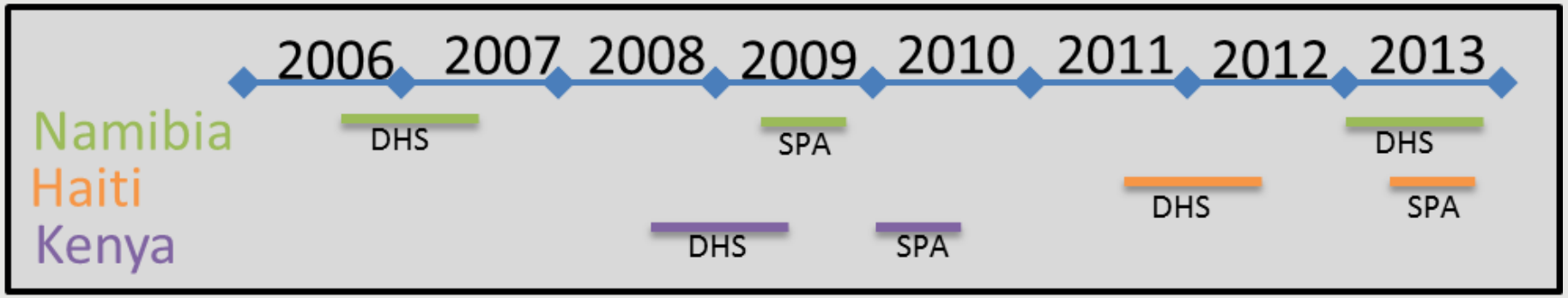
Linking Considerations

- **SPA/DHS survey date**
  - Are the dates of the DHS and SPA surveys close enough in time to make a valid assumption that the services/commodities/quality at a facility was the same as when the DHS data was collected?



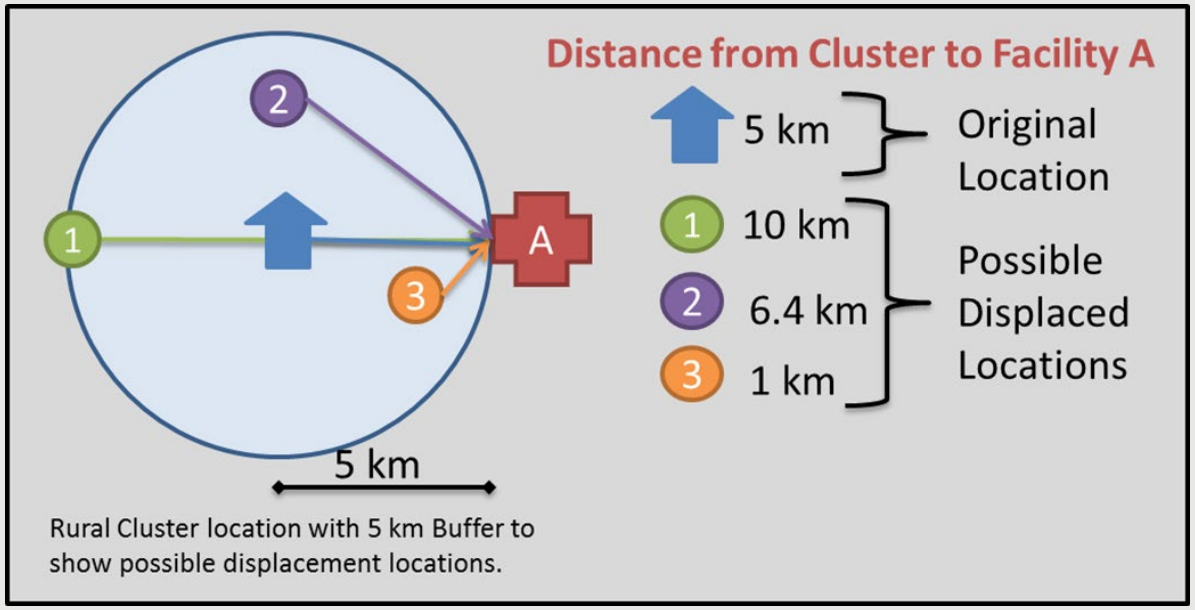
Linking considerations continued

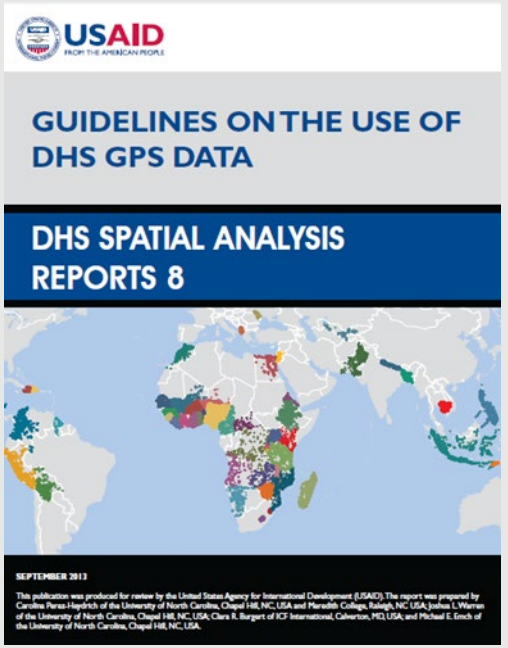
- **Indicator reference period**
  - Is the indicator reference period of the DHS indicator close enough in time to the SPA survey to likely be relevant?
    - ANC visit from 1 year ago versus 3 years ago

Linking considerations continued

DHS cluster displacement

- Can the question of interest be framed to consider the larger, "service environment" instead of the "closest facility" to a cluster or the exact distance to the closest facility?





Linking considerations continued

- **Health system**
  - Is the service or commodity being analyzed only available from facility based providers? (not available from community health workers or pharmacists)

Q&A for Plenary 6: Overview of Nutrition Content in Facility Surveys

Q: How do you calculate iron coverage in the SPA survey? Is it from the five women that are sampled per facility?

A: The data presented here came from the facility inventory, not based on the observation. So this is just whether or not facilities have IFA, but in terms of the other data that I juxtaposed with the DHS, that is whether during that observation, the provider was observed either prescribing the IFA or providing it.

Q: You mentioned immunization, antenatal care and sick child visits. Is there any possibility of expanding these categories to better incorporate some other nutrition indicators? Or are we limited to those three types of visits?

A: Not specifically addressed.

Q: With regard to the collection of observational data, can you talk about how you try to address the Hawthorne affect? In my experience, it takes 2-3 days for that effect to start tapering off. If you are doing an impact evaluation, it doesn't matter as much as long as the Hawthorne Effect is similar across areas, but if you are trying to do descriptive analysis of the content of care being observed, then it would be helpful to know how significant a Hawthorne Effect to expect.

Q: More remote facilities often only provide ANC services on certain days of the week. Do you get the lists ahead of time? Do you ever have issues where you get to the facility and ANC is not being provided? What do you do then?

A: When the data is collected from health facilities, this all happens in just one day, maybe two days. So it's a very rapid assessment. We get the list of providers and facilities ahead of time. In terms of the Hawthorne Effect, this is happening very quickly. This is one caveat to understand.

Q: In Nigeria, we have both Service Delivery Indicators (SDI) and SARA combined into our National Health Facility Survey. We looked at availability and readiness of service provision; quality and safety; and management and finance. The management and finance section allowed us to examine states that are not doing well, with frequency of strike actions. This also relates directly to user fees charged by health facilities. This brought a wealth of information to us. The data also really helped the level of human resource quality at the district and state levels. We can see where staff are not properly trained, or where resources are not properly distributed. WHO hasn't been involved in surveys in Nigeria. Why is that?

UNFP also conducts facility surveys in my country. They are assessing family planning, however, it is skewed to favoring facilities where they are actually providing services. So it results in a clouded impression demonstrating that family planning services in Nigeria are excellent when they aren't necessarily so. I would like to see *all* of the actors collaborating on health facility surveys in Nigeria, beyond just SDI and SARA.

Q: In Nigeria, with a population of over 200 million people, we did a survey that included 10% of health facilities, including private ones. The state decided to do a census survey, while the national facility survey did sample survey. Can you explain the advantages and disadvantages of the census survey versus sample survey?

A: This question is about resources as well as about the size of your country. Either way both kinds of surveys are nationally representative. In terms of how the sample is selected, depending on what the country's needs are, you could decide to sample just public facilities, but in most countries we end up sampling both public and private ones in order to have a better representation of formal health facilities both at the regional and national levels.

Q: I was surprised that the 'delivery services' are not part of the SPA. I understand that there are issues around observation, but client exit interviews can be very powerful and in the BFHI manual, client interviews are the major part of the assessment. This has changed to a smaller set of indicators in the revised version, but still we're emphasizing the importance of client exit interviews. There is a wealth of information about importance of exit interviews and the lack of correlation between the interviews with providers and interviews with clients, even to the extent that in one country they have eliminated the provider interviews altogether because they know that the *client* interviews is where the real information is.

A: Delivery services are included in the SPA. There is information on that, but the exit interviews only happen after the observation. Unfortunately, it's really hard to standardize these exit interviews, and to think about what that would look like for delivery services is a big question. This meeting is a great forum to raise that topic. Perhaps it's a suggestion for what SPA could look like in the future, but this is a limitation that we have in terms of what information we collect.

A: In the harmonized approach, we are acknowledging that exit interviews and provider interviews are part of the quality and safety of care assessments. The issue we struggle with is that we managed to find just one generalized form of client interviews that we could actually promote in countries. The problem with client interviews is that they are very technically intensive; you need a specialist by service area to be asking the questions. We thought we could first rely on the traditional areas like family planning, immunization, ANC, but we are still in process for standardizing them and put them forward for implementation.

You are right. We are trying to help countries bring it all together in one place so that they can avoid what happened with UNFPA. Collecting data at the facility level is a huge investment of time and resources, but it remains so specific to one area, and not others, that there is some waste and non-representation. That's why the modules have both a core approach and extended approach. We usually have a stakeholder's kick-off meeting and everyone has to come and decide which service areas we are going to focus on. It remains a national survey, but UNFPA might request some extra questions to be asked on commodities or utilization. So they put the money on the table, the country agrees, and says they also want to include some questions on malaria, or TB, for example. This way the resources are pooled and the questions are consolidated, and it avoids fragmentation of facility surveys.

We are not doing this to disqualify a SPA from happening. What we are trying to do is harmonize the indicators so that when a SPA is done, the country registers the results of SPA, then when the next survey is to happen, there has to be a point at which we reflect on the last point of measurement, the last indicator collection. This minimizes the possibility that we are measuring indicators that are not a close match to each other, and prevents what happened in Nigeria, and now in Kenya. We ensure that the surveys are 'aligned'. You are right; we need to be harmonizing and formalize the major surveys. We are now updating them, so hopefully this will happen. This (today) is a timely meeting. If the nutritional aspects have to be updated, then it's a double gain. It gets updated in the SPA, and as part of the ongoing harmonization as well.

A: It's actually very difficult to align the many surveys and indicators. The Health Data Collaborative is an initiative that includes many partners, and the idea is that we will all come together in a country-led

process, and look at harmonizing surveys at the country level. I was part of the recent teleconference for Kenya, and the country team is saying that in these areas, they have a harmonized set of questions that have been tested. It's an ongoing process.

Q: On the four indicators mentioned under IYCF, I noted the exit interviews in the ANC piece, which I think is useful, but then on the provider side, all of the indicators are related to 'training'. Training can mean anything, so I'm wondering just how useful that is? Is there any space to change this to competency-based questions or something like that?

A: Not addressed.

Q: One of the things that is frequently asked in facility surveys is about the availability of height stadiometers and other related tools. We've had a session on the tremendous efforts needed to ensure the data quality on height measurements in surveys. We know that in clinical practice, you are amplifying all of those errors. I have a philosophical question. I don't ever recommend that someone should measure and track heights on a monthly basis (or anything else) in these programmatic settings since we know how much error there is. I'm troubled by this. Do we as a nutrition community want heights to be measured in clinical practice? Does measuring heights actually amplify the errors and undermine the quality efforts that these teams are making?

A: They do assess whether there are stadiometers in the facility. But in terms of growth monitoring services, at least for sick children, weight is the only thing that is assessed, (not height), in the SPA surveys.

Q: What is the justification for a *sick* child observation, as opposed to a well child in SPA? And is there any scope for a well child being included.

A: any routine monitoring visits are less likely to be affected by issues of availability, the correct care, etc., because ANC is only provided certain days of the week, immunization is the same. So unfortunately, the aspects of the regular routine care is not as critical as treatment, i.e. when the child arrives fevered, with diarrhea, etc. The people who told us how to measure this say they want to know what happens around the disease episode.

Day 2 Working Groups

Introduction to WG Sessions 3 & 4

Aims of WG Sessions 3

- **GOAL:** To formulate recommendations to improve the nutrition content of health facility assessments
- **AIMS**

1. To identify information gaps in nutrition service availability & quality that are amenable to facility surveys
2. For priority gaps, to identify whether they can be addressed in the Service Provision Assessment (SPA)

IYCF practice, Diet Quality, Food Security group will continue Day 1 content

Service Provision Assessment: Four data collection questionnaires

Facility inventory/audit

Service availability e.g. antenatal care, family planning, sick child
General service readiness
Service-specific readiness

Provider interview

Provider qualification, in-service training
Supervision
Perception of the work environment

Client observation

Checklists cover basic elements of service delivery

- ANC
- Family Planning
- Sick Child

Client exit interview

Client understanding and satisfaction

- ANC
- Family Planning
- Sick Child

Icons created by Rauan, Wilson Joseph, Alax Kwa, and TukTuk Design from Noun Project

Key discussion topics

A. Identifying gaps in coverage data that are appropriate to measure in facility surveys

B. Proposed modifications to SPA core questionnaire modules

A. Identifying gaps in availability or quality data that are appropriate to measure in facility surveys

For interventions or practices assigned to your working group:

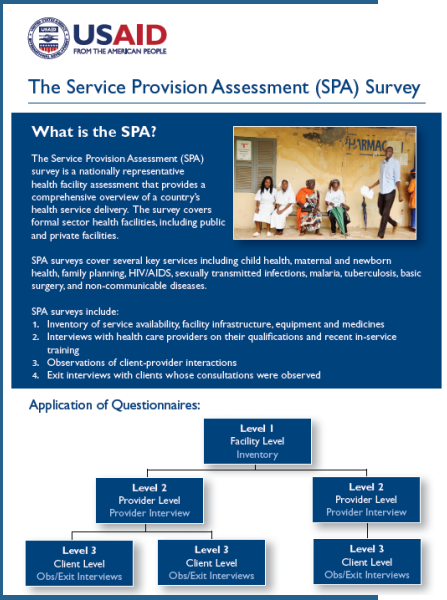
- What content is needed from facility surveys?
- What content relevant to these interventions is currently available in the SPA?
    - e.g. staffing, training, supplies, equipment, supervision, client satisfaction etc
- What content is appropriate to add to the SPA?

B. Proposed modifications to SPA questionnaires

- **Key discussion points to document**
- rationale for the addition or change *including how the data will be used*
  - which intervention(s) it relates to
  - module: facility assessment, provider interview, client observation, client exit interview
  - recommended wording (to extent possible)
  - examples of use or supporting research
  - Prioritization: Please classify each proposed change as Tier I, Tier II, or Tier III.

Resource Materials

- *Dropbox → WG Resources →Question Library→ Facility Surveys*
  - *Questionnaires for SPA, SARA, PMA2020, etc*
  - *Facility survey calendar from HDC*



Nutrition indicators for antenatal care services

Indicator	Description[1]	Questionnaire
IFA supplementation		
Iron/ folic acid/ IFA pills for women available	Iron, folic acid, and IFA pills are available and valid (not expired) in any service area of the facility such as the general area or ANC service area. Not all country SPAs include a filter on whether the pills are valid.	Facility inventory[2]
IFA pills provided/prescribed to client	Observed the provider prescribe or give the client iron pills, folic acid, or IFA during the visit.	ANC observation
Counseling on the purpose of IFA /how to take the pills/ side effects of the pills	Observed the provider explain the purpose, how to take the pills, and any side effects of iron or folic acid pills among women who were provided or prescribed iron, folic acid, or IFA pills.[3]	
IFA pills provided/prescribed	Client report that she was provided/prescribed iron, folic acid, or IFA pills on this visit, past visits, or both visits.	ANC client exit interview
Counseling provided on how to take iron pills/side effects of the pills	Client report that provider explained how to take the iron pills and the side effects of iron pills on this visit, previous visits or both .[4]	
Client's knowledge of iron pills side effects	Client identified at least one side effect of iron, folic acid, or IFA pills: nausea, black stools, or constipation.[4]	

Aims of WG Session 4

- **GOAL:** To review prioritization of household survey recommendations & specify R&D needs

- **AIMS**

1. Revisit prioritization of proposed changes for both HH surveys to confirm their relative importance
    - *Make a list of all new questions proposed to DHS core (for Plenary 8)*
2. For “Tier III” priorities, specify what sort of research & redevelopment is needed and at what scale

A. Revisiting recommended changes & relative priority

2 Questions: 1) where does it belong (core, module, other) 2) Should it be done now

Topic	Proposed Change	1. Where does it belong?			2. Should it be done now?
		DHS /MICS core	DHS Module	Other PBHS	Tier / Priority

Two ways to priroitize

1. **Where does it belong?**
   - **Household: A) DHS/MICS core B) DHS module C) other PBHS**
2. **Should it be done now?**

- **Tier I:** it is feasible now & it should be prioritized
- **Tier II:** it is feasible now but it is not essential or no consensus
- Tier III: requires additional R&D

Input for Plenary 8

- Group should submit list of 3 highest priority **additions** to **DHS CORE**
- Be realistic about what you define as “new”
  - NOT small edits of current questions
  - BUT if adding a response creates training burden, etc
- We will ask you to email to Shauna <Shauna.Hargrove@gatesfoundation.org>

B. Specifying Research & Development Agenda

For each Tier III recommendation, please discuss and document:

- R&D questions / problems that need to be addressed
  - recommended methods
    - (e.g. secondary analysis of existing data, types of new data collection)
  - scale of R&D required (e.g. single small pilot; testing across multiple cultural contexts, etc)
  - opportunities to carry out
    - groups working in related areas
    - upcoming surveys or other contexts where to test

WG Room Assignments

WG	Color	Room
MICYN Counseling and Support Interventions	BLUE	Connected - dining room
Micronutrient Interventions	RED	Across Hall
Child Growth: Screening, Promotion, Treatment Interventions	YELLOW	Plenary room – Left side
IYCF practice, Diet Quality, Food Security	GREEN	Plenary room – Right Side

Day 2
GROWTH INTERVENTIONS

Working Group Session 3&4 Report Out

3A. Summary: Data gaps that are amenable to facility-based surveys

- Growth monitoring during pregnancy and childhood are already covered
  - Defer to the MICYN counseling group about ”Promotion”
- Gap is around “Acute Malnutrition”

3B. Proposed modifications to SPA core questionnaires

- Currently “malnutrition” assessment & treatment is too general

SECTION 12: CHILD CURATIVE CARE SERVICES

1200	**CHECK Q102.03** CURATIVE CARE SERVICES AVAILABLE ☐		NO CURATIVE CARE SERVICES ☐ NEXT SECTION OR SERVICE SITE	
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE CURATIVE CARE SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT CURATIVE CARE SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.			
1201	Please tell me the number of days per month that consultations or curative care for children under 5 are offered in this facility, and the number of days per month as outreach, if any. USE A 4-WEEK MONTH TO CALCULATE # OF DAYS	(a) # OF DAYS PER MONTH SERVICE IS PROVIDED AT FACILITY	(b) # OF DAYS PER MONTH SERVICE IS PROVIDED THROUGH OUTREACH (VILLAGE LEVEL) ACTIVITIES	
01	Consultation or curative care services for sick children	# OF DAYS ☐☐	# OF DAYS 00=NO SERVICE ☐☐	

1202	Please tell me if providers of child health services in this facility provide the following services	YES	NO
01	DIAGNOSE AND/OR TREAT CHILD MALNUTRITION	1	2
02	PROVIDE VITAMIN A SUPPLEMENTATION TO CHILDREN	1	2
03	PROVIDE IRON SUPPLEMENTATION TO CHILDREN	1	2
04	PROVIDE ZINC SUPPLEMENTATION TO CHILDREN	1	2

Needs to specify “assess and treat or refer child acute malnutrition”

Addition to HW Interview

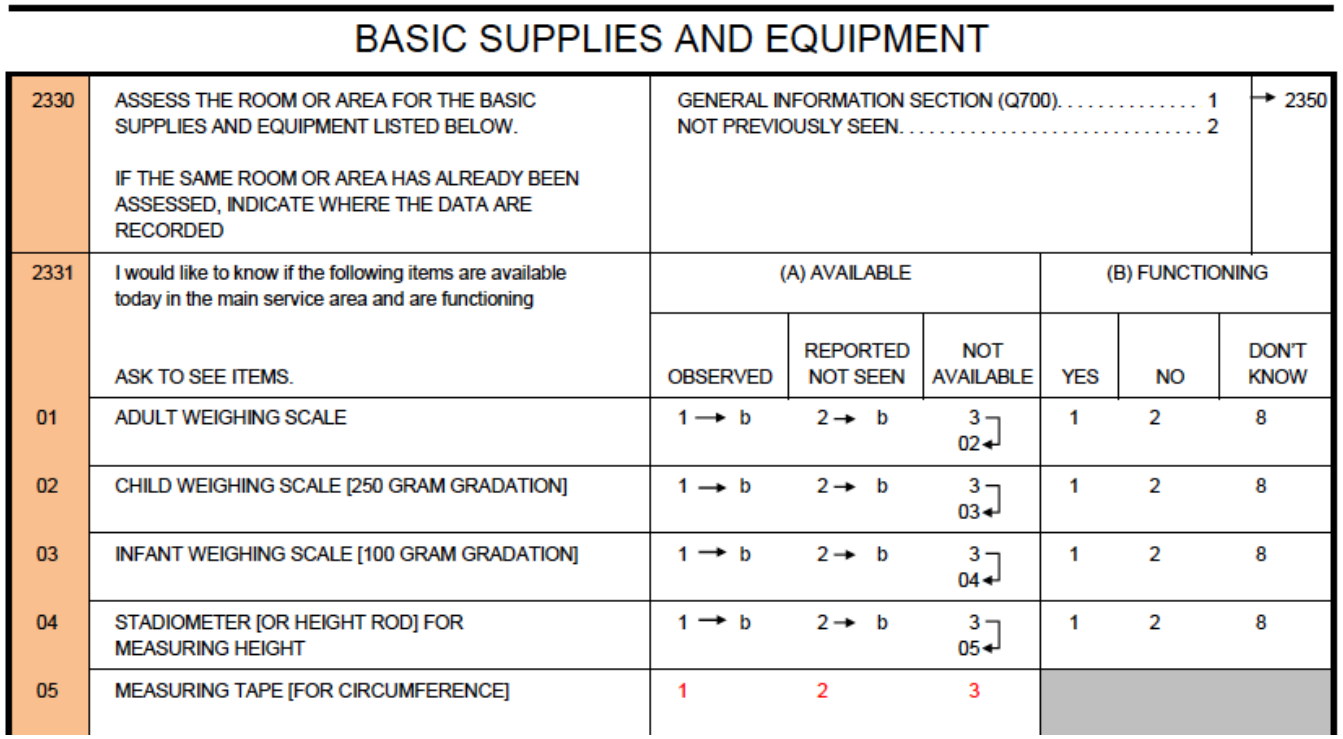
3. CHILD HEALTH SERVICES

300	In your **current** position, and as a part of your work for this facility, do you personally provide any **child vaccination** services?	YES. . . . . 1 NO. 2	
301	In your **current** position, and as a part of your work for this facility, do you personally provide any **child growth monitoring** services?	YES. . . . . 1 NO. 2	
302	In your **current** position, and as a part of your work for this facility, do you personally provide any **child curative care** services?	YES. . . . . 1 NO. 2	
303	Have you received any ***in-service training, training updates*** ***or refresher training*** on topics related to child health or childhood illnesses?	YES . . . . . 1 NO 2	→ 400

304	Have you received any ***in-service training or training updates*** in any of the following topics [READ TOPIC] IF YES: Was the training, training update or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	EPI OR COLD CHAIN MONITORING	1	2	3
02	INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES	1	2	3
03	DIAGNOSIS OF MALARIA IN CHILDREN	1	2	3
04	HOW TO PERFORM MALARIA RAPID DIAGNOSTIC TEST	1	2	3
05	CASE MANAGEMENT / TREATMENT OF MALARIA IN CHILDREN	1	2	3
06	DIAGNOSIS AND/OR TREATMENT OF ACUTE RESPIRATORY INFECTIONS	1	2	3
07	DIAGNOSIS AND/OR TREATMENT OF DIARRHEA	1	2	3
08	MICRONUTRIENT DEFICIENCIES AND/OR NUTRITIONAL ASSESSMENT	1	2	3
09	BREASTFEEDING	1	2	3
10	COMPLIMENTARY FEEDING IN INFANTS	1	2	3
11	PEDIATRIC HIV/AIDS	1	2	3
12	PEDIATRIC ART	1	2	3
13	OTHER TRAINING ON CHILD HEALTH (SPECIFY)_____	1	2	3

- Needs to specify training specific to country CMAM protocols & any related follow-ups

Addition to facility inventory



BASIC SUPPLIES AND EQUIPMENT

2330	ASSESS THE ROOM OR AREA FOR THE BASIC SUPPLIES AND EQUIPMENT LISTED BELOW. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION SECTION (Q700). . . . . 1 NOT PREVIOUSLY SEEN. 2					→ 2350
2331	I would like to know if the following items are available today in the main service area and are functioning ASK TO SEE ITEMS.	(A) AVAILABLE			(B) FUNCTIONING		
		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	ADULT WEIGHING SCALE	1 → b	2 → b	3 → 02	1	2	8
02	CHILD WEIGHING SCALE [250 GRAM GRADATION]	1 → b	2 → b	3 → 03	1	2	8
03	INFANT WEIGHING SCALE [100 GRAM GRADATION]	1 → b	2 → b	3 → 04	1	2	8
04	STADIOMETER [OR HEIGHT ROD] FOR MEASURING HEIGHT	1 → b	2 → b	3 → 05	1	2	8
05	MEASURING TAPE [FOR CIRCUMFERENCE]	1	2	3			

- For Acute Malnutrition Treatment
  - Review whether supplies (RUTF/RUSF), guidance, & job aids are available

4A. Household Survey Prioritization

Topic	Proposed Change	1. Where does it belong?			2. Should it be done now?
		DHS / MICS core	DHS Module	Other PBHS	Tier I, II, III
Pregnancy weight gain	Add: cascade of three new questions on whether pregnant woman weighed, more than once, discussion about weight (could be in ANC-current pregnancy or recall to last pregnancy)	X		X	I
Assistance during pregnancy	Add: received food or cash assistance during pregnancy, type of assistance, type of food, how long (make type of food context-specific		X	X	II

4A. Household Survey Prioritization

Topic	Proposed Change	1. Where does it belong?			2. Should it be done now?
		DHS / MICS core	DHS Module	Other PBHS	Tier I, II, III
Growth monitoring	Add: child had weight, height, or MUAC measured (make recall period context-specific, can be removed for countries in which screening for acute malnutrition not applicable)	X		X	I
Food assistance for child	Replace: received food or special food supplement from program during recall period to be determine, type of food, (make type of food context-specific) Remove: DHS CORE FQ525A		X	X	II

4B. Specifying Research Agenda (Tier III)

- Cash transfers – look across multiple MICS country contexts to see how current questions are used
- Need population-based coverage indicators along the CMAM cascade

Day 2
[IYCF, DIET QUALITY, FOOD SECURITY]

Working Group Session 3&4 Report Out

Major Gaps

- Children <2 yo's: Unhealthy food consumption
- WRA: No information on consumption
- Food insecurity: Limited data available (this is SDG indicator)

4A. Household Survey Prioritization

Topic	Proposed Change	1. Where does it belong?			2. Should it be done now?
		DHS / MICS core	DHS Module	Other PBHS	Tier I, II, III
Children <2	Sub-divide child food list to capture unhealthy foods (differentiate by source) • No F&V • SSBs • Junk food	X			I
WRA	New question on MDD-W (includes unhealthy foods)	X			I
Food insecurity	New question on Food Insecurity Experience Scale (8 items)	X			I

4A. Household Survey Prioritization

Topic	Proposed Change	1. Where does it belong?			2. Should it be done now?
		DHS / MICS core	DHS Module	Other PBHS	Tier I, II, III
Children <2	Delete bottle-feeding for children other than the youngest (DHS)	X			I
Children <2	Delete count of solid/semi-solid foods for <6 mos (DHS)	X			I
Children <2	Delete probing on medicines/vitamins (MICS)	X			I

4A. Household Survey Prioritization

Topic	Proposed Action	1. Where does it belong?			2. Should it be done now?
		DHS / MICS core	DHS Module/ Expanded MICS	Other PBHS	Tier I, II, III
Children 2-<5 y	Consider application of dietary assessment question to all children < 5 a. MDD/healthy diet b. Unhealthy diet		X		III
Quantitative dietary assessment	Explore opportunities for piggybacking nutrition survey onto other platforms			X	II

4B. Specifying Research Agenda (Tier III)

- Explore ways to gain time efficiency (analyze CAPI information on where time is spent
- Test FIES with using first 3 questions as a screener for other questions
  - Need software for in-country analysis of FIES
- Test if probing on solid/semi-solid foods could be shortened for infants < 6mos.
- Develop indicators on diet among adolescents

4B. Specifying Research Agenda (Tier III)

Ongoing research:

- Gallup study on indicators of diet quality in 15yrs +
- INTAKE study on indicators of diet quality of NPNL women

Topic	Proposed Change	1. Where does it belong?			2. Should it be done now?	Notes
		DHS /MICS core	DHS Module	Other PBHS	Tier / Priority	
FORTIFICATION						
All fortification vehicles	Add question to permit separation of fortifiable food	yes			I	model exists in PM2020. Promote also for LSMS
All fortification vehicles	Develop detailed module of coverage and utilizization		X	X	III	
Salt iodization	Developing a new spot test that provides a yes/no result	[eventually]			III	
Salt iodization	Explore potential for sample shipping of YES samples (for quantitative testing)	[possible]	[If not possible in core]		II	
Salt iodization	Where did you get the salt? (for those who did not get salt)	X				
CHILD MICRONUTRIENTS						
	Reword recall question about iron-containing supplements to be last 6 months (consume or get needs to be resolved)	X				
Iron containing supplements	When yes response: Add type of supplement; where received				III	Requires work to align with local program
SQ-LNS	Remove from core DHS		X	X		
Child nutrients	525a drop question	X			III	
PREGNANT WOMEN						
Calcium supplementation	Develop standardized indicators (similar to Iron)		X	X	III	
	Ask first about any iron containing supplement	X			I	
	Modify to report for pregnancy in past 2 (or 5 years - review)	X			I	
	Add question to ask where received purchased	X			I	
Iron supplements/ IFA/ MMN	Keep current question on quantity consumed	X			no change	Ensure appropriate interpretation
WOMEN OF REPRODUCTIVE AGE						
	Any FA supplement in past 6 months	X			I	May require feasibility assessment / adpatation in country
	Any Fe containing supplement in past 6 months	X			I	
Iron supplements/ IFA/ FA/ MMN	Add question to ask where received purchased	x				
All groups/ all programs	Comprehensive compendium of recommended coverage and utilization indicators (and associated questions)		X	X	III	

Q&A and Discussion for Working Group Day 2 Report Out

1. Child Growth WG
2. MYCIN WG
3. IYCF, Diet Quality and Food Security WG
4. Micronutrient WG

Child Growth WG

Q: Under growth monitoring, wouldn't you want the weight 'and' height (not 'or')? And we should note that there are age considerations?

A: Yes, we can adjust that. And yes, there are age considerations.

MYCIN WG

Q: In the IYCF counseling indicator that you added, what is the denominator for that indicator?

A: Children less than 24 months.

Q: When you talk to the men, is it to talk about his own child? Or any child in the HH?

A: We didn't get into that level of detail. This is an issue that will have to be investigated further. It's intended to investigate whether men are exposed to IYCF counseling or just the women.

IYCF, Diet Quality and Food Security

Q: I'm thinking about the purpose of the unhealthy diet questions and the ability to track this over time as countries go through transition. You might be able to increase the sensitivity of the indicator if you used a longer recall period, like number of times over seven days instead of yes/no in the past day.

A: I don't think we discussed that specifically. We did talk about it in relation to biofortified crops, but we decided that when this data is collected it's not meant to be representative at the individual level, since what we consume in one day is not very meaningful. In that respect, the 'yes/no in the past day' approach might work fine. The other issue is that we wanted to keep questions as consistent as possible, i.e. not changing the recall period and potentially confusing the respondent.

Q: What is your justification for deleting the questions you listed for children under 2 years of age?

A: The minimum meal frequency data is usually used for children 6-23 months. We were suggesting to not ask the questions for children of less than six months, since for them, we are interested in whether they are being exclusively breast feed.

Q: For the food security indicators, there is an option for 3 months, 6 months and a year. Which is preferred?

A: We did not discuss this, but my understanding is that they usually use a standard 12 month period. It is a good point for discussion if it's adopted.

Q: Across the use of all the food security scales, people use whatever recall period makes sense. I would love to have it in the MICS, but if our priority is global monitoring, and the Gallup World Poll gives us annual data on 150 or more countries, I can't see how that can be a priority. I think that if it's in the MICS, it would be because we think it's important to relate it to child development. What we know about that is suggests that if we had even a couple of the least severe items; that would probably be good enough. Regarding the analysis issue, it's not fully scale equivalent across contexts. Post data collection, FAO has done analysis to calibrate each country relative to each other. That only has to be done once. But I don't see how this could be a priority if global monitoring is what we're really about.

A: My only point for clarification is that food security is an SDG indicator, and the Gallup World Poll is currently collecting it. I'm not sure the extent to which that funding is going to continue. I don't know to what extent it's secured for the future.

Q: We had a long discussion about whether the unhealthy foods were home prepared, purchased from a vendor, or process packaged, etc. Did that land in Tier 2?

A: For the unhealthy foods, we wanted to know more than whether these foods were consumed. We also wanted to know the source as well, e.g. home prepared, etc. We assigned that to Tier 1.

Micronutrient WG

No questions

सत्यमेव जयते
Government of India

(स्थापना / Established in 1956)
बेहतर भविष्य के लिए क्षमता निर्माण
Capacity Building for a Better Future

Contents of NFHS -5
(2019-2020)

Dr. S.K. Singh

New Contents Areas added in NFHS-5

- Pre-school education
- New dimensions on Household environments
- Sharing of sleeping rooms with animals
- Disability (Eight major groups)
- Death registration

- Menstrual hygiene and bathing practices
- Methods and reasons for Abortion
- Incentives for use of PPIUD
- Couple of additional dimensions on new born care and breastfeeding counseling
- Expanding domain on Immunization by adding JE, Rota. Penta 'etc.
- Expanding components of micronutrients to children below age 5 years
- Use of mobile phone and internet for financial transitions
- Frequency of alcohol and tobacco use
- Sexual rights of woman

- Additional components in NCDs(HbA1C, Malaria parasite and Vit. D3)
- Expanded age range of diabetes, hypertension and also for risk factor

Number of Questions in Different Questionnaires in NFHS-4 and NFHS-5

NFHS-4(2015-16)	NFHS-5 (2019-20)
❖Household - 77	❖Household - 86
❖Man – 202	❖Man - 220
❖Woman – 468	❖Woman – 533
❖ Biomarker- 173	❖ Biomarker - 179

Q&A for Plenary 9: Response from Country, Survey Program & Development Partners Representatives

Q: Can we try to get more input from the countries to see if they agree with the priorities we've come up with?

Q: Can we continue to discuss the idea of linking, integrating and collaborating between surveys, while cognizant of the fact that we don't want to overburden the surveys themselves.

Q: We talked about how some of the priorities in this room are not necessarily the priorities of governments. Over time, when visiting countries, do the priorities of the countries change with changes in leadership? Or is it fairly consistent in the lack of harmony between what this community wants versus what countries want.

Q: When you go to a country for a design visit, it's important to realize that nutrition is just one piece of the bigger puzzle, even though for us it's the most important. If the country decides that it's a priority, then we will prioritize it. But it depends upon them. Another issue is that some of the other surveys have less training and less rigorous sampling methodologies. This makes it challenging for us because we don't cut corners. The conversation has to be about the quality of data that you get when you take that approach.

A: Just because a topic is not brought up during a survey steering committee meeting, does not necessarily mean that it's not important to a country. When we are designing a survey, we ask: What are the things that seem to come through from multiple countries? It's usually not something like 'counseling related to weight gain in pregnant women', but that doesn't mean that if it's brought to their attention they wouldn't find it important. And yes, global health priorities change over time, NCDs and desire for information from older respondents, these are all changes that have been taking place over the years.

A: In India, we are finalizing the contents of the current round. We are following DHS's pattern. But still, our country and different ministry departments are keeping on the forefront. For example, we started with maternal and child health. We know that there is a drastic reduction in child morbidity in the country, but about 50% of this is due to malnutrition. That is why we have changed the questionnaire title to child health and nutrition. We have kept these questionnaires intact, which is why we are slightly overburdened in terms of the number of questions.

Q: Thank you to USAID and ICF for the new DHS. In the last year of talking about budget cuts, some of us were petrified that DHS might go away. We are asking for more data, but the reality is that we are really grateful for what we have. Would it be possible to have more detail on the upcoming revision process to the DHS? Are there fixed time points or windows so that we as a community come together and do the prep work necessary to feed into that process.

A: The DHS was just awarded last week, so we are only just starting the process. We plan to open a panel and forum exactly like last time. This will take place within the next six months. We divide the suggestions by topic, since there are many sections of the questionnaire, then we look at the priorities. This is a fantastic forum for hearing the priorities for all different stakeholders in various settings. You can submit your suggestions directly to the DHS User Forum or directly to us. We will give this feedback to the committee.

There is an overarching committee and committees by subject. When something is added, there must be justification. And when we remove something, there must also be justification. It's a dynamic process.

For example MDGs don't exist anymore. And now we have the opportunity to look at SPA as well, and see what questions are appropriate there. This process will be similar to DHS 7, but more comprehensive since SPA will be involved too. We also know that additional modules are extremely useful because they are standardized. As soon as the Forum is open, we'll make sure it's transparent. We will likely have criteria for submitting changes. If you want to submit, you'll have to meet these criteria.

A: The contract is brand new so we haven't talked about the process yet. The intention is to have both the SPA revision and the DHS core questionnaire revision, and have both be as transparent as possible. The DHS User Forum is a great place to submit questions, and many times your question has already been answered there. For the last core questionnaire revision, people submitted their suggestions to the Forum five years ago, and they are still there, so you can go and see that list of suggestions. At USAID we hold ourselves to the same standard so we also submit our suggestions to the Forum. The recommendation process will likely start in early 2019, and you'll have lots of forewarning.

A: We also go back occasionally and use the submitted suggestions for other issues. For example, some of the recommended changes and questions didn't make it to the core questionnaire last round, but when we developed the most recent module on maternal health care, we went back to the Forum and used some of the questions that weren't used previously.

MIYCN Working Group Notes

Sessions 1 & 2

Working Group Chair: Purnima Menon
Note taker: Audrey Buckland

Working Group Sessions 1 (85 min) & 2 (60 min)

Recommendations to improve the nutrition content of population-based household survey questionnaires

Discussion topics

We generally recommend working through each section (A, B, C) for all interventions on your list before moving to the next – and including D Prioritization but WG chairs have freedom to modify:

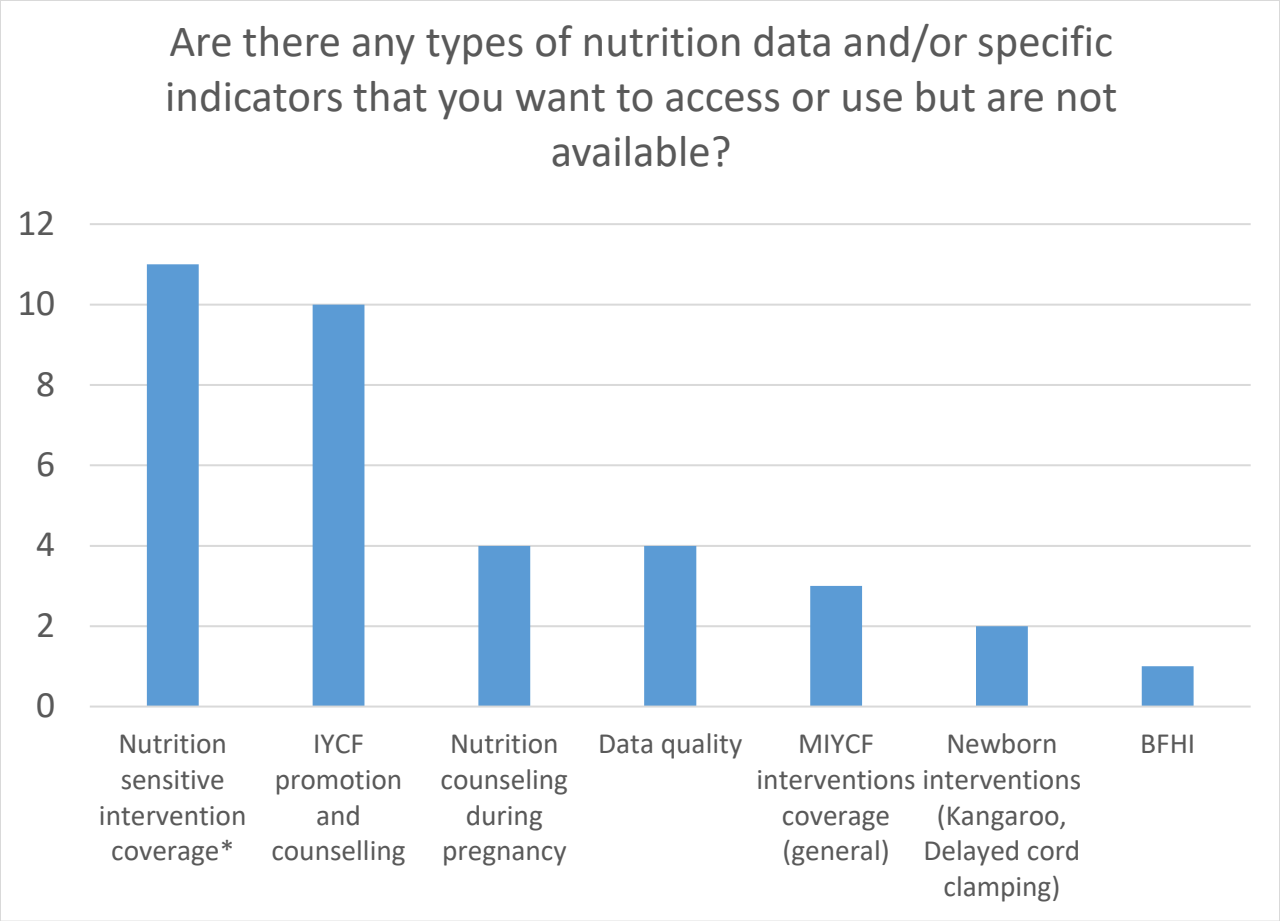
A. Identifying gaps in coverage data that are amenable to PBHS

1. For interventions or practices assigned to your working group[1]:
   - What coverage data are currently available in the major population-based survey platforms[2]?

Intervention	Population	DHS	MICS	PMA2020	NI	IFPRI	Other
MICYN counseling during pregnancy	Pregnant women			Yes		Yes	DHS Nepal
Support for early initiation of breastfeeding	At delivery			Yes			
Breastfeeding counseling during PNC	2 days post delivery	Yes	Yes	Yes		Yes	
Counseling/support for exclusive and continued breastfeeding (1m+ post partum)	Child<24m			Yes	Yes	Yes	DHS Nepal
Counseling for complementary feeding	Child<24m			Yes	Yes	Yes	DHS Nepal
Cross-cutting IYCF promotion via	Child<24m				Yes	Yes	DHS Nepal

FLW, community platform and/or mass media							
Other maternal support interventions (BFHI, maternity protection, etc.)	TBD			Yes			

- What coverage data have nutrition data users prioritized/" demanded"[2]?
  - We didn't really discuss this slide



- What are the priority coverage data gaps[3]?
  - Other BFHI interventions
    - In April WHO and UNICEF launched guidance for BFHI. It includes an appendix with facility based monitoring indicators like monitoring of breastfeeding promotion and support in facilities. Is that something we'd look at - Overall compliance to BFHI standards is an indicator?
    - http://www.who.int/nutrition/publications/infantfeeding/bfhi-implemetation-2018-appendix.pdf?ua=1
  - Maternal nutrition
  - Breastfeeding counseling
  - Complementary feeding counseling

2. For the priority coverage data gaps, which of these are best suited measurement by:

a. Modifications or additions to the DHS* or MICS (*Differentiate between: DHS Core[4] & DHS Modules[5])

- **Addition of IYCF counseling questions**

4xx	During the pregnancy, did a health care provider or community worker talk with you about breastfeeding?	YES NO DON'T KNOW	
5xx	During the first month after (NAME)'s birth (but after first two days), did a health care provider or community worker talk with you about breastfeeding?	YES NO DON'T KNOW	
6xx	In the last six months, did a health care provider or community worker talk with you about how to feed your child?	YES NO DON'T KNOW	No…(Skip to 6xx)
6xx	What topics did he or she talk to you about?	1) BREASTFEEDING 2) NOT GIVING WATER IN THE FIRST SIX MONTHS OF LIFE 3) FEEDING OTHER FOODS STARTING AT 6 MONTHS OF AGE 4) FEEDING A VARIETY OF FOODS 5) FEEDING ANIMAL SOURCE FOODS 6) HANDWASHING BEFORE FEEDING **TOPIC LIST CAN BE REDUCED OR EXPANDED**	

- **Modification of existing question**

457	During the first two days after (NAME)'s	YES NO	

	birth, did any health care provider do the following: a) Examine the cord? b) Measure temperature? c) Counsel you on danger signs for newborns? d) Counsel you on breastfeeding e) Observe breastfeeding? (d and e are new)	DON'T KNOW	

- **Maternal nutrition counseling**

b. Modifications or additions to type of national/large-scale population based household survey (PBHS)?
   - Almost all of the MIYCN counseling interventions are amenable to inclusion in PBHS

c. Other types of data collection – NOT household survey (e.g. administrative)
   - Some could be verified/examined in facility assessments too (content and ANC counseling)

3. For data gap intervention or practices amenable to a) DHS/MICS or b) other PBHS – prioritize order in which they will be addressed by your group (consider dividing into sub-groups to facilitate review).

   Chair – Some of these issues you're raising, we'll discuss tomorrow. Today we're focusing on information we should get from interviewing mothers, if it's information to get at facilities, we'll discuss tomorrow.
   - Comments from group - You can ask at about these BFHI standards at a facility or at the hh to get percentages.
   - We are moving away from hospital certification, wanting to support practices.
   - Chair – So for "Other BFHI interventions," we want to specific components and put forward for considerations questions we could potentially look at that in hh survey

- Question – Are all the interventions listed interventions that a government implemented, or that someone (programs) is looking at?

    - Chair – A lot of the work that we're involved in is in programs. If there's something missing that leaps out, we should use that in our prioritization. Scan the list from that perspective.
- We should discuss IYCF "promotion" vs "counseling"
    - Chair – The issue of language around counseling/support comes up in several interventions on the list. For MICYN we can think about dietary counselling, use of supplements, use of services
    - MICYN counseling – refers to dietary practices, supplements, use of services
- Suggestion to add population – adolescents
- Chair – Summary of the Monday meeting looking at IYCF counseling coverage measurement (7 of us were there):
    - We looked at how IYCF counseling has been captured in the DHS and MICS and how it's measured by researchers
    - There were three working groups:
        - One group looked at DHS/MICS questionnaires and made suggestions for where questions could be asked to provide data
        - One group looked at extended guidance for IYCF counselling
        - One group discussed research needs for IYCF counseling
    - Where we landed – Breastfeeding and complementary feeding counseling core questions:
        - Suggestion for the addition of 3 questions:
        - 1 - Breastfeeding counseling during pregnancy
            - The DHS currently has a question about what a healthcare provider did during an ANC visit, so the group suggested including whether provider counseled the pregnant woman on breastfeeding.
            - The denominator is mothers of children under 2 yrs of age or mother with child born less than 2 yrs ago
            - So the question could be: Did a health worker/CHW talk with you about breastfeeding during ANC?
        - There is already a question at PNC (within the first 2 days after birth)
        - 2 – In the first month after the child's birth, did a health worker/CHW talk with you about breastfeeding (so that covers the 1-month post-partum period)
        - 3) In last 6 months did a healthcare provider/CHW talk with you about how to feed your child?
            - Include the follow-up question – What did they talk with you about? Include breastfeeding and complementary feeding as response options.

        - These new questions went out to the working group on Monday after the meeting for their feedback/confirmation
            - The group was pretty evenly split on whether to include the 1-month post-partum question.
            - For the third suggested question, the group preferred asking did they talk with you about feeding your child, then ask what they talked with you about and include breastfeeding and complementary feeding as response options. (Rather than asking straight out: Did someone talk with you about breastfeeding? Did someone talk with you about complementary feeding?)
        - The Monday meeting participants didn't discuss maternal nutrition counseling during ANC, interventions related to BFHI, or cross-cutting mass media or promotion.
        - So, for those who weren't there on Monday, do we want to go through breastfeeding counselling again or can we move onto the new intervention topics?
        - Let's get reactions from those who weren't in the Monday meeting on the above
    - Reactions:
        - Was there an attempt to define counseling vs promotion?
            - We would benefit from a working definition of counseling vs promotion vs just giving a message
            - Talking about quality of counselling and the effect
            - On Monday, we landed on the phrase "did somebody talk with you about" – This gets the basic reach, but then you need extended work much beyond that phrase to get at the quality
            - Did someone "talk to you" vs "with you" – "With you" gets at more of a discussion between the provider and mother, although it doesn't full capture what counseling is. However, we have to make some tradeoffs for these platforms [large population based surveys], rather than getting the detail of a quality interaction.
        - We usually ask questions about the time period of "in the last 5 years," but we're typically interested mostly in 24 months. Is the first set of indicators is asking about anytime in the last 5 yrs? Comprehending quality of counseling with a long recall is risky. Should we restrict the time frame?

        - We are suggesting that IYCF counseling is only asked to mother of child under 2, and we ask about the last 6 months which line up with Vitamin A and deworming questions timeframe
        - The ANC module of the core DHS questionnaire collects data on women with a birth in the last 5 years, which is different than what we're talking about. We could add a filter question.
        - The ANC question would say during the last pregnancy that occurred within the last 5 years.
        - From the DHS perspective, it's better to collect more data than less, so we probably wouldn't recommend a filter.
    - The Chair will provide a summary printout of the Monday meeting to this working group
        - For breastfeeding and complementary feeding counseling questions, we will use the summary of the Monday consultation, and focus our efforts on maternal nutrition counselling and BFHI interventions
        - Who was in the Monday consultation? It included people from several organizations, DHS, USAID, about 30 people in total
- Will prioritize maternal nutrition and BFHI for discussion now

A. Proposed modifications to DHS*/MICS questionnaires (*Core or Modules)

4. For each new question or recommended edit/change to an existing question, please discuss and document

   See tables for this level of detail. My notes below contain the flow of the discussion for each intervention.

5.

a) the rationale for the addition or change
b) which population it relates to
c) who will answer the question(s)
d) recommended wording of question (to extent possible)
e) provide examples of surveys or studies that have used the recommended question, collected similar data or otherwise support the proposed addition or change[6]
f) recommend how data for any new questions could be summarized/tabulated/presented to facilitate use of in reports (e.g. as means vs. cut-off, by which indicators? by which subgroups/levels?)
g) *Prioritization:* Please classify each proposed change as Tier I, Tier II, or Tier III.
    - Tier I: it is feasible to implement this change in the next ~12 months & it should be prioritized
    - Tier II: it is feasible to implement this change in the next ~12 months but it is not essential / not everyone agrees

- Tier III: implementing this change in the next 2-5 years will require additional research

Maternal Nutrition

- When we say nutrition counseling during pregnancy, the breastfeeding counseling is taken care of by the inclusion of question in ANC module.
    - Content areas we might want an indicator around for maternal nutrition?
    - We tried to include this in the PMA2020 BF and K surveys.
        - We pretested to find what messages women were getting in countries, some adapted to local context. ("Eating lots of leaves")
        - What counts as counseling on maternal nutrition?
        - Need specificity on messages and types of practices we're interested in is important here.
        - What does WHO say on the content of maternal nutrition counseling?
        - Counseling during pregnancy – healthy eating and physical activity, increasing daily energy and protein intake, balanced energy protein supplementation (covered in the diet intervention list), calcium, Vit A, deworming
        - Counseling about healthy eating and physical activity, counseling about increasing daily energy and protein intake
    - What do we specifically focus on?
        - A&T includes timing of IFA and calcium, physical activity, weight monitoring and management
        - But we should focus on what's in a guideline or on what indicators already exist
        - Diet counseling recommendations included for A&T – Diet diversity (MDDW in other parts of survey) to address healthy eating, consume more food/extra meal to increase energy, rest.
    - Data availability, we don't have an indicator
        - For nutrition counseling during pregnancy – diet and physical activity, but not counseling relating to other interventions.
        - Programmatically there are other messages, but for counseling we focus on **diets** and **physical activity**. (2 content areas)
        - No global indicators for these recommended interventions but we have policy guidance from the WHO. There is some work to be done on a clear indicator definition
    - Question – Why do we not look at IFA counselling?
        - IFA supplementation use is widely available, we don't have counseling, but we're getting data on practice.

        - Counseling is included in health facility surveys – how to take the pills, purpose, side effects. In the DHS program but in the facility survey.
        - A question about nutrition counseling – Then include response options of what the counseling included. Eating more, having supplements, physical activity. We could include response options.
        - We have an indicator on IFA, but not on counseling.
        - If we just measure the use, we won't necessarily know why they use or don't use.
    - Data availability table – Maternal counseling during pregnancy there isn't anything in DHS or MICS, but there is a very robust ANC module.
        - Looking at DHS questionnaire ANC
        - Maybe the content we're discussing – Did you receive nutrition counseling during pregnancy, then ask about the topics.
        - The wording on that question is important. Some women will respond, but if you want specifics of IFA you may need to go more in depth. Most women think about diet when asked about nutrition counseling.
        - So there is a significant data gap in this area, looking at DHS questionnaire as a starting point.
        - In countries with health facility assessments, we'll know if services are provided as to whether getting counseling on these elements.
        - The encouragement to consume IFA is observed, but the side effects isn't really provided. So consuming IFA is a core message provided, but not really side effects.
        - If women really understood why they should take iron supplements, they would.
        - But side effects issue and acceptability of pill size. Is it a supply issue or information issue?
        - How important (prioritization) is it to know if nutrition counseling is provided during pregnancy and the content? Clearly a gap, countries are getting info on ANC, but…
        - It's important, if you see things aren't going well programmatically you want to know why. You want an evidence based intervention, so if you know what they're counselled on you have a starting point. Very relevant information for programs.
        - Counselling should address IFA concerns, diet and physical activity.
        - Consensus that it's important to know.
        - What is already collected that can be further analyzed, ANC nutrition counseling, but in nutrition we aren't connecting it analytically. What data gaps exist to further analyze the data to answer questions.
        - Linking SPA and DHS? If you can collect at the provider level, connect.

        - Question in Nepal – Generic question about nutrition counseling and a follow-up question about content. Categories could be adapted to include calcium if relevant.
    - Would we prompt women or go with a free response?
        - If the stem question is, “Did you receive nutrition counseling,” they may not think of managing IFA side effects as nutrition counseling, so you need to prompt them.
        - If it’s open ended, the enumerator must be well trained to code the responses properly.
        - Within the IFA and calcium questions that country wants – Specific question vs general question. General diet related advice then look for key messages. When respondent hears nutrition, they usually think of food so you might as well say did you get advice on food to eat or how much to exercise. Then ask the supplement group if they’re thinking about counseling.
        - Is physical activity under nutrition counseling?
            - **Counseling about diet, consumption about micronutrients, physical activity (or rest??).**
            - **If we prioritize –** We need coverage of dietary advice, physical activity, supplements. So what’s the recommendation – ask about all of the supplements from the micronutrients group??
            - Dietary advice, physical activity advice, supplement advice – which do we want to capture.
            - Counseling on weight gain? And BP management? Weight gain is on the front page.
            - During last pregnancy when you went for ANC, we ask if things were performed (not counseling).
            - Current question in DHS about content ANC – Were any of the following done at least once? BP, urine, sample, tetanus, IFA, deworming,
            - Add a question into this area ask did they talk with you about breastfeeding? Same approach we could slip in diet, physical activity, micronutrients?
            - We’re moving to client’s experience, so were they satisfied with the support they were given? From the facility side are they delivering what they should. She may not know what blood pressure is.
            - Want to know if she was satisfied with support given from the facility. This could be a more general question about how was the perception of your care during your pregnancy?

- In another mode you ask details
- Coverage- who needs the service? If every pregnant woman should receive service, only look at something at facility you only capture women who went for ANC. Since counseling happens outside of facility, it's good to look outside of SPA.
- If other groups say did they counsel of HIV, etc. during ANC it can get long.
- We just want to focus on what we want for maternal nutrition counseling. Reasonably generalizable way of asking about diet physical activity and supplement-related counseling. We recognize there's nuances, but not focusing on that.

  - Will summarize Monday discussion, before we start BFHI discussion

BFHI

- We could discuss CF questions, but perhaps we discuss BFHI next. Asking whether population based survey is the best place to gather info on that.
  - http://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018-appendix.pdf?ua=1 Appendix p. 6-7 (Table 3)
  - The first 2, we don't need to look at, look at the 8 clinical practice indicators.
  - ANC is dealt with
  - Skin-to-skin contact okay
  - Early initiation of bf
  - Are we talking hospital or wherever the mom delivers? This is in the context of hospitals, but big picture we want the, irrespective of where born.
  - Received support with learning to bf after delivery – not in the DHS. Just asked if someone observed.
  - Mothers whose babies received only breast milk during their stay at facility
  - Exclusive bf during hospital stay, more appropriate for a spa exit interview (also a practice, not counseling coverage)
  - Babies stayed with them since birth (rooming in)
  - We have a lot of this covered in existing questions in the DHS
  - Referral to community support – Report they can access bf support in their community. This one may be critical to have.
  - Ex: When you were discharged did anyone tell you were to go for support?
    - However not all women need support.
    - Not everyone needs support, but since you don't know who needs it everyone should receive the referral
  - Yes, to that one.
  - Last one is composite, so don't need to discuss
  - So, add in the referral to community support
  - Look into support for bf after delivery – is it covered sufficiently?

        - Postnatal care is already in the DHS as observation, in the first 2 days after birth. Not right after delivery.
        - We don't have specific question of support right after delivery.
        - In the existing delivery questions, chest, skin to skin, in first 2 days did someone observe bf.
        - Did someone counsel you in bf or observe bf immediately is in the DHS
    - Shouldn't edit the first 2 days to right after, because that's specific to the newborn community
    - Filter question place on the chest, then support
    - Existing question missing support
        - Immediately after birth was name put on your chest
        - If yes, was name bare skin touching your bare skin?
    - You could also ask did the baby suck? Those kind of questions do come up. So we need to think about how far you want to go
    - We want to know if the health workers do what they're supposed to do. Did the worker help you initiate bf? Interviewers want to know the details or what if she says this or that.
    - Did the baby suck is the outcome, but we're interested in whether the provider is doing what they're supposed to be doing.
    - We have early initiation of bf indicator to measure outcome.
    - If you ask did someone help you put baby to your breast? She will probably remember that. Was someone there to support yes/no. Chest, immediate is more complicated. You remember if someone was there to support you or not.
    - **We asked this in PMA – After you delivered, did a health provider help you put the baby to the breast?**
    - We didn't have any problems training this one.
    - We have experience, indicator in the BFHI implementation guidance to support.
    - So we'll recommend adding "**After you delivered, did a health provider help you put the baby to the breast?"**
    - **Add referral for community support too**
    - This should be a tier 1 probably
- Recap
    - Mothers with a child under 2 years 6 mo recall for IYCF counseling
    - Add diet related counseling Tier 1, same formulation as bf, in the ANC module include as an option code
    - Think about supplements (IFA, MMN, calcium) counseling, not necessarily a Tier 1 for us. Very amenable to facility surveys. (Tier 1 for tomorrow)

Why are these counseling coverage indicators/questions this important to consider?

- When the survey was done, there's a need for these indicators?

- Or the WHO (what Bo was saying), bf has a target, so to improve if you need counseling and we need to measure it.
- Justification for counseling interventions?
    - We know that if you don't have counseling, it's hit or miss on whether you'll achieve these indicators.
    - It's not just exclusive breastfeeding, creating an enabling environment for mothers. We need to better understand the conditions she's in.
    - Link with complementary feeding is forgotten often
        - Did they talk in last 6 mo? How to feed your child and then ask what breastfeeding or complementary feeding?

We are talking about the core questions now

- Other supportive interventions?
- CF is 6 months sufficient?
- Cross cutting IYCF promotion via CHW

Cross cutting IYCF promotion

In last 6 mo did a healthcare worker or CHW talk to you with…

- Change to CHW, mass media? Community platform – peer group, mothers support group
    - Community platform and mass media, keep differentiated? As tier 2?
    - Some countries don't have those community platforms and rely on health worker or CHW, may not have mass media.
    - If we take the word "health" out, we could community worker?
    - But CHWs are trained? But sometimes they're not trained?
    - But do we distinguish between qualified sources of info?
- Creating an enabling environment is critical
- CHW counseling is usually geared towards the mother, but is there anything geared towards others and that's missing.
    - Maybe include this in the men questionnaire
    - Include in hh questionnaire? Ask another hh member?
- With programming we're going across the hh members, but we're not reporting on it
- Family structure and enabling environment is critical and we're looking at them programmatically
- Did you or any other family member receive counseling?
    - Capture anyone in the hh
    - In a PBHS how important is that level of specificity?
- Men questionnaire – There are some questions about counselling

Report out

- Important to understand the enabling environment to improve prevalence estimates
- Interventions assigned to our group for discussion. Intervention population is listed, not the population proposed for counseling coverage.
- Components for IYCF counselling interventions were also discussed on Monday.
- There's a huge gap for MICYN counseling during pregnancy
- Data gaps amenable to PBHS – Almost all of them are amenable
- 4 areas of potential counseling support needed
    - Supplements, not tier 1
    - Strongly felt diet and physical activity should be included as counseling indicators
    - BFHI indicators
        - We went through the guidelines – out of those indicators we picked 2 indicators
        - This question asked in PMA2020 – Tested and worked.
    - Community platforms and mass media – could be in the male questionnaire. Not a tier 1 priority, tier 2 for countries with interventions using mass media platforms

Questions?

- Growth group wanted to wait to hear what we said. Tracking weight gain during pregnancy
- What is core vs expanded set of questions? Did they talk with you at all generally about this thing or do you need to ask about specific content? Nothing currently about bf messages
- A lot of practices need a question about counseling. You could deepen a question about IFA practice by asking about counseling, but we focused on areas where we saw a total gap.
- Question in micronutrients too – link to other groups
- Monday – Messages that mothers receive about feeding aren't always positive
- Counseling paired with supplement – SPAs and health facility assessment, observations of ANC. How IFA is given to mothers and if counseling is accompanying distribution of supplements?

6. ***Are there any nutrition-related questions from the current DHS/MICS core questionnaires that are not deemed useful (from experience and/or online survey results) and can be dropped? What is the rationale for this?***

B. For coverage data gaps better addressed in other types of PBHS

7. For each new or modified question proposed, please discuss and document:

a) the rationale for the addition or change
b) the type(s) of population-based HH survey it is recommended for [7]
c) which population it relates to
d) who will answer the question
e) recommended wording of question (to extent possible)
f) provide examples of surveys or studies that have used the recommended question, collected similar data or otherwise support the proposed addition or change[7]
g) *Prioritization:* Please classify each proposed change as Tier I, Tier II, or Tier III.

- Tier I: it is feasible to implement this change in the next ~12 months & it should be prioritized
- Tier II: it is feasible to implement this change in the next ~12 months but it is not essential / not everyone agrees
- Tier III: implementing this change in the next 2-5 years will require additional research

Session 1 Notes:

[1] Groups should briefly review list to ensure completeness. We recognize that nutrition-sensitive interventions are limited - most are out of scope for DHS-type surveys and so we recommend prioritizing discussion of indicators with more information. A summary of all interventions under review across groups is available under WG Resources Folder

[2] DataDENT team will provide background slide summarizing this information that WG can modify for use in report out.

[3] A "data gap" could be completely missing information, incomplete information (e.g. a question is asked about receipt but does not account for a minimum dose) or inappropriately-captured data (e.g. particularly question has been shown not to be valid or there is a "better practice" known)

[4] proposals should focus primarily on questionnaire wording changes. Changes to other aspects such as sampling, training, data quality checks, etc should be briefly noted/documented for record but will not be addressed in detail.

[5] examples of special topical modules are at DHS program website here. It is also possible for a country to add specific questions to the country survey based on national stakeholder request.

[6] *Examples:* Has there been any documented cognitive testing, validation or other systematic question design work?
[7] Provide most specific description feasible – e.g. if SMART survey; LSMS – but more general descriptions such as "a periodic national nutrition survey" are fine

WORKING GROUP SESSION 3: Recommendations to improve the nutrition content of facility assessments (60 MINS)

A. Identifying gaps in nutrition data that are amenable to health facility surveys

1. For interventions or practices assigned to your working group:
    - What data related to these interventions are currently available in the SPA? (e.g. staffing, training, supplies, equipment, supervision, client satisfaction etc)
    - Which data are amendable to be added to the SPA?

B. Proposed modifications to SPA core questionnaires

ANC

- First reviewing WG session day 2 slides containing instructions for the group
- ANC observations are already in the SPA
- Whether woman was counseled on purpose of IFA, when to take pills, side effects
- Breastfeeding counseling and dietary counseling
- Maternal diet physical activity, micronutrient supplements, bf – The four areas we discussed yesterday
- How does SPA define counseling?
    - Whether message is given – Did they talk about these things is what's assessed in the observation.
    - It's challenging to assess the quality and make it standard and comparable
    - What is the minimum criteria – "Talking about" is what was decided upon
    - Not every provider is even trained on how to provide counseling
    - So maybe the survey should use a different word there – messaging on x,y,z
- Looking at 4 elements of maternal nutrition – physical activity is needed
    - If we look at SPA training questionnaires
    - Counseling in ANC (wide range of topics listed)
    - Add into the training assessment of the service provider interview – include some specificity related to training on maternal nutrition or 4 key areas (micronutrient supplementation, physical activity, etc.)
    - This will give us info on whether they were trained, sure, but do people really know?
    - Could we ask a knowledge question?? Can you name key messages to give to a pregnant woman?
        - SPA – How that question is asked. Ask same set of questions to all providers, then filter out data. So they'll ask someone in family planning all of these questions, so there should be a filter question. But you also have smaller facilities with generalists
        - You could have a filter – Have you assessed in an ANC consultation in the last 6 mo? In those small facilities it would be yes.

        - So far there's nothing on knowledge, just their training.
        - When we do frontline worker interviews we ask about knowledge a lot.
        - We don't want to suggest radical changes
        - If there's nothing about knowledge about family planning, etc…
        - If there's consensus, we could note as a tier 1 add as tier 2. Other topical groups may be interested in knowledge questions.
        - Melinda – If nutrition adds knowledge question, other groups will want to.
    - So to recap – We're glad facility observations include ANC, asking about iron, but not calcium or multiple micronutrients. Countries may be interested in adding based on their delivery.
    - A country should update the other sections as well. What content should be edited at the country level? Adaptation of the questionnaire
    - Maternal nutrition – proposing service observations consider including other supplements, more specificity to check on content of ANC nutrition counseling (heads nodding)
    - Do we suggest breaking up the training question that's there to be more specific?
        - Newborn and family planning community would probably be happy about that too.
        - Micronutrient group isn't asking question about calcium in household questionnaire, so should we recommend it in the facility questionnaire?
        - Calcium inclusion in household surveys – There are places with big reporting issues. It's an important intervention, especially at facilities.
        - Don't think it's automatic that if not in household survey not in SPA
        - The micronutrients group will probably include multiple micronutrients in audit
    - What about job aids in facilities?
        - Is it part of audit? Don't think so.
        - Consider including it for nutrition, and would probably apply to other groups
        - R will check with colleagues about if it's included
    - Client exit interviews
        - IFA counseling, clients' knowledge
        - BF counseling included
        - Is dietary counseling included there?
    - Group looking at growth and supplements will look at the therapeutic milks

Breastfeeding and delivery

- Not looking like BFHI, nothing on sick child
- Sick child – there are 10 steps that facilities should have (posters, etc.)
- In the audit
- The document we looked at yesterday, Table 2 appendix recommended indicators for facility based assessment.
    - Display of products
    - Display of policy
    - Staff knowledge
    - Exit interviews is a different section

    - Not having promotion of breastmilk substitutes visually
    - On the clinical side there are indicators you could measure in exit interviews
- Is facility being assessed baby friendly?
    - We could get a sense of it through the SPA
    - Could be at the management level.
    - 10 steps need to do through interviews
    - The questions to decide baby friendliness may be in different spots in the questionnaire, then analytically you compile it – that could be a tier 1
    - A key component of guidance is mainstreaming BFHI
- Recommendation is to do a BFHI assessment in SPA?
    - Some questions are already in the SPA.
    - Listed some that were included
- Knowledge on breastfeeding is in the code
- Audit – observation of policy and promotion of breastmilk substitute
- BFHI – In the code about procurement of formula
- Supporting breastfeeding – It's about knowledge and display of products and policy
- Check for prescription?
    - It's not everywhere people use prescriptions
    - Say provided instead of prescriptions?
- Is there a question about rooming in? (R will check)
- Emphasis on quality of care – delivery exit interview, should we advocate for that?
    - Putting forth that we should?
    - Beyond bf issue
    - Possibly include after delivery exit interview
    - Administered by someone who didn't just care for her
- Chair recapping – Health facility assessments at each stage in the PPT, people are agreeing
    - In the absence of knowledge do you want to check on training related to the code?
    - In client interviews, check for promotion or prescription of formula
    - There's a list of questions that could go into exit interview
- BF counseling or IYCF counseling more generally? What we want in the health facility assessments?
- If there's a reason to conduct a post birth exit interview, we want to include nutrition.
- Don't know if it's been proposed for SPA from maternal health
    - Issue is sample size – small facilities very few deliveries

IYCF counseling

- Rooming in should be just for low birthweight babies
- Service provider interview – training included (see back of SPA USAID sheet), include knowledge too?
- Client observations – predominantly happening during sick child visits
    - Exit interviews care received (see online copy)
- Does anything need to be included in facility audits? Job aids, posters?

- Exit interview – Include whether provider gave breastmilk substitute? That's what we're suggesting.
- Availability of IMCI tour book in audit?
    - This is all in the context of IMCI
    - Those chart books are intended to be used by providers in the context of the visit
    - It's a job aid
- There's a section on non-communicable diseases, don't' know about counseling
- Starting plenary 7 on time
- What is the content of client exit interview for sick child?
    - Whatever is observed is also covered in client exit interview
    - Infant feeding during illness, solids, liquids
- IYCF counseling – facility audits check if IMCI chart book is there, any job aids
    - Service provider interview includes training content and practice observation
    - Client exit interviews, want to check if recommendations were made for formula
- Do you have the IMCI guidelines chart book is there! So never mind.
- Job aids are there, but not topic specific to nutrition

Recap

- If there's ever a post-delivery exit interview in the SPA – We want to include if received support for putting baby to the breast? Yes, and there are a whole bunch of things that would be in there too.
- What is desirable in health facility assessments?
- Maternal nutrition – No disagreement
- BFHI –Display of products or items with names or logos of companies. Include question on code training?
- IYCF – Nods from group

2. For each new question or change to an existing question proposed, please discuss and document:
    a) the rationale for the addition or change – including how the data are likely to be used (e.g. for quality adjusted coverage; for systems improvement, etc)
    b) which intervention(s) it relates to
    c) how (& by whom) the question will be answered (e.g. inventory; exit interview, etc)
    d) recommended wording of question (to extent possible)
    e) provide examples of surveys or studies that have used the recommended question, collected similar data or otherwise support the proposed addition or change (to extent possible)
    h) *Prioritization:* Please classify each proposed change as Tier I, Tier II, or Tier III.
    - Tier I: it is feasible to implement this change in the next ~12 months & it should be prioritized

- Tier II: it is feasible to implement this change in the next ~12 months but it is not essential / not everyone agrees
- Tier III: implementing this change in the next 2-5 years will require additional research

WORKING GROUP SESSION 4: Revisiting prioritization and Tier III research priorities (60 MINS)

A. Revisiting Prioritization of Proposed Changes

1. Review changes for three different types of surveys & reconsider Tier I, II, III prioritization
2. Make ranked list of any Tier I/II NEW questions recommended by group for inclusion in DHS Core or Modules & submit to JHU team (T Aung & A Buckland)
    - *These new questions will be considered under Plenary 8 Cross-WG prioritization exercise*

These edits were made in real time to the working group report out PPT and should be reflected in the appendix below. Our top three questions to put forth for the full group prioritization exercise were:

1) Maternal nutrition – During the pregnancy did a health care provider talk with you about what foods to eat when you are pregnant? If yes, which topics?

2) Breastfeeding counseling (in ANC module) – When you were pregnant with NAME, did a health care provider/CW talk with you about breastfeeding?

3) IYCF counseling in male and female questionnaires – In the last 6 months, did a health care provider/CW talk with you about how to feed your child? If yes, what topics?

B. Specifying Research Agenda

3. For each Tier III recommendation, please discuss and document:
    a) the questions that need to be addressed through further research
    b) recommended methods for addressing (e.g. secondary analysis of existing data, types of new data collection)
    c) scale of research required (e.g. single small pilot; testing across multiple cultural contexts, etc)
    d) researchers or institutions that are working in related areas
    e) opportunities / recommended contexts (e.g. upcoming large surveys)

Annex A: Note taking template for proposed modifications to DHS/MICS questionnaires

Intervention or practice	**Maternal Nutrition**
Type of change (new; modification of existing question; remove)	New question
If DHS – for core or module?	Core
Describe change	The group suggested a new stem and follow-up question to the DHS core. An expanded set of questions could be added about maternal nutrition in a module (or in other PBHS) and could include questions/response options. Ideally, we could look at several counseling content areas including diet, micronutrient supplementation, and physical activity/rest.
Rationale	There is some data availability in surveys for maternal nutrition counseling during pregnancy, but we do not have an indicator. If you see that things aren't going well programmatically, you want to know why. It's helpful to know what women are counselled on, so that you have a starting point for evidence based interventions.
Population being asked about	
Respondent for question	
Recommended wording	During this pregnancy did a health care provider or community worker talk with you about what foods to eat?
Evidence supporting recommendation	Alive and Thrive has included questions on maternal nutrition counseling for their program evaluations. They focus on diets and physical activity. There are no global indicators for these recommended interventions, but we have policy guidance from WHO. There is work to be done on a clear indicator definition.
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc)	
Priority Tier – I, II, III	Tier I
Other comments / notes	

Intervention or practice	BFHI interventions
Type of change (new; modification of existing question; remove)	New question
If DHS – for core or module?	DHS module or other PBHS
Describe change	New question: After you delivered (CHILD), did a health provider help you put the baby to the breast? There could also be additional questions to cover 2 other BFHI indicators, but these were less fleshed out by the group: 1) Referral to community support, 2) rooming-in. These could also be added in a module or other PBHS.
Rationale	There is no question about breastfeeding support right after delivery. From a behavioral standpoint, it's helpful to know if a health provider helped a mother put her baby to her breast and we think she would recall that interaction.
Population being asked about	
Respondent for question	
Recommended wording	After you delivered (CHILD), did a health provider help you put the baby to the breast?
Evidence supporting recommendation	This question was asked in the PMA2020 population based household surveys in Kenya and Burkina Faso and was well received. There are 8 clinical practice indicators in the BFHI implementation guidance appendix and this question corresponds to one of those indicators (see table 3): http://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018-appendix.pdf?ua=1
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc)	
Priority Tier – I, II, III	Tier I on Day 1, Tier II on Day 2 (but our focus was on selecting our top 3 questions)
Other comments / notes	

Intervention or practice	**Breastfeeding counseling during ANC**
Type of change (new; modification of existing question; remove)	New question
If DHS – for core or module?	Core
Describe change	During the pregnancy, did a health care provider or community worker talk with you about breastfeeding?
Rationale	From Monday's meeting and discussed in our WG: Provide data to support country reporting on Global Nutrition Monitoring Framework indicator on coverage of breastfeeding counseling programs. Current GNMF indicator: *Proportion of women with a child <24 months of age who received at least one counseling contact in the last one year*. [NOTE – this indicator can be reformulated with TEAM, and based on data availability] The WHO breastfeeding counseling guidance document (coming out the end of 2018) outlines that breastfeeding counselling should be promoted to all pregnant women and mothers antenatal, up to 24 months of age at least 6 times.
Population being asked about	
Respondent for question	
Recommended wording	During the pregnancy, did a health care provider or community worker talk with you about breastfeeding?
Evidence supporting recommendation	
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc)	
Priority Tier – I, II, III	I
Other comments / notes	

Intervention or practice	**Breastfeeding counseling within 1 month after birth**
Type of change (new; modification of existing question; remove)	New question
If DHS – for core or module?	Module or other PBHS
Describe change	During the first month after (NAME)'s birth (but after first two days), did a health care provider or community worker talk with you about breastfeeding?
Rationale	From Monday's meeting and discussed in our WG: Provide data to support country reporting on Global Nutrition Monitoring Framework indicator on coverage of breastfeeding counseling programs. Current GNMF indicator: *Proportion of women with a child <24 months of age who received at least one counseling contact in the last one year*. [NOTE – this indicator can be reformulated with TEAM, and based on data availability]
Population being asked about	Children under 24 mo
Respondent for question	Mothers with a child under 2 years
Recommended wording	During the first month after (NAME)'s birth (but after first two days), did a health care provider or community worker talk with you about breastfeeding?
Evidence supporting recommendation	
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc)	
Priority Tier – I, II, III	Tier II
Other comments / notes	Inclusion of this question was in contention and discussed in depth on Monday's meeting. Ultimately, a majority of participants who responded to a follow-up email about inclusion suggested that it should be in the core. However, that exercise didn't get into prioritization of questions. By the time we revisited this question during our group's prioritization exercise on Thursday, it got bumped to a Tier II.

Intervention or practice	**IYCF counseling**
Type of change (new; modification of existing question; remove)	New questions
If DHS – for core or module?	Core, and could also go in the men's questionnaire
Describe change	In the last six months, did a health care provider or community worker talk with you about how to feed your child? Follow-up question – If yes, what topics did he or she talk to you about? (Include topics on breastfeeding and complementary feeding)
Rationale	From Monday's meeting and discussed in our WG: Provide data to support country reporting on Global Nutrition Monitoring Framework indicator on coverage of breastfeeding counseling programs. Current GNMF indicator: *Proportion of women with a child <24 months of age who received at least one counseling contact in the last one year*. [NOTE – this indicator can be reformulated with TEAM, and based on data availability]
Population being asked about	
Respondent for question	
Recommended wording	In the last six months, did a health care provider or community worker talk with you about how to feed your child? Follow-up question - What topics did he or she talk to you about? (Include topics on breastfeeding and complementary feeding)
Evidence supporting recommendation	
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc)	
Priority Tier – I, II, III	Tier I

Other comments / notes	

Intervention or practice	**NetCode – Infant formula**
Type of change (new; modification of existing question; remove)	New question
If DHS – for core or module?	Module, a context-specific option for countries to add to their DHS, or other PBHS
Describe change	In past 6 mo have you seen or heard any promotion at health facility about milk products for children under 6 mo? In the past 6 months have you heard or seen a promotion or message in the media from companies that sell baby milk products for children under 3? In past 6 mo have you received any free samples of baby milk products for children under 3 yrs?
Rationale	These questions cover the enabling environment. Looking at the International Code of Breastmilk Substitutes (global nutrition policy), in practice there may be limited accountability and every opportunity to collect this information is helpful.
Population being asked about	
Respondent for question	
Recommended wording	
Evidence supporting recommendation	http://www.who.int/nutrition/publications/infantfeeding/netcode-toolkit-monitoring-systems.pdf
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc)	

Priority Tier – I, II, III	Tier II
Other comments / notes	Not everyone agreed that this is a context-specific issue, but ultimately the group was okay with including a base question in a module + having expanded question options at the country level.

Intervention or practice	**Community platform**
Type of change (new; modification of existing question; remove)	New question
If DHS – for core or module?	Module (base generic question) + context specific option
Describe change	The addition of a content or campaign specific question
Rationale	
Population being asked about	
Respondent for question	
Recommended wording	No specific question at this time
Evidence supporting recommendation	
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc)	
Priority Tier – I, II, III	Tier III
Other comments / notes	

Intervention or practice	**Exposure to formula/breastmilk substitute promotion**
Type of change (new; modification of existing question; remove)	New question
If DHS – for core or module?	Module (base generic question) + context specific option
Describe change	
Rationale	
Population being asked about	
Respondent for question	
Recommended wording	No specific question at this time
Evidence supporting recommendation	
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc)	
Priority Tier – I, II, III	
Other comments / notes	

Note: I deleted Annex B. The way we framed our discussion on Day 2 was that anything that was considered for a DHS module, could also be considered for other PBHS

Annex C: Note taking template for proposed modifications for SPA (Facility Survey)

Relevant intervention(s)	**NetCode – Infant formula**
Briefly describe change	Addition of 3 questions: In past 6 mo have you seen or heard any promotion at health facility about milk products for children under 6 mo? In the past 6 months have you heard or seen a promotion or message in the media from companies that sell baby milk products for children under 3? In past 6 mo have you received any free samples of baby milk products for children under 3 yrs?
Rationale – how will data be used?	
How & by whom will be answered (e.g. inventory; exit interview, etc)	Exit interview
Recommended wording	We didn't get to the point of recommended wording.
Evidence supporting recommendation	These questions cover the enabling environment. Looking at the International Code of Breastmilk Substitutes (global nutrition policy), in practice there may be limited accountability and every opportunity to collect this information is helpful.
Priority Tier – I, II, III	Tier I
Other comments / notes	

Annex D: Note taking template for Research Agenda

Topic area / intervention/practice	
Research Questions	
Applicable to which survey type(s)?	
Rationale – how will data be used?	
Scale required	
Researchers or institutions working in area	
Potential opportunities / recommended contexts	
Other comments / notes	

MIYCN Working Group Notes

Sessions 3 & 4

Working Group Chair: Purnima Menon
Note taker: Audrey Buckland

Session 3: Recommendations to improve the nutrition content of facility assessments (60 MINS)

Proposed modifications to SPA core questionnaires

ANC

- First reviewing WG session day 2 slides containing instructions for the group
- ANC observations are already in the SPA
- Whether woman was counseled on purpose of IFA, when to take pills, side effects
- Breastfeeding counseling and dietary counseling
- Maternal diet physical activity, micronutrient supplements, bf – The four areas we discussed yesterday
- How does SPA define counseling?
    - Whether message is given – Did they talk about these things is what's assessed in the observation.
    - It's challenging to assess the quality and make it standard and comparable
    - What is the minimum criteria – "Talking about" is what was decided upon
    - Not every provider is even trained on how to provide counseling
    - So maybe the survey should use a different word there – messaging on x,y,z
- Looking at 4 elements of maternal nutrition – physical activity is needed
    - If we look at SPA training questionnaires
    - Counseling in ANC (wide range of topics listed)
    - Add into the training assessment of the service provider interview – include some specificity related to training on maternal nutrition or 4 key areas (micronutrient supplementation, physical activity, etc.)
    - This will give us info on whether they were trained, sure, but do people really know?
    - Could we ask a knowledge question?? Can you name key messages to give to a pregnant woman?
        - SPA – How that question is asked. Ask same set of questions to all providers, then filter out data. So they'll ask someone in family planning all of these questions, so there should be a filter question. But you also have smaller facilities with generalists
        - You could have a filter – Have you assessed in an ANC consultation in the last 6 mo? In those small facilities it would be yes.
        - So far there's nothing on knowledge, just their training.
        - When we do frontline worker interviews we ask about knowledge a lot.

        - We don't want to suggest radical changes
        - If there's nothing about knowledge about family planning, etc…
        - If there's consensus, we could note as a tier 1 add as tier 2. Other topical groups may be interested in knowledge questions.
        - Melinda – If nutrition adds knowledge question, other groups will want to.
    - So to recap – We're glad facility observations include ANC, asking about iron, but not calcium or multiple micronutrients. Countries may be interested in adding based on their delivery.
    - A country should update the other sections as well. What content should be edited at the country level? Adaptation of the questionnaire
    - Maternal nutrition – proposing service observations consider including other supplements, more specificity to check on content of ANC nutrition counseling (heads nodding)
    - Do we suggest breaking up the training question that's there to be more specific?
        - Newborn and family planning community would probably be happy about that too.
        - Micronutrient group isn't asking question about calcium in household questionnaire, so should we recommend it in the facility questionnaire?
        - Calcium inclusion in household surveys – There are places with big reporting issues. It's an important intervention, especially at facilities.
        - Don't think it's automatic that if not in household survey not in SPA
        - The micronutrients group will probably include multiple micronutrients in audit
    - What about job aids in facilities?
        - Is it part of audit? Don't think so.
        - Consider including it for nutrition, and would probably apply to other groups
        - R will check with colleagues about if it's included
    - Client exit interviews
        - IFA counseling, clients' knowledge
        - BF counseling included
        - Is dietary counseling included there?
    - Group looking at growth and supplements will look at the therapeutic milks

Breastfeeding and delivery

- Not looking like BFHI, nothing on sick child
- Sick child – there are 10 steps that facilities should have (posters, etc.)
- In the audit
- The document we looked at yesterday, Table 2 appendix recommended indicators for facility based assessment.
    - Display of products
    - Display of policy
    - Staff knowledge
    - Exit interviews is a different section
    - Not having promotion of breastmilk substitutes visually

    - On the clinical side there are indicators you could measure in exit interviews
- Is facility being assessed baby friendly?
    - We could get a sense of it through the SPA
    - Could be at the management level.
    - 10 steps need to do through interviews
    - The questions to decide baby friendliness may be in different spots in the questionnaire, then analytically you compile it – that could be a tier 1
    - A key component of guidance is mainstreaming BFHI
- Recommendation is to do a BFHI assessment in SPA?
    - Some questions are already in the SPA.
    - Listed some that were included
- Knowledge on breastfeeding is in the code
- Audit – observation of policy and promotion of breastmilk substitute
- BFHI – In the code about procurement of formula
- Supporting breastfeeding – It's about knowledge and display of products and policy
- Check for prescription?
    - It's not everywhere people use prescriptions
    - Say provided instead of prescriptions?
- Is there a question about rooming in? (R will check)
- Emphasis on quality of care – delivery exit interview, should we advocate for that?
    - Putting forth that we should?
    - Beyond bf issue
    - Possibly include after delivery exit interview
    - Administered by someone who didn't just care for her
- Chair recapping – Health facility assessments at each stage in the PPT, people are agreeing
    - In the absence of knowledge do you want to check on training related to the code?
    - In client interviews, check for promotion or prescription of formula
    - There's a list of questions that could go into exit interview
- BF counseling or IYCF counseling more generally? What we want in the health facility assessments?
- If there's a reason to conduct a post birth exit interview, we want to include nutrition.
- Don't know if it's been proposed for SPA from maternal health
    - Issue is sample size – small facilities very few deliveries

IYCF counseling

- Rooming in should be just for low birthweight babies
- Service provider interview – training included (see back of SPA USAID sheet), include knowledge too?
- Client observations – predominantly happening during sick child visits
    - Exit interviews care received (see online copy)
- Does anything need to be included in facility audits? Job aids, posters?
- Exit interview – Include whether provider gave breastmilk substitute? That's what we're suggesting.

- Availability of IMCI tour book in audit?
    - This is all in the context of IMCI
    - Those chart books are intended to be used by providers in the context of the visit
    - It's a job aid
- There's a section on non-communicable diseases, don't' know about counseling
- Starting plenary 7 on time
- What is the content of client exit interview for sick child?
    - Whatever is observed is also covered in client exit interview
    - Infant feeding during illness, solids, liquids
- IYCF counseling – facility audits check if IMCI chart book is there, any job aids
    - Service provider interview includes training content and practice observation
    - Client exit interviews, want to check if recommendations were made for formula
- Do you have the IMCI guidelines chart book is there! So never mind.
- Job aids are there, but not topic specific to nutrition

Recap

- If there's ever a post-delivery exit interview in the SPA – We want to include if received support for putting baby to the breast? Yes, and there are a whole bunch of things that would be in there too.
- What is desirable in health facility assessments?
- Maternal nutrition – No disagreement
- BFHI –Display of products or items with names or logos of companies. Include question on code training?
- IYCF – Nods from group

Session 4: Revisiting prioritization and Tier III research priorities (60 MINS)

These edits were made in real time to the working group report out PPT and should be reflected in the appendix below. Our top three questions to put forth for the full group prioritization exercise were:

1) Maternal nutrition – During the pregnancy did a health care provider talk with you about what foods to eat when you are pregnant? If yes, which topics?

2) Breastfeeding counseling (in ANC module) – When you were pregnant with NAME, did a health care provider/CW talk with you about breastfeeding?

3) IYCF counseling in male and female questionnaires – In the last 6 months, did a health care provider/CW talk with you about how to feed your child? If yes, what topics?

Specifying Research Agenda

1. For each Tier III recommendation, please discuss and document:
   a) the questions that need to be addressed through further research
   b) recommended methods for addressing (e.g. secondary analysis of existing data, types of new data collection)
   c) scale of research required (e.g. single small pilot; testing across multiple cultural contexts, etc)
   d) researchers or institutions that are working in related areas
   e) opportunities / recommended contexts (e.g. upcoming large surveys)

Annex A: Note taking template for proposed modifications to DHS/MICS questionnaires

Intervention or practice	**Maternal Nutrition**
Type of change (new; modification of existing question; remove)	New question
If DHS – for core or module?	Core
Describe change	The group suggested a new stem and follow-up question to the DHS core. An expanded set of questions could be added about maternal nutrition in a module (or in other PBHS) and could include questions/response options. Ideally, we could look at several counseling content areas including diet, micronutrient supplementation, and physical activity/rest.
Rationale	There is some data availability in surveys for maternal nutrition counseling during pregnancy, but we do not have an indicator. If you see that things aren't going well programmatically, you want to know why. It's helpful to know what women are counselled on, so that you have a starting point for evidence based interventions.
Population being asked about	
Respondent for question	
Recommended wording	During this pregnancy did a health care provider or community worker talk with you about what foods to eat?
Evidence supporting recommendation	Alive and Thrive has included questions on maternal nutrition counseling for their program evaluations. They focus on diets and physical activity. There are no global indicators for these recommended interventions, but we have policy guidance from WHO. There is work to be done on a clear indicator definition.
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc)	
Priority Tier – I, II, III	Tier I
Other comments / notes	

Intervention or practice	**BFHI interventions**
Type of change (new; modification of existing question; remove)	New question
If DHS – for core or module?	DHS module or other PBHS
Describe change	New question: After you delivered (CHILD), did a health provider help you put the baby to the breast? There could also be additional questions to cover 2 other BFHI indicators, but these were less fleshed out by the group: 1) Referral to community support, 2) rooming-in. These could also be added in a module or other PBHS.
Rationale	There is no question about breastfeeding support right after delivery. From a behavioral standpoint, it's helpful to know if a health provider helped a mother put her baby to her breast and we think she would recall that interaction.
Population being asked about	
Respondent for question	
Recommended wording	After you delivered (CHILD), did a health provider help you put the baby to the breast?
Evidence supporting recommendation	This question was asked in the PMA2020 population based household surveys in Kenya and Burkina Faso and was well received. There are 8 clinical practice indicators in the BFHI implementation guidance appendix and this question corresponds to one of those indicators (see table 3): http://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018-appendix.pdf?ua=1
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc)	
Priority Tier – I, II, III	Tier I on Day 1, Tier II on Day 2 (but our focus was on selecting our top 3 questions)
Other comments / notes	

Intervention or practice	**Breastfeeding counseling during ANC**
Type of change (new; modification of existing question; remove)	New question
If DHS – for core or module?	Core
Describe change	During the pregnancy, did a health care provider or community worker talk with you about breastfeeding?
Rationale	From Monday's meeting and discussed in our WG: Provide data to support country reporting on Global Nutrition Monitoring Framework indicator on coverage of breastfeeding counseling programs. Current GNMF indicator: *Proportion of women with a child <24 months of age who received at least one counseling contact in the last one year*. [NOTE – this indicator can be reformulated with TEAM, and based on data availability] The WHO breastfeeding counseling guidance document (coming out the end of 2018) outlines that breastfeeding counselling should be promoted to all pregnant women and mothers antenatal, up to 24 months of age at least 6 times.
Population being asked about	
Respondent for question	
Recommended wording	During the pregnancy, did a health care provider or community worker talk with you about breastfeeding?
Evidence supporting recommendation	
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc)	
Priority Tier – I, II, III	I
Other comments / notes	

Intervention or practice	**Breastfeeding counseling within 1 month after birth**
Type of change (new; modification of existing question; remove)	New question
If DHS – for core or module?	Module or other PBHS
Describe change	During the first month after (NAME)'s birth (but after first two days), did a health care provider or community worker talk with you about breastfeeding?
Rationale	From Monday's meeting and discussed in our WG: Provide data to support country reporting on Global Nutrition Monitoring Framework indicator on coverage of breastfeeding counseling programs. Current GNMF indicator: *Proportion of women with a child <24 months of age who received at least one counseling contact in the last one year*. [NOTE – this indicator can be reformulated with TEAM, and based on data availability]
Population being asked about	Children under 24 mo
Respondent for question	Mothers with a child under 2 years
Recommended wording	During the first month after (NAME)'s birth (but after first two days), did a health care provider or community worker talk with you about breastfeeding?
Evidence supporting recommendation	
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc)	
Priority Tier – I, II, III	Tier II
Other comments / notes	Inclusion of this question was in contention and discussed in depth on Monday's meeting. Ultimately, a majority of participants who responded to a follow-up email about inclusion suggested that it should be in the core. However, that exercise didn't get into prioritization of questions. By the time we revisited this question during our group's prioritization exercise on Thursday, it got bumped to a Tier II.

Intervention or practice	**IYCF counseling**
Type of change (new; modification of existing question; remove)	New questions
If DHS – for core or module?	Core, and could also go in the men's questionnaire
Describe change	In the last six months, did a health care provider or community worker talk with you about how to feed your child? Follow-up question – If yes, what topics did he or she talk to you about? (Include topics on breastfeeding and complementary feeding)
Rationale	From Monday's meeting and discussed in our WG: Provide data to support country reporting on Global Nutrition Monitoring Framework indicator on coverage of breastfeeding counseling programs. Current GNMF indicator: *Proportion of women with a child <24 months of age who received at least one counseling contact in the last one year*. [NOTE – this indicator can be reformulated with TEAM, and based on data availability]
Population being asked about	
Respondent for question	
Recommended wording	In the last six months, did a health care provider or community worker talk with you about how to feed your child? Follow-up question - What topics did he or she talk to you about? (Include topics on breastfeeding and complementary feeding)
Evidence supporting recommendation	
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc)	
Priority Tier – I, II, III	Tier I

Other comments / notes	

Intervention or practice	**NetCode – Infant formula**
Type of change (new; modification of existing question; remove)	New question
If DHS – for core or module?	Module, a context-specific option for countries to add to their DHS, or other PBHS
Describe change	In past 6 mo have you seen or heard any promotion at health facility about milk products for children under 6 mo? In the past 6 months have you heard or seen a promotion or message in the media from companies that sell baby milk products for children under 3? In past 6 mo have you received any free samples of baby milk products for children under 3 yrs?
Rationale	These questions cover the enabling environment. Looking at the International Code of Breastmilk Substitutes (global nutrition policy), in practice there may be limited accountability and every opportunity to collect this information is helpful.
Population being asked about	
Respondent for question	
Recommended wording	
Evidence supporting recommendation	http://www.who.int/nutrition/publications/infantfeeding/netcode-toolkit-monitoring-systems.pdf
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc)	

Priority Tier – I, II, III	Tier II
Other comments / notes	Not everyone agreed that this is a context-specific issue, but ultimately the group was okay with including a base question in a module + having expanded question options at the country level.

Intervention or practice	**Community platform**
Type of change (new; modification of existing question; remove)	New question
If DHS – for core or module?	Module (base generic question) + context specific option
Describe change	The addition of a content or campaign specific question
Rationale	
Population being asked about	
Respondent for question	
Recommended wording	No specific question at this time
Evidence supporting recommendation	
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc)	
Priority Tier – I, II, III	Tier III
Other comments / notes	

Intervention or practice	**Exposure to formula/breastmilk substitute promotion**
Type of change (new; modification of existing question; remove)	New question
If DHS – for core or module?	Module (base generic question) + context specific option
Describe change	
Rationale	
Population being asked about	
Respondent for question	
Recommended wording	No specific question at this time
Evidence supporting recommendation	
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc)	
Priority Tier – I, II, III	
Other comments / notes	

Note: I deleted Annex B. The way we framed our discussion on Day 2 was that anything that was considered for a DHS module, could also be considered for other PBHS

Annex C: Note taking template for proposed modifications for SPA (Facility Survey)

Relevant intervention(s)	**NetCode – Infant formula**
Briefly describe change	Addition of 3 questions: In past 6 mo have you seen or heard any promotion at health facility about milk products for children under 6 mo? In the past 6 months have you heard or seen a promotion or message in the media from companies that sell baby milk products for children under 3? In past 6 mo have you received any free samples of baby milk products for children under 3 yrs?
Rationale – how will data be used?	
How & by whom will be answered (e.g. inventory; exit interview, etc)	Exit interview
Recommended wording	We didn't get to the point of recommended wording.
Evidence supporting recommendation	These questions cover the enabling environment. Looking at the International Code of Breastmilk Substitutes (global nutrition policy), in practice there may be limited accountability and every opportunity to collect this information is helpful.
Priority Tier – I, II, III	Tier I
Other comments / notes	

Annex D: Note taking template for Research Agenda

Topic area / intervention/practice	
Research Questions	
Applicable to which survey type(s)?	
Rationale – how will data be used?	
Scale required	
Researchers or institutions working in area	
Potential opportunities / recommended contexts	
Other comments / notes	

Micronutrients Working Group Notes

Sessions 1 & 2

Working Group Chair: Lynette Neufeld
Note taker: Tricia Aung and Shannon King

SESSIONS 1 (85 MIN) & 2 (60 MIN)

Recommendations to improve the nutrition content of population-based household survey

Discussion session: The notes in this section reflect points of discussion and comments from individual/ several participants. Conclusions and recommendations of the group are noted below.

- The session began with some discussion on the placement of indicators and interest in understanding the use of listed micronutrient products in the context of child feeding. The Working Group Chair suggested considering the micronutrient group in the context of products rather than practice to understand the line of distinction from other working groups.
- One individual asked whether DataDENT had looked at the recommendations made to DHS during the last call for changes. She anticipated that many of the same changes would be discussed and asked if we had feedback on why proposed changes were not accepted. A USAID representative that works on DHS commented that there was not a formalized response to the proposed questions, but the submissions are still online. She described how there were several USAID and DHS meetings to discuss the proposed changes, but notes from these meetings are currently not public. She additionally stated that just because something was not accepted last time shouldn't preclude its resubmission. Several in the group reiterated that understanding the rationale for why something wasn't accepted would be important (for framing the resubmission).
- The Working Group Chair proposed six intervention groups based on the nature of the intervention, group they are directed to, and the way the intervention is rolled out.
    1. **Fortification (household response)** – iodized salt, staple food fortification
    2. **Supplements for women (varying age)** – iron or IFA supplements, folic acid supplementation, multiple micronutrient supplementation
    3. **Pregnant women** - iron or IFA supplements, folic acid supplementation, multiple micronutrient supplementation, calcium supplementation, vitamin D (dropped from the list), postpartum vitamin A supplementation
    4. **Routine supplementation for children at a population level** – Deworming (<5), pediatric iron supplements, MMS – MNP or tablets, SQ-LNS, and fortified infant cereal
    5. **Zinc supplementation (for children with diarrhea)**
    6. **Vitamin A supplementation (episodic delivery)**
- After some discussion, the group decided not to propose indicators/ data collection for Vit D supplementation or postpartum Vit A supplementation. Discussion and comments: There are no recommendations for vitamin D supplementation with pregnant women. It's currently not yet recommended, but WHO is reviewing this during the next month. One group member commented how there is little data on vitamin D status and the literature does not currently

support recommendations by WHO on supplementation for the prevention of preeclampsia or other birth outcomes. The group decided to table vitamin D from discussions for now. Postpartum vitamin A supplementation is currently not WHO recommended but is part of some countries' programs. But given few countries and lack of WHO recommendation, the group decided that postpartum Vit A would not be a topic to pursue in multi country platforms, although perhaps relevant in individual country surveys with a policy/ program in place.

- Some countries are moving towards routine vitamin A supplementation, so this may be treated differently from episodic vitamin A supplementation and more similar to other actions at health centers.
- Postpartum vitamin A supplementation is also currently not WHO recommended, but is part of some countries' programs.
- An indicator like MMS-MNP is probably not amendable to a household survey because the program guidance depends on the country and dosage/periodicity is variable.
- WHO recommends weekly/intermittent folic acid for adolescents, and there are some countries that are doing this.
- Although some countries do not currently have specific food fortification programs, for the purposes of thinking about the future of DHS/MICS, they should be discussed.
- Group should focus on mandatory fortified products given the challenge of determining fortification coverage levels in settings with voluntary fortification programs.
- It was noted that for most products, surveys currently do not distinguish whether the products is purchased by the individual or received from a healthcare provider.
- Are we interested in assessing health systems coverage vs. behaviors at the household levels? These are two different aspects.
- With revisions to the core DHS questionnaire, USAID/ICF will also revise the SPA questionnaire and there is interest in expanding nutrition questioning.
- DHS and MICS approach modules differently. With DHS, core questionnaire questions are asked in every country (with few exceptions, including countries opting out of the Men's questionnaire). Countries opt into DHS modules depending on interest. With more module options, there is the risk that countries will choose too many modules and the survey will become unruly.
- Under DHS 8, USAID/ICF will undertake more innovative sampling methods/split-sample designs with flexibility for more modules that can be asked to a sub-set.
- Specially biofortified food products (like sweet potatoes) are not captured with the current set of indicators; potential questions for biofortification was identified as a research priority
- Note for DHS/MICS reference: There is global guidance on calculating VAS coverage by semester and annually, and national and district level monitoring manuals and a PECS manual (GAVA). I think UNICEF also has another paper on this as well (could ask Julia Krasevec)..

- USAID representative mentioned that there is more space in the household questionnaire compared to the women's questionnaire. Some questions could be asked to a household head instead of a woman/mother.

Key Points

- There was general agreement that coverage data on micronutrient interventions would be even more meaningful for program decision making if linked with micronutrient status data
- The group agreed that despite potential availability of health facility data for a product, there are so many limitations to health facility data that it's still critical to ask about coverage/receipt of products for any "national" programs for each/any product in national HH surveys, even if only collected every 5 years.
    - For infants and young children, the group agreed that a recall period of 6 months for most products is appropriate because this is in line with most WHO guidelines for these products
- Our wish would be to have a comprehensive overview of supplement/ fortification nutrient sources for each of our priority groups
    - **The group concluded that a comprehensive compendium/module of standardized micronutrient questions developed for potential inclusion in any survey is needed. USAID/ICF representatives echoed that this would be very useful and something similar exists for family planning.**
- Age groups included in surveys don't usually align perfectly with WHO guideline– so can't make conclusions about coverage on WHO recommendation age group generally
- Adolescents are becoming higher priority among donors – definitely girls but increasingly boys
- The group highlighted that with micronutrients there is an additional challenge in terms of understanding what we want to know
    - Coverage of ANY product regardless of origin
    - Coverage of public health programs that distribute those products
- The group noted the gap of data for elderly
- Most of interest are item that are part of national programs/ policies implemented at-scale.
- Potential questions for biofortification was identified as a research priority
- **The top three priorities identified by the group after the two days of discussion all involved iron supplementation for both women and children.** Unresolved was where food fortification would be prioritized in relation to the other three priorities.

Intervention or practice	Iron or IFA supplements	Folic acid supplementation	Multiple micronutrient supplementation (MMNS)	Calcium supplementation	Vitamin D	Postpartum Vitamin A supplementation (low-dose for high deficiency pop)	Deworming	Pediatric iron supplements	MMS - MNP or tablets	SQ-LNS	Vitamin A supplementation (high-dose)	Zinc supplementation with ORS for children with diarrhea	Salt (iodine; DFS)	Food fortification: wheat; maize; sugar; oil; bouillon; rice	Fortified Complementary Foods	Elderly	Weekly Iron and Folic Acid (WIFA) Supplementation
Type of change (new; modification of existing question; remove)	Currently in DHS; Add to MICS – Merge IFA/MMNS with slight modification	Add to DHS/MICS – Only for WRA/adolescents	Add to DHS/MICS – Merge IFA/MMNS	Not yet, but could be in DHS/MICS	Not yet, but could be in DHS/MICS	Not in DHS/MICS	Currently in DHS – Drop or move	Currently in DHS; Add to MICS Modify questions	Currently in DHS – change period and separate iron from MNP.	Not in DHS/MICS	Currently in DHS – possibly modify question	Keep – no change	Currently in both DHS/MICS. Modify question	Not currently core in DHS/MICS. Modify to target foods in nationally fortified program	Currently in DHS/MICS	Add to DHS – diet? Situation?	Add to DHS/MICS – intermittent IFA
If DHS – for core or module?	Core	Core	Core				Core	Core	Core		Core	Core	Core	core			
Describe change	Ask about any source of iron in one question, not just IFA; Add source; Potentially change asking for pregnancies during the past 2 years. Slight wording to include the option of MNP within brackets.	Source not likely needed unless program related; add source; don't worry about amt	Include in IFA/ Fe question				Consider drop for PW, may keep for children. May be better places somewhere else in survey other than the nutrition module.	Change time of question from 2 weeks to 6 months.	Currently DHS has 2 questions about consumption of iron/sprinkles 7 day recall. Would drop one to eliminate duplication. To align with international guidance would change recall to 6 period.	No existing programs at-scale, but should work on indicators so that will be ready to add once guidelines come out. Will likely be targeted?	We feel there is value in keeping survey indicators given weaknesses of administrative data. Might be ways of improving the question.		Adding a follow-up question for respondents who have no salt in household, and asking where it's from	Focusing on foods fortified as part of a national program and identifying where the food is from		Add	Add
Rationale	WHO guidelines linked to iron; others depend on local programming; source of interest; source can be of interest to governments; need to check how asking for pregnancy in the past 2	Only in WRA where country guidelines of concern	WHO guidelines linked to iron; others depend on local programming	Need to specify when to include and how to measure 3-4 tablets/d			Current guidelines for pregnant women are to reduce worming. From a nutrition perspective, it is less important however may be important to others.		Increase number of children captured.	Currently there are no guidelines for a preventative program. It is very expensive and unlikely to reach a lot of people.			This follow-up question would distinguish between households that don't use salt vs. households that currently don't' have salt in their household.	Food fortification of at least one food vehicle has been implemented in most countries globally but little is known about who consumes the fortified/ fortifiable food, and therefore			

	(or 5 years) would influence sample size.													the potential for impact			
Population being asked about	PW, WRA/ AD	WRA/AD	PW	PW	PW	PLW	PW	Child < 5	Child < 5	Child < 5	Child < 5	Child < 5	HH	HH	Child < 24m	Elderly	Ado/ WRA
Respondent for question	PPW, WRA/AD	WRA/ AD	PPW	PPW	PPW	PPW							Household respondent	Household respondent			Ado/ WRA
Recommended wording	1. In the past 6 months have you taken any iron containing supplements ? 1b. (IF YES) Where did you get those supplements ? 2. In the past 6 months have you taken any folic acid containing supplements ? 2b. (IF YES) Where did you get those supplements ? For pregnant women, same wording but change to 6 months instead of pregnancy period.	See Iron or IFA.	DHS					1. Reword recall question about iron-containing supplements to be last 6 months (consume or get needs to be resolved) 2. If YES, what is the supplement (potential to only use this question in countries that have national programs) For programs that have MNP or iron, include subdivision of type of supplement provided by country. 3. If YES, ask source (purchased vs. provided – disaggregation could include sprinkles)					If someone responds "no salt in household" to HQ145, ask "Did you use salt in the household in the last week?" If YES, "Where did you get the salt from?" (PMA question) Add question "Did you use bullion cubes in the last week?	Should be copied from PM2020 questionnaire (adapted based on that experience if needed)			

Evidence supporting recommendation																	No existing guidelines but needed
Recommendations for data tabulation or display																	
Other comments (including about methods, quality, etc)	Would need to ask the question specific to the formulation the country is providing to the population.	Folic acid came up 5 years ago during revisions because of the different formulations, pregnant women might not be able to know if their supplements have folic acid or not.		Develop list of parameters for when to include	Review guidelines as they come out	Identify why country is choosing to do this			Reword to generic terminology as standard question then adapt to context (i.e., delete Sprinkles which is a commercial brand from core question).				Would want to develop a new rapid yes/no test for testing, which doesn't exist. There are concerns with the validity of this test. For salt samples testing positive, would want to explore the potential for shipping a sample for quantitative testing, but there are concerns about logistics.				
Priority Tier – I, II, III	I	I?	I	III	III	III	III	I	I	III	Already core	Already core	I	II	II		
Other comments / notes	HHSurvey or Facility: distinguish what type of supplement Type II: Can "Nutrition" have optional pull-in/ out questions on source vs core questions.			Question whether enough countries have a program.				Concern that mothers don't' know whether sprinkles contain iron.	During the last revision, the time period changed from 7 days to 2 weeks. Would want to know who is actually using this data.	This should be explored for a different survey.			Recommend not using a rapid test to get a sense of PPM levels. This should be done with a special study. For both fortified foods and iodized salt, need to	During the last round of revisions, a module on food fortification was rejected from DHS. Want to explore why it was rejected. New rapid test kits for			

	Will have to look into how changing to 2 years would affect sample size.												conduct a complementary study linked to biomarkers to measure fortifiable levels (outside DHS/MICS).	other food vehciles should be developed, research priority			

Micronutrients Working Group Notes

Session 3 & 4

Working Group Chair: Lynette Neufeld
Note taker: Tricia Aung and Shannon King

Session 3: Recommendations to improve the nutrition content of facility assessments (60 mins)

Overall, the group agreed that the facility survey was generally fine and little discussion needed related to micronutrients. Below are general recommendations:

- Expand facility inventory list to align with micronutrients utilized within the national programs. Countries can advocate for what should be on the list to ensure the list is appropriate to what their facilities should be delivering to patients. For example if the national policy includes MN powders instead of IFA for women, this should be reflected on the list.
- Need clarification on whether facility inventory questions capture whether products target children or women.
    1. Add MMN to facility inventory for women
    2. Add MN powders for children
    3. Add calcium for women
    4. Specify zinc for children vs. women
    5. Iron pills should be changed to iron syrup (for children)
    6. Add vitamin A for children.
- Add multiple micronutrients in ANC observations. Add thiamine to the list.
- Would be helpful to have a list of micronutrients that countries should have (common across most contexts) vs. a list of things that a country may have (varies by country) to help the development of the supplement list during country consultations
- Make sure counseling and training would include IFA.
- Add a WELL CHILD observation for some sort of facility-based survey- don't usually attend clinics for well child and even if they attend then it is difficult to capture because you only attend for a few minutes. This could be during an immunization day.

Research Agenda

The following items were discussed needing additional research:

- Developing a yes/no test kit for salt iodization.
- Identifying whether SQ-LNS should be asked in a different survey.

Final Recommendations:

Proposed changes are summarized in the Micronutrient WG Day 2 Presentation.

Intervention or practice	Iron or IFA supplements	Folic acid supplementation	Multiple micronutrient supplementation (MMNS)	Calcium supplementation	Vitamin D	Postpartum Vitamin A supplementation (low-dose for high deficiency pop)	Deworming	Pediatric iron supplements	MMS - MNP or tablets	SQ-LNS	Vitamin A supplementation (high-dose)	Zinc supplementation with ORS for children with diarrhea	Salt (iodine; DFS)	Food fortification: wheat; maize; sugar; oil; bouillon; rice
Type of change (new; modification of existing question; remove)	Currently in DHS; Add to MICS – Merge IFA/MMNS with slight modification	Add to DHS/MICS – Only for WRA/adolescents	Add to DHS/MICS – Merge IFA/MMNS	Not yet, but could be in DHS/MICS	Not yet, but could be in DHS/MICS	Not in DHS/MICS	Currently in DHS – Drop or move	Currently in DHS; Add to MICS Modify questions	Currently in DHS – change period and separate iron from MNP.	Not in DHS/MICS	Currently in DHS – possibly modify question	Keep – no change	Currently in both DHS/MICS. Modify question	Currently in core DHS/MICS. Modify to target foods in nationally fortified program
If DHS – for core or module?	Core	Core	Core				Core	Core	Core		Core	Core	Core	core
Describe change	Ask about any source of iron in one question, not just IFA; Add source; Potentially change asking for pregnancies during the past 2 years. Slight wording to include the option of MNP within brackets.	Source not likely needed unless program related; add source; don't worry about amt	Include in IFA/ Fe question				Consider drop for PW, may keep for children. May be better places somewhere else in survey other than the nutrition module.	Change time of question from 2 weeks to 6 months.	Currently DHS has 2 questions about consumption of iron/sprinkles 7 day recall. Would drop one to eliminate duplication. To align with international guidance would change recall to 6 period.	No existing programs at-scale, but should work on indicators so that will be ready to add once guidelines come out. Will likely be targeted?	We feel there is value in keeping survey indicators given weaknesses of administrative data. Might be ways of improving the question.		Adding a follow-up question for respondents who have no salt in household, and asking where it's from	Focusing on foods fortified as part of a national program and identifying where the food is from
Rationale	WHO guidelines linked to iron; others depend on local programming; source of interest;	Only in WRA where country guidelines of concern	WHO guidelines linked to iron; others depend on local programming	Need to specify when to include and how to measure 3-4 tablets/d			Current guidelines for pregnant women are to reduce worming. From a nutrition perspective,		Increase number of children captured.	Currently there are no guidelines for a preventative program. It is very expensive and unlikely			This follow-up question would distinguish between households that don't use salt vs. households	PMA2020 categories of where food is from is helpful.[1]

[1] 00's of countries have mandatory fortification of at least one food vehicle, and almost no information on who consumes that fortifiable food (potential for impact). This information is a critical part of understanding potential complementarity/ overlap of micronutrient approaches, and potential for impact within various population subgroups

	source can be of interest to governments; need to check how asking for pregnancy in the past 2 (or 5 years) would influence sample size.						it is less important however may be important to others.			to reach a lot of people.			that currently don't' have salt in their household.	
Population being asked about	PW, WRA/ AD	WRA/AD	PW	PW	PW	PLW	PW	Child < 5	Child < 5	Child < 5	Child < 5	Child < 5	HH	HH
Respondent for question	PPW, WRA/AD	WRA/ AD	PPW	PPW	PPW	PPW							Household respondent	Household respondent
Recommended wording	1. In the past 6 months have you taken any iron containing supplements ? 1b. (IF YES) Where did you get those supplements ? 2. In the past 6 months have you taken any folic acid containing supplements ? 2b. (IF YES) Where did you get those supplements ? For pregnant women, same wording but change to 6 months	See Iron or IFA.	DHS					1. Reword recall question about iron-containing supplements to be last 6 months (consume or get needs to be resolved) 2. If YES, what is the supplement (potential to only use this question in countries that have national programs) For programs that have MNP or iron, include subdivision of type of supplement provided by country. 3. If YES, ask source (purchased vs. provided – disaggregati					If someone responds "no salt in household" to HQ145, ask "Did you use salt in the household in the last week?" If YES, "Where did you get the salt from?" (PMA question) Add question "Did you use bullion cubes in the last week?	Did you or anyone else in your household eat foods with X in the past week? If YES, the last time your household got X, where did you get it from? Categories of responses (countries would select appropriate : a. Purchased b. Made at home or in the community c. Social program

	instead of pregnancy period.							on could include sprinkles)						
Evidence supporting recommendation														
Recommendations for data tabulation or display														
Other comments (including about methods, quality, etc)	Would need to ask the question specific to the formulation the country is providing to the population.	Folic acid came up 5 years ago during revisions because of the different formulations, pregnant women might not be able to know if their supplements have folic acid or not.		Develop list of parameters for when to include	Review guidelines as they come out	Identify why country is choosing to do this							Would want to develop a new rapid yes/no test for testing, which doesn't exist. There are concerns with the validity of this test. For salt samples testing positive, would want to explore the potential for shipping a sample for quantitative testing, but there are concerns about logistics.	
Priority Tier – I, II, III	I	I?	I	III	III	III	III	I	I	III	N/A	N/A	I	II
Other comments / notes	HHSurvey or Facility: distinguish what type of supplement Type II: Can "Nutrition" have optional pull-in/ out			Question whether enough countries have a program.				Concern that mothers don't' know whether sprinkles contain iron.	During the last revision, the time period changed from 7 days to 2 weeks. Would want to know who is	This should be explored for a different survey.			Recommend not using a rapid test to get a sense of PPM levels. This should be done with a special study. For	During the last round of revisions, a module on food fortification was rejected from DHS. Want to explore why

	questions on source vs core questions. Will have to look into how changing to 2 years would affect sample size.								actually using this data.				both fortified foods and iodized salt, need to conduct a complementary study linked to biomarkers to measure fortifiable levels (outside DHS/MICS).	it was rejected. New rapid test kits for other food vehciles should be developed, research priority

IYCF / Diet / Food Security Working Group Notes

Sessions 1 & 2

Working Group Chair: Laurence Grummer-Strawn and Megan Deitchler
Note taker: Swetha Manohar

Sessions 1 (85 min) & 2 (60 min)

Recommendations to improve the nutrition content of population-based household survey questionnaires

Overall summary of Day 1:

These notes follow the discussions that took place among members of the 'IYCF/Diet/Food Security' group. Please note that because of the nature of the indicators requested of this group to focus on, this group did not discuss indicators for consideration in facility-based surveys and focused solely on recommendations for DHS, MICS and other PBHS as well as related research priorities. As a result, the discussion on the first day was not as rushed and the group had more time to discuss the indicators currently available on IYCY/diet/food security and the general performance of these indicators in the field. Discussions on Day 1 ended with limited recommendations of specific indicators with an intent to flesh out recommendations further as well as research priorities during discussions on Day 2.

Attendees: Megan (FHI 360), Laurence (WHO), Alissa (HKI), Keith (HarvestPlus), Mimi (WB), Jenni (Tufts), Kirsten (USAID), Ellen (Gates), Carla (EU), Bo (MICS), Mara (USAID)

A. Identifying gaps in coverage data that are amenable to PBHS

- The moderators began this session with taking the lead to address the question below (what are current data available and which populations are they collected on).
- The focus was on the current data available, predominantly in DHS/ MICS surveys with trying to maintain closest attention to the highest priority groups which the moderators listed as 4 groups: IYCF for < 2 years, diets of 2-5 year old children, diets of women of reproductive age (WRA), and food insecurity.
- To capture diet in < 2 year old, 2-5 year olds and women, moderators suggested that indicators reflect intake of both healthy and unhealthy foods

Population	Broad focus of indicator

< 2 year olds	IYCF – healthy & unhealthy
2-5 year olds	Diet - healthy & unhealthy
WRA	Diet - healthy & unhealthy
Household	Food insecurity

- The moderators asked if the group all agreed to the embedding of healthy/unhealthy in each population group or if they felt this ought to be done differently
- CONSENSUS: The group agreed to the break down as is (healthy and unhealthy for child and women)
- Mention was made to make a side note/ "parking lot" comment that when interpreting data, keeping in mind seasonality is important.
- Questions about the age range for WRA – are we discussing younger girls since there is the issue of child marriage? Group agreed on the broad and established range of 15-49 years which allows further disaggregation by age group.
- Moderators comment that food insecurity was added to the group's plate later in the organization of this meeting.
- The group noted that there is sparse data on adolescents, especially with regards to dietary data. Specific indicators may not need to be identified but perhaps these groups ought to be a respondent group.
- If we are going to focus on adolescent children – are we talking about both girls and boys? 10-14, 15-19 year olds?
- What about men? Little work on metrics for men.
- It appears then that only 5-10 year olds and elderly are left out.
- Children 5-10 are important. But there is no standard methodology to measure their diet.
- What is it that we need to measure in terms of 5-10 year olds?
- For men, it may be more important to capture unhealthy foods.
- **Consensus: Let's leave groups as they are 0-2 year olds, 2-5 year olds 5-10 year olds, 10-14 year olds, WRA (15-49 year olds), men and come back to discuss these groups**

IYCF

- The WHO/UNICEF IYCF indicators are currently under review through WHO/UNICEF consultations. MDD and MAD were discussed in June in NY. A broader consultation was held in July in Geneva. The standard list of IYCF indicators is proposed to expand from 15 to 17 indicators.
- Larry summarized the indicators and described what changes to the core DHS and MICS would be required to implement them. The distinction between core and optional indicators is being removed since the data are already collected.
- A new indicator on supplementation in the first 3 days is being added. Data for this indicator already exist in MICS/DHS. The current skip logic may need to be changed in DHS, but this is under discussion.
- EBF in first the 6 months will stay as it is. While the indicator is problematic in terms of how it is measured, there are no good alternatives and it is widely used.

- Predominant breastfeeding indicator will remain. PBF allows for the infant to consume water-based liquids. Juice is currently permitted in the list of 'allowed liquids' when calculating the indicator, which should be not be the case for PBF. This would not require a change in questionnaire, only in how the indicator is calculated.
- A new indicator on mixed breastfeeding and other milk feeding is proposed. The data are already there, so no new questions are needed.
- Minimum Dietary Diversity was changed last summer to account for BF as a food group because before, the tabulation method penalized children who were being BF but not receiving another source of dairy.
- There are currently 2 indicators on continued BF. The recommendation from the consultation is to pool those indicators together, largely for sample size considerations.
- The calculation of Minimum Meal Frequency was mis-written in the IYCF indicators document, so corrections are being made. A slight change has also been proposed to ensure that at least one meal of complementary foods is consumed. No changes in the questionnaire are needed.
- Minimum acceptable diet will be changed based on changes on the previous 2 indicators (MDD and MAD) because it is a conglomeration of the previous 2 indicators.
- A new indicator on consumption of non-dairy animal source foods is being proposed. While unhealthy meats, like sausage or bacon, would count as an animal source food, there may be interest in separating these out.
- Three new indicators on unhealthy diet are proposed for addition: Sugar sweetened beverage consumption, Consumption of foods of minimal intrinsic nutritious value, and Lack of fruits and vegetables.
- For sugar-sweetened beverages, there was discussion at the technical consultations about creation of sugar sweetened beverages at home. This would require adding a new question about whether the respondent added sugar to beverages at home.
- Consumption of foods of minimal intrinsic nutritious value was another new indicator, but there are challenges with how to operationalize it. It is proposed to probe on 3 different distinct food categories (cakes and sweet biscuits, chocolate and confectionary, and fried starchy foods). These would be markers of unhealthy eating, not a comprehensive assessment of all unhealthy foods. How to collect information to capture data for this indicator is still under discussion, within WHO and UNICEF.
- Consumption of no fruits or vegetables in the previous day was a third new indicator to capture consumption of unhealthy foods for the infant and young child age group. This indicator does not require the addition of any new questions.
- No change in milk frequency and bottle feeding indicators.
- Age appropriate BF is a conglomeration so is actually being removed.
- Median duration of breastfeeding is also being removed. The MICS currently asks about continued BF up to 3 years in order to calculate the median duration. If the age range in the questionnaire is cut back to only 2 years, countries would not be able to calculate median duration.
- Consumption of iron fortified foods is also proposed for deletion as an indicator. The micronutrient group may wish to consider how to capture consumption of micronutrient powders or fortified food

Dietary intake of WRA

- Megan walked through the *current state of knowledge for this group* even if not comprehensive.
- Most work has been done on WRA so focused on this group.
- MDD-W (minimum dietary diversity for women) is a food group indicator. It is binary where if a woman achieves 5 or more food groups out of 10, it reflects a minimum dietary diversity being met. Research has been done with a number of datasets across different seasons and countries. The results show the indicator has good prediction at a population level, with women consuming 5 or more food groups out of 10 being more likely to have consumed a diet of higher micronutrient adequacy than those who consumed less than 5 food groups out of 10. The metric has been used since it was adopted in 2014 routinely in USAID's Feed the Future (FtF) and Food for Peace (FFP) surveys, recently in a MICS survey in Tajikistan and the country's national surveillance system. It is in the LSMS in 1 country (Tanzania). Other platforms have used it too.
- MDD-W is not incorporated in MICS or DHS.
- Ongoing initiative that Gallup World Poll is undertaking to understand diet quality i.e. coming up with metrics to evaluate diet quality in 140+ countries – low, middle and high income. World Poll has about 1000 per country in terms of sample size so we should not think too much about disaggregating.
- They randomly select one individual in the household who is the respondent who is 15 years or older using Kish grid model. These indicators pertain to WRA but also include men and adolescents 15 years and older. They are trying to develop a food list method (of apprx. 23 food groups) used in the instrument and it allows to capture different elements of diet quality (MDD-W but also indicators based on guidance reflected in the WHO healthy diet fact sheet).
- It is funded by the Swiss and GAIN, and possibly other donors as well. So far the work they have been doing is secondary data analysis of national datasets for Brazil and the US looking at quantitative 24 hour dietary recall data as a gold standard for developing a set of proxy indicators. Their hope is to do this with more national datasets to reflect different country contexts, but they do not currently have the funding for this. They are looking to develop a gold standard for healthy and unhealthy food groups that are predictive of diet related NCD-risk. The set of food groups that they are proposing to use to collect the indicators will also allow for tabulation of the MDD-W indicator amongst others. Anna Herforth is leading this work; when last consulted with her about the effort she said they were in the middle of the analysis and thus do not yet have clear recommendations about indicators to recommend.
- The model MDD-W questions include unhealthy food groups. However, groups are examining how these may be associated with risk of NCDs. Some of these details are unclear as there are ongoing meetings to tease this apart.
- A point of clarification about this effort - They are trying to derive a set of indicators in the healthy and unhealthy bucket. They plan to incorporate the MDD-W, so the food groups would allow one to calculate the MDD-W (to represent a proxy for a diet higher in micronutrient adequacy) and healthy and unhealthy intake. They plan is not to stretch the MDD-W to other population groups but instead just tabulate a mean score for groups that are not WRA.[1]

[1] This was the common understanding at the time of this consultation. However, the technical advisory group for the Gallup work met one week later and this point was brought into question.

- Intake released an RFP earlier this year to support creation and validation of an indicator of dietary quality for non-pregnant, non-lactating women of reproductive age in low- and middle-income countries. Just to keep in mind since work will take place in the next 2 years.

Children (2-4 years)[2]

- Megan walked through the *current state of knowledge for this group* which is less developed in terms of the scope of indicators available in this demographic group. DataDENT helped with pulling some research on indicators for this group. Some of that research suggests that both MDD and MDD-W work equally well in predicting micronutrient intake.
- Predominantly, what seems to be used is a dietary diversity indicator for this age group
- The DHS used to collect data in children <5 but now data are only collected on < 2. There are no recommended indicators for children 2-4 years old.
- DHS is very indicator driven and is more interested in what indicators are needed than simply in recommending questions to ask.
- Including 2-5 year olds in diet assessment is costly since it takes a long time to go through a proper dietary intake/ 24 hr recall. It may be better target certain surveys instead of using MICS or DHS for this age group. It may be that there are no indicators for this age group because there isn't consensus that this group is important or how to address it.
- We can park this but also possibly we want to discuss later about designing large scale nutrient interventions: understanding nutrient intake or diversity of a population.
- This may also be a 'parking lot' issue but something USAID has been looking at consumption of wild foods which is of intersectional interest in terms of intake of wild animals, food security issue, resilience issue. It has implications for data collection and really all it is an issue of disaggregating, are you eating wild or domestic animals, etc. It is important because as people eat these wild foods you will lose biodiversity and you also lose iron source foods.

Lunch being served so wrapping up

Food insecurity

- Larry went through *the current state of knowledge* for this group
- FAO recommends use of the Food Insecurity Experience Scale (FIES). All the examples shared with us from the different HH surveys are based on FIES. Other indicators of food insecurity are commonly used in emergency settings, including the Food Consumption Score (FCS) or the Consolidated Approach for Reporting Indicators of Food Security (CARI).

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[2]There was some discussion over whether this group is best represented by 2-4 or 2-5 years. The group agreed that they were all referring to the same age span, just disagreeing over how best to reflect that in language. For precision, this referred to indicators for children 24-59 months of age.

- FIES uses a series of 8 questions that get progressively more severe. FAO reports on the FIES in the annual State of Food Security and Nutrition in the World report. This report has been limited by the inability to connect household food insecurity to nutritional outcomes.
- 8 questions are a lot for a DHS survey to incorporate and it could be a hard sell. In Larry's discussions with FAO, he was told that depending on the country, it may be possible to drop some questions. It may be possible to use the first 3 questions as a screener because if the respondent says "no" to the first three questions, they are unlikely to say "yes" to any of the next 5 questions. In terms of prevalence of moderate to severe food insecurities, maybe 10-15% of respondents would need to go through the whole module. So, this might be an option- a modified, shorter module of the FIES for incorporation into the DHS, MICS or other PBS.
- FIES was adopted as the food insecurity indicator in the SDGs.
- A problem with FIES is that it cannot be computed in the country. FAO has been leading efforts on analysis. Data are collected and sent to FAO to conduct the Rasch modeling to create the standard indicators and calibrate them for use across countries. FAO has provided the programming to USAID/DHS to be able to perform the Rasch modeling. The group recommended that routines be developed so the FIES can be computed in-country.
- The HFIAS indicator (a precursor to the FIES) could be hand calculated. The Household Hunger Scale (HHS) identifies a core set of questions from HFIAS that are culturally comparable and can be used across the countries. One of the benefits of the HHS is that it is shorter but one of the drawbacks is that it really only captures the most severe level of food insecurity (i.e. "hunger") and so people interested in being able to discriminate are not able to do so. And countries are interested in capturing the distribution.
- The FIES allows for tabulation of moderate and severe food insecurity. The HHS questions are essentially the last 3 questions of the FIES, capturing only severe food insecurity or hunger (hence the name Household Hunger Scale).
- HHS was used in certain low-income countries, and it typically shows moderate levels of hunger but in less food insecure countries, like Guatemala, it showed very little hunger.
- FIES was developed to be global…including high income countries. That's quite a broad scope of contexts it is meant to represent and reflect food insecurity levels for. It may not discriminate very well for the purpose of highly food insecure countries. Also, the HHS focuses on a 30 day recall period and frequency of food insecurity experiences during those 30 days as a way to discriminate. The FIES, in contrast, uses a 12 month recall period but no frequency. Both indicators capture similar concepts but with different underlying principles.
- The group considered that maybe FIES is more for another survey instead of MICS and DHS because otherwise it may take the real estate space.
- We may want to recommend FIES as an indicator that is included in a specific survey

A2. For the priority coverage data gaps, which of these are best suited measurement by:

a. **Modifications or additions to the DHS* or MICS (*Differentiate between: DHS Core & DHS Modules)**
b. **Modifications or additions to type of national/large-scale population based household survey (PBHS)?**

- What do we want to prioritize?

0-2 year old: IYCF

- A good overview has been given about IYCF/WHO indicators, and the WHO/UNICEF consultation in July 2018 led to a number of recommendations for indicators for children for 0-2 years. There is a lot of working going on globally on this, so we may be able to let our recommendation be that we default our recommendations be that we recommend whatever WHO/UNICEF comes up with for IYCF indicators for the 0-2 year age group.
- Group agrees but do not want our strong recommendation about this group to drop off when reporting our or in the notes because we are not discussing this in detail.
- For clear documentation: group would like to go with the WHO/UNICEF guidance for 0-2 years for IYCF indicators – DO NOT LET THIS DROP OFF OUR DOCUMENTATION.
- Concern was raised about the recommendation to delete the indicator on median duration of BF. Not having data up to 3 years of age may be problematic.
- Concern was also raised that some of the new IYCF indicators have not been validated. Are we ready to move ahead on these as Tier 1 indicators?
- There was disagreement about the extent of the work involved when changing indicators even if the questions are not changed.
- Asking about liquid or supplementary foods in the first 3 days is a difficult question in the field. There should be a careful examination of the questions about experiences around the time of birth.
- There was considerable discussion on whether the list method or spontaneous 24 hr recall is the better method. There is no gold standard for dietary recall for this age group. FAO has received funds to validate the list, open recall approach and a quantitative 24 hr recall to ascertain which method is best when testing data collection for the MDD-W, so there is some of this work going on.
- When thinking about the work FAO is doing, it was brought up by HKI that unhealthy foods are not part of their analyses because those are not listed in the datasets they are working on. But HKI has these foods to compare what was reported spontaneously versus what was reported upon probing so that could be shared.
- Based on survey implementor experience, the item based approach was terrible in terms of field realities based on interviewer experience and survey experts. Once they switched to open 24 hr recall, it was a 100% better.
- Would be good to see when we switched from item based to 24 hr recall to see what differences are. CSPro will do this very easily – ICF did this.
- MICS and DHS different BF question – why do we do it differently? It would be great to just have one approach of what exactly works.
- **What is the consensus for IYCF 0-2 year old children?**
  Consensus is that they are Tier 1. But research to improve how it is collected is important.

Women (WRA)

- Over the past 5 years, there has been considerable development and research on MDD-W. In the revision of the DHS 5 years ago, the MDD-W was suggested for inclusion in the core module of the DHS, but decision was made based on space to not include. So, if we want to include, we need to

have a strong justification with lots of support. The DHS has actually collected the data on food group consumption for WRA before the MDD-W was developed/validated.

- The group felt that we should include healthy and unhealthy components for dietary intake indicators.
- The group discussed various issues on the length of the dietary assessment. The more you add, the more the quality of the questionnaire deteriorates. 24 hr recall 10 minute piece is hard. Can we just pick one woman and one child in each HH to respond to these recalls? It's complex, but generally, the issue is just respondent fatigue. LSMS modules for Food for Peace can take 3-5 hours. Respondent burden is definitely an issue. Can the food list be shortened to just a 1-2 item list?
- There is a huge gap in the knowledge of everyone other than children<2 eat in the world. It's important to recognize that gap. Maybe DHS and MICS survey platforms aren't the best ones to capture this but it is needed somewhere. Data collected in other surveys and be triangulated instead of overburdening the same surveys.
- Household expenditure on food is an alternative approach to understanding consumption. These data could feed into understanding NCD prevalence, programs and related decisions. However, data at the household level does not describe individual level feeding behaviors. The data may be more meaningful for food security than diets.
- Consensus: WRA does need an indicator, likely MDDW but we have not confirmed for sure which indicator for sure. Concern that there is a respondent burden and should be noted.

B4. Proposed modifications to DHS*/MICS questionnaires (*Core or Modules)

Plenary: Report out

- Expanded work to understand how important diet is
- Expand demographic groups to 0-2, 2-5, 5-10,10-14 (boys and girls), 15-49 year old populations
- Want to support WHO/IYCF for 0-2 year old children but also there are recommendations about how best to collect this information. There are 5 indicators to be deleted but there other that have been added. Some concern expressed about removing the ability to calculate the median duration of breastfeeding indicator.

- These are recommended as Tier 1 indicators but to note there is some work to be done to identify how best to collect data for some of the new indicators recommended (particularly, of unhealthy diet patterns).
- Respondent burden is an issue of concern that was discussed at length
- The group did not fall squarely on which indicators and at which level/tier to include most indicators as much time was spent discussing the lay of the land in terms of indicators available.
- MDD-W is the indicator we are thinking of to recommend for WRA.
- Funders might want to prioritize funding research to look at methods to look at how best to collect this data and validate indicators
- Gallup World Poll is developing indicators of diet quality, and unhealthy food consumption. These indicators would be appropriate for individuals 15 years+, and would help to fill the gap of dietary data on men. The work to develop those indicators is underway. INTAKE is also supporting work to develop indicators of diet quality, this effort is just beginning.
- HHS, FIES, HFIAS, FCS are being considered as household food security indicators to recommend.
- We recognized different survey platforms could possibly collect some of these data better than others.
- LSMS is collecting certain household level data related to consumption that can be used for the purpose of research that can be drawn from.
- IYCF indicators: the biggest change to note is that we have added consumption of unhealthy food for children under two years of age (SSB, junk foods). We are having discussions as to how to include these questions across the different populations.
- Audience: Do we have a sense of how far along we are with asking these new questions related to IYCF and FIES? Answer: We think we are ready to include by the end of the year and have the wording of questions ready.
- Audience: Is there a way to add additional foods to the food list questions to specify which foods are iron-rich or Vitamin A rich foods. Countries need clarity on the RAE criterion to classify a food a vitamin A rich. Answer: In the WHO/ UNICEF IYCF indicator measurement guide, it does include a list of Vitamin A rich and iron-rich foods to use when working in country. However, details about specific nutrient content is not provided.

IYCF / Diet / Food Security

Sessions 3 & 4

Working Group Chair: Laurence Grummer-Strawn and Megan Deitchler
Note taker: Swetha Manohar

Sessions 3 & 4 (85 min) & 2 (60 min)
Recommendations to improve the nutrition content of population-based household survey questionnaires and defining research priorities

Overall summary of Day 2: Discussions started off with revisiting the priority coverage data gaps, prioritizing indicators for inclusion into MICS, DHS and other PBHS and, research priorities. The discussion did not follow the DG template outlined thus notes more so reflect the discussions which did follow a clear linear order to reach consensus. Moderator discussed how SPA surveys may not be appropriate for dietary intake indicators so perhaps to focus on PBHS.

- Moderators review the following with group:
  A1. What are the priority coverage data gaps?
  - Children < 2y : unhealthy food consumption (no information), growing concern globally
  - Women RA: No data on food consumption (incomparable indicators used in different types of research/ survey)
  - Food insecurity: Limited availability (big gap), no standard indicator use

A1. Revisiting Prioritization of Proposed Changes
Review changes for three different types of surveys & reconsider Tier I, II, III prioritization

B4. Proposed modifications to DHS*/MICS questionnaires

C6. For coverage data gaps better addressed in other types of PBHS

- To move forward, moderators proposed an approach to address these gaps in the DHS/MICS:
  I. Sub-divide child food list to capture unhealthy foods (e.g. splitting out cakes and cookies and pastries)
     Moderators list this is as a 'Moderate size change'
  II. New questions on MDD-W including unhealthy food groups
     Moderators list this is as a 'Large addition/change'
  III. New questions on FIES (with possible proposal to skip last five questions if response to the first 3 questions are "no")
     Moderators list this is as a 'Large addition/change'

- Looking to group for consensus….do the recommendations above reflect our discussions? Yesterday, our groups was being considerate of respondent burden and quality, but today we should be able to present actual modules/indicators to put forward, so they can compete with other proposals. These indicators above reflect well-established indicators.
- What's not included is other age groups (2-5 years, 5-10 year, adolescents and men are not included as a population to collect data on)

Food insecurity

- For FIES, it is being recommended because of the SDG. The inability of countries to analyze their own data is a concern, though. FAO has expressed willingness to help, so perhaps put this back on FAO to figure out how countries can process their own country data.
- FIES is validated on the basis of all 8 questions. The proposal to skip the rest of the questions if the first 3 screening questions are answered "no" has not been validated. Respondents answering "no" to the first 3 questions are not likely to answer positively to the next set of questions. FAO could test this proposal very quickly.

Distinguishing home-prepared and commercial foods

- The group discussed the need to distinguish between unhealthy foods that are home-prepared and commercially prepared, since interventions are different depending on the source of these unhealthy foods. The proposed WHO/UNICEF IYCF indicators do NOT make a distinction between home-prepared and commercial foods because from a dietary intake perspective you will not make a distinction between those two groups. The group pushed back since there are issues with these different sources which relate to quality of diet. We need to consider context. For example, in Nepal, all children are going to consume pan fried potatoes, but this is different from French fries. Asking about packaged foods could help, but it is complicated. For example, sugar and flour are packaged. The ARCH project did make these distinctions, but it is too much to undertake for DHS/MICS surveys. Processed foods may also reflect foods have been fortified.
- At the end of the day, we are looking for trends and patterns in diet quality. Understanding the penetration of processed foods into the diet would relate more to policies and decisions related to food environment and marketing of foods.
- It is valuable to see why we are seeing healthy and unhealthy practices but given real estate on the questionnaire – we might not be able to assess. This is similar to not getting to why ASF are not consumed for example. Purpose of DHS is to ascertain how bad is this problem and whether it is changing over time.
- Perhaps another survey platform is where this further categorization can move to.

- PMA 2020 includes additional questions related to whether unhealthy foods (sugar foods and savory snacks) consumed were prepared by local vendor, made at home, or processed packaged.
- Based on debrief, the PMA surveys showed good variability in the response – Burkina Faso and Kenya trialed these questions and it went well. Sometimes not helpful when 100% of kids were eating sugar-sweetened foods but which is why asking these additional questions allow you to establish some granularity. But then we need to have a target of where to go from there. In order to use this data, we need to know if it was packaged, local prepared/purchased, or made at home, etc.
- It is important to include and think about because even if this data is used for advocacy purposes, you need to know where to go from there. A suggestion is that with these questions: sugar foods, SSB, savory snacks – was it homemade, packaged, or locally prepared/purchased perhaps this data can be looked at carefully to see if the granularity was helpful because the first surveys did not include these groups and the second did so these can be compared. This is research that can be done quickly and can be a research agenda.
- This extremely valuable but then this would be a major change to the existing questions and indicators and perhaps this is a research agenda.
- But this is just an additional 3 questions
- It's not just 3 additional questions, there are survey instrument considerations. For list based approach, you don't need to revisit for each item. But for open recall, this is a better approach, you would need to go through each potato item, you need to ask how it was prepared – 24 hourrecall.
- But what do we want to do with healthy/unhealthy indicator? It has more to do with changes in food systems, etc. and if we think about the double burden, it is likely that this unhealthy consumption is coming from processed foods. It is less likely to do with sugar in tea that mum made which is a home based intervention. But if it is packaged food – then we can point to industry. The power of these additional questions/ granularity is being able to point to industry. But the question is what are we looking at dietary patterns or…
- Ideally both dietary patterns from home or street vendor or grocery store. Looking at PMA 2020 data, if consumption of all unhealthy foods is high…. what is the point of asking without granularity?
- If we are to add, it is not adding 3 questions (referring to indicators for 0-2, MDDW and FIES)
- The case is made for marketing of food for children for IYCF being a policy response for which this collected data can reflect adherence.

Survey burden

- What about MDDW? What do we want to know about this? Do we want unhealthy foods?
- So, if we are saying to include unhealthy foods 0-2 children, MDDW and then separately also including FIES, it is likely more adding 16 questions in terms of the instrument.

- Are we collecting unhealthy foods + 3 additional questions on source from kids and women?
- Perhaps too much of an ask to collect on both and perhaps just focus on kids.
- Kids versus women - why prioritize? Why collect the unhealthy food data from kids versus women, if we have to pick?
- Very high consumption in 2-5 year olds (double as younger children) and that is why PMA wanted to understand where that was coming from. Also, very high in the rural areas. Women's data reflected 5-7% of unhealthy food intake…need to look at round 1 first.
- What kind of information are we losing as we do not collect snack food for 2-5 year old children?
- We are losing lot because we are not capturing these kids, but we need to prioritize for a survey like DHS.
- The reason that we don't have data on this age groups is because we don't have an INDICATOR for 2-5 year. Do we want to consider then 0-2 year olds, collect information on source of unhealthy foods?
- Feed the Future calculate all children under-five because they need to know. They don't calculate an indicator but have this information.
- Would be useful to have data on 0-5 years.
- It would take a lot of time under five.
- Could we just get this information on most recently born child?
- But this is adding
- Not supposed to discuss sampling, would be good to randomly select child. But issue will remain that there is not validated indicators for 24-59 mos.
- So maybe development of an indicator is a Tier 2 or 3 indicator.
- Would it be better to use a different indicators like MDDW?
- But perhaps within DHS/MICS we recommend a module 2-5 year can be offered (countries can decide whether they want) even if the indicator is not validated.
- A diet module perhaps?

Biofortification

- Could we consider adding some reflection of biofortification because the other group did not want to consider biofortification as a type of fortification because it is not captured right now. They should be captured in the food lists or add question to about it or add a question.
- Has this tried to be done with Harvest Plus? Lots of donor money for biofortification programs, very little coverage data.
- This might work well as a dietary module for those countries have scale.
- Can we collect this data beyond crops that are visibly different in color? Hard to include for non-visibly biofortified foods as indicators need to be developed
- Biofortification projects are being asked to tack on to other surveys to establish coverage data.

- Orange fleshed veg, color maize – could be explicitly added or added in a dietary module.
- Biofortified crops in 30 countries now but are in 60 countries. Mainstream breeding into programs already existing. For something to be successful.
- The ability to track biofortified is important but perhaps asking about these foods deserve further consideration. One can add it to the list of foods if using list method to ascertain intake.
- Important to have color cards in the field when administering these questions as aids.
- People agree with this, especially those groups focused on ag-nutrition and resilience projects.
- Might be best to capture consumption of biofortified foods, in specific countries, where relevant/appropriate, through adapting the questionnaire for country-level use
- Some discussion about staple biofortified versus non-staple foods and how to consider this.
- This level of specificity might not be best, a note needs to be made that this is piloted and done elsewhere.
- Need to wrap up to move forward to discuss other issues.

Questions that could be deleted

- Deleted questions for consideration:
  DHS
  Q470. Bottle feeding for all children under 5 (skip logic needs to changed)
  Q652. Do not need this question for children < 6 months of age
  Q653 Do not need it in children < 6 months of age
- On Q 650, we go into a lot of details on what solid foods children are eating. But we don't need this detail for infants <6 months old. Indicators on quality of diet are for children 6-23 months old. We could just ask about whether children eat solid/semi-solid foods, so we can save time. The group felt this is a nice idea but needs validation. EBF is an important indicator so we need to be careful about changing the data collection on it.
- In MICS, the probe about ORS or medications could be removed. However, it is important that these are not counted in "other liquids" so it may be necessary to retain the probe.

Quantitative dietary data

- While quantitative information on diet intake may not be possible in DHS or MICS, they could be incorporated into other population-based household surveys. Quantitative dietary data are generally lacking and there isn't an existing global survey platform.
- What is donor appetite on global quantitative dietary surveys? There may be a need for a standalone nutrition survey. The micronutrients meeting on Tuesday proposed a micronutrients biomarkers module for DHS. If countries want it, they can demand it.

- Gates is not likely to invest in a global platform on collecting data even if there is a desire to see more information on dietary intake and quality. Demand has to come from countries, but it is unlikely unless there is a collective effort that one donor alone would take this up by themselves.
- If there was a global investment from many different donors, it might be considered.
- One aim of INTAKE's is to improve quality of dietary data for large scale surveys in low and middle income countries that are interested in collecting quantitative dietary intake data..
- How much time does it take for 24 hour quantitative interview – it takes about 2 hours to do it well per person.
- LSMS conducts multiple household visits in order to reduce respondent burden in a single interview. This could be a model for collecting more extensive nutrition data without lengthening the DHS or MICS core questionnaire. World Bank reported that this is expensive. But respondents prefer an interview of 2-3 hours instead of 6-7 hours. In urban areas this more of a problem but they have shorter modules, because they are not producing. Interviewer teams stay longer in the area for 3 days + when they spread out the interviews. They don't leave till they finish. There are issues of finding the respondent for a second interview.
- **Consensus: Other PBHS could/should have a quantitative dietary assessment but it will take careful consideration and work. Quantitative dietary data is not appropriate for DHS/MICS but could potentially be linked to these surveys.**

B3. Specifying research agenda.

- Moderator summarized key research issues that have come up:

  1) From FIES- research to explore skipping the last 5 questions if the answer to the first 3 questions of the FIES is "no".

  2) Compare and validate list-based or open recall approach on food consumed (research currently planned by FAO in relation to the MDD-W).

  3) Develop/validate an indicator of dietary diversity and unhealthy eating for children 2-4 years old.

  4) For the EBF indicator and related questions – confirm if asking directly about sold/semi-solid consumption in first 6 months is sufficient.

  5) Use CAPI data from earlier surveys carried out to conduct analyses of time taken to ask nutrition/dietary related questions, to inform where there may be challenges/bottlenecks to be addressed, or where further gains in efficiency might be possible. Anything else?

- Biofortified foods to be added as a note to include when adapting the food group lists in countries where there has been large scale biofortification introduced. For consideration for research:

comparing methodological recall 7 day or 24 hour recall for biofortified foods and ascertain if there is a different because is there a concern of underestimation if only asking about past 24 hrs. A comment was made that back in early 2000s some work was done to compare recall periods, they landed on 24 hour recalls. A one day 24 hour recall is not meaningful when you think about it at an individual level but at a population it is fine. Also, asking about foods using a 24 hour recall but for specific foods asking about a week's frequency is confusing to respondents and would take additional foods.

Report out

- Did not focus on facility based surveys and focused on PBHS.
- We had identified many demographic groups that could benefit from having dietary data, but narrowed things down.

  Major gaps
  - For children < 2 year old: not collecting data on unhealthy food consumption (recognize many children are eating processed foods), need to capture, monitor and track
  - WRA: no information on consumption on healthy or unhealthy foods
  - Food insecurity: Limited data available (SDG indicator) - not currently collected in major surveys, collected in different and inconsistent ways

- Recommendations

  Tier 1

  - Children < 2

  Sub-divide child food list to capture unhealthy foods (further subdivide foods captured in questionnaire and source)
  Indicators: No fruits & vegetables , sugar sweetened beverages, junk food
  Recommend that: DHS/MICS collect

  - WRA

  New question on MDD-W, which is developed, validated and has been collected in many different country contexts; when collecting MDD-W, recommend to also include unhealthy foods
  Indicator: MDD-W
  Recommend that: DHS/MICS collect

  - Food insecurity

Include FIES validated tool with 8 items developed by FAO. It has been used and is validated.
State of art to collect food security across countries DHS/MICS
Recommend that: DHS/MICS collect

Recommend deleting

Bottle feeding does not need to be asked to all children, just children under 2 years of age (DHS)
Delete frequency question asked about sold/semi-solid foods for <6 mos (DHS)

Tier II

- Quantitative dietary assessment: recognize that qualitative assessment of diet does not provide granular information, explore opportunities for piggybacking periodic quantitative dietary assessment surveys onto other platforms (other pop based health survey)

Tier III

- Consider 2-5 years old children: consider application of dietary assessment question to all children < 5. Could be considered in an expanded MICS or DHS module.
  Research would need to be carried out to explore the most appropriate dietary diversity indicator for this age group, but the food groups for MDD-W or MDD might provide a good starting point; In addition, the food groups to be used for unhealthy diet for children 6-23 months could likely be used.

Discussion about how useful these indicators of healthy and unhealthy are and that there is still a need for quantitative dietary intake data perhaps looks for opportunities to piggy back to other PBHS.

4B. Research agenda

- Explore ways to gain time efficiency
- Test FIES with using first 3 questions as a screener for other questions. This is question for FAO perhaps.
- Additionally, another question for FAO is the need for software for in-country analysis of FIES and how capacity building efforts might need to be targeted to countries analyze FIES data
- Test if probing on solid/semi-solid foods could be shortened for infants <6 months
- Explore if it would be possible to drop asking about vitamins/medicine in MICS for tabulation of EBF

- Develop and validate indicators of dietary diversity among children and adolescents (note: this relates to the new WHO guidance on dietary guidelines for adolescents)
- Develop and validate indicators for children 24-59 months of age.
- Look at open recall vs use of a list based approach for collection of dietary data (FAO is doing in relation to MDD-W)
- We agreed that adding additional questions to gain granularity on source of unhealthy foods should be explored: processed packaged, local vendor or home prepared.

Some ongoing research that we should note:

- Gallup study on indicators of diet quality in those 15 years and older which would be applicable to men also as well as women.
- INTAKE is also supporting work to develop and validate indicators of diet quality for non-pregnant, non-lactating women in low- and middle-income countries

Other points reported out on:

Audience:

Q. What is the purpose of capturing 24 hour vs 7 day recall for unhealthy food if you are trying to track changes over time in consumption?

A. The data is not meant to be representative at individual level so 24 hour recall should be fine. We also did not want to confuse respondents with the use of a different recall period. In addition, when look at a 24 hour recall period for the consumption of unhealthy foods for 2-5 years olds in Burkina, intake was already so high from a 24 hour recall that if we had a 7 day recall, it might just be at 100% which might not be useful to us.

Q. Why delete the meal frequency indicator?

A. Currently, the question on semi-solid, solid meal frequency is asked of all caretakers with children <24 months. We are only proposing that this question does not need to be asked for children <6 months, since they are not included in the tabulation of the minimum meal frequency indicator. The deletion proposed would not affect the tabulation of the minimum meal frequency indicator.

Q. For FIES, there is an option for recall periods – 3, 6 and 12 months, which do you recommend?

A. We did not discuss the recall period we would recommend for FIES, but the standard is 12 months. It is sometimes modified to capture seasons which is hard, but Feed the Future uses 12 months; this might be a point for further discussion. [i]

Q. There might a research question because for recall period tucked in there for FIES. Generally, am in support of including FIES but Gallup already collects foods security data so what would be the justification? One justification might be because of links with child development. Regarding the analysis issue, the data needs to be calibrated post data collection and so don't know how this is global priority.

> A. Gallup is collecting now but this is being phased out. It is an SDG indicator and so it is important to include but points related to analysis are taken.[1] Retaining the 12 month recall period may be important to ensure comparability across countries.

Comment? Lots of discussion on unhealthy food source (locally made, home-made, purchased) – this is a Tier 1 recommendation.

Annex A: Note taking template for proposed modifications to DHS/MICS questionnaires [2]

Intervention or practice	**IYCF indicator (healthy and unhealthy)**
Type of change (new; modification of existing question; remove)	Modification
If DHS – for core or module?	Core
Describe change	Further split categories of foods/beverages consumed to identify unhealthy foods consumed (specifically foods of minimal intrinsic nutritional value and sugar sweetened beverages)
Rationale	To track trends in consumption of unhealthy foods that are reflective of changing food environments and systems, and pose a risk for healthy growth and development
Population being asked about	Children under 2 years
Respondent for question	Caretaker of child

[1] As a follow up to this, at a recent meeting with Gallup, they reported that the initiative to collect the FIES through the Gallup World Poll was a 5 year initiative which has reached its end. In other words, the FIES will no longer be collected through the Gallup World Poll unless there is another infusion of funding/donor support, which does not appear to be the case at this time.

[2] These templates have not been thoroughly edited. If they are to be submitted to DHS, more specific technical detail and justification/rationale should be added and a more thorough edit should be done.

Recommended wording	Per WHO/UNICEF guidance on the revised IYCF
Evidence supporting recommendation	WHO/UNICEF have convened meetings to review the list of standard IYCF indicators in use and have included this change
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc.)	
Priority Tier – I, II, III	Tier I
Other comments / notes	Include source of unhealthy foods to questions asked about unhealthy food intake

Intervention or practice	**IYCF indicators for all children under 2 years**
Type of change (new; modification of existing question; remove)	Modification
If DHS – for core or module?	Core
Describe change	Include all modifications suggested by WHO/UNICEF taskforce that is currently reviewing these indicators; though some deletions proposed by WHO/UNICEF (e.g. deletion of ability to calculate median duration of breastfeeding) might warrant further discussion.
Rationale	To update the IYCF indicators to reflect most up-to-date guidance from WHO/UNICEF, and other stakeholders, based on experience collecting data on the indicators and interpretation of the data.
Population being asked about	Children under 2 years of age
Respondent for question	Caretaker of child
Recommended wording	Per WHO/UNICEF guidance on the revised IYCF

Evidence supporting recommendation	WHO/UNICEF have convened meetings to review the list of standard IYCF indicators in use and have included this change
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc.)	
Priority Tier – I, II, III	Tier I
Other comments / notes	

Intervention or practice	**Dietary intake among WRA**
Type of change (new; modification of existing question; remove)	New
If DHS – for core or module?	Core
Describe change	Include questions to tabulate MDD-W, as well as questions to report on unhealthy foods consumed
Rationale	To track trends in consumption of dietary diversity, as well as trends in consumption of unhealthy foods
Population being asked about	Women of reproductive age, 15-49 years
Respondent for question	Women of reproductive age, 15-49 years
Recommended wording	Per FAO/FANTA guidelines
Evidence supporting recommendation	Validated indicators with supporting peer-reviewed publications
Recommendations for data tabulation or display	

Other comments (including about methods, quality, etc.)	
Priority Tier – I, II, III	Tier I
Other comments / notes	

Intervention or practice	**Food Insecurity**
Type of change (new; modification of existing question; remove)	New
If DHS – for core or module?	Core
Describe change	FIES
Rationale	To track food insecurity in a nationally – representative sample but also be able to compare food insecurity across different country contexts
Population being asked about	Household members age 15 years and older[3]
Respondent for question	Household members age 15 years and older
Recommended wording	Per FAO guidelines

[3] This needs to be checked with FAO if used in the Gallup World Poll. It can likely be used unless a new set of calibration models were used for different respondent types/ages (since one could expect responses to vary by demographics such as age/sex, etc.). For the calibration across countries to be most accurate/correct, all things related to whom/how the questions are asked should be held constant.

Evidence supporting recommendation	The indicator has been adopted as a SDG.
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc.)	Computation of this indicators needs to take place externally i.e. most likely outside of the country. FAO has supportive programs to compute this indicator, but data needs to be first calibrated to allow for cross-country comparisons. To advocate for inclusion in MICS or DHS, it would be recommended that FAO provide the tools/training to allow for countries to tabulate the data themselves.
Priority Tier – I, II, III	Tier I
Other comments / notes	SDG indicator

Annex B: Note taking template for proposed modifications for other types of PBHS

Intervention or practice	Quantitative dietary intake
Suggested survey type(s)	Other PBHS
Type of change (new; modification; removal)	New
Describe change	Add a quantitative dietary intake module to a PBHS. This data could support other data collection platforms like DHS and MICS to provide complementary data, on a periodic basis
Rationale	Exists a need for quantitative dietary intake data, data gap
Population being asked about	Children, WRA, men, adolescents
Respondent for question	

Recommended wording	
Evidence supporting recommendation	
Priority Tier – I, II, III	???
Other comments / notes (including about methods, quality, etc.)	

Intervention or practice	Dietary intake for 2-5 year old
Suggested survey type(s)	DHS/MICS
Type of change (new; modification; removal)	New
Describe change	Develop indicator for dietary diversity and unhealthy eating among 2-4 years olds
Rationale	Data gap for this age group, no validated indicator
Population being asked about	Children 2-4 year olds
Respondent for question	Caretaker of child
Recommended wording	
Evidence supporting recommendation	

Priority Tier – I, II, III	Tier III
Other comments / notes (including about methods, quality, etc.)	Consider testing the food groups for MDD-W and MDD (excluding Bmilk) for this age group, and exploring “best” cut-offs

Annex D: Note taking template for Research Agenda

Topic area / intervention/practice	*Please see notes*
Research Questions	
Applicable to which survey type(s)?	
Rationale – how will data be used?	
Scale required	
Researchers or institutions working in area	
Potential opportunities / recommended contexts	
Other comments / notes	

[i] As a side note, if the recall period is adapted from the standard 12 months that this would need to be discussed with FAO. Because, the calibration for cross-country comparative results that FAO carries out assumes implicitly that a standard recall period (12 months) is used.

Child Growth Working Group Notes

Sessions 1 & 2

Working Group Chair: Edward Frongillo
Note taker: Quinn Marshall

Sessions 1 (85 min) and 2 (60 min)

Recommendations to improve the nutrition content of population-based household survey questionnaires.

A. Identifying gaps in coverage data that are amenable to PBHS

The Working Group began with a short discussion about whether there were any missing interventions in our assigned list:

WG Discussion points:

- The Working Group noted that birthweight and low birthweight not well featured in the existing population-based household surveys.
- The group discussed whether interventions addressing overweight, obesity, and the double burden were covered in the existing surveys, anticipating that these may become more important issues moving forward. There was recognition that weight monitoring during pregnancy and growth monitoring for children should be able to integrate counseling for both undernutrition and overweight/obesity. More attention may also need to be placed on obesity in women, for their own health, rather than solely for improving birth outcomes.
- Another Working Group should more specifically address counselling.

1. For interventions or practices assigned to your working group[1]:
   a. What coverage data are currently available in the major population-based survey platforms[2]?
   b. What coverage data have nutrition data users prioritized/"demanded"[2]?
   c. What are the priority coverage data gaps[3]?

We were able to see in the attached power point slides provided that DHS and MICS included coverage data for management of severe and moderate acute malnutrition, but that our other interventions were not covered. We did not engage in a discussion which of the gaps should be prioritized at this point, but rather proceeded to discuss each intervention in order.

2. For the priority coverage data gaps, which of these are best suited measurement by:

a. Modifications or additions to the DHS* or MICS (*Differentiate between: DHS Core[4] & DHS Modules[5])
b. Modifications or additions to type of national/large-scale population based household survey (PBHS)?
c. Other types of data collection – NOT household survey (e.g. administrative)

The Working Group's discussion on these topics did not take place in this order. As we had a more in-depth discussion on each intervention, we were able to identify which interventions should be assessed in DHS and MICS, and whether they belong in Core or Module, as well as what is better covered in other types of household surveys or other types of data collection, but we did not do this just by looking down the list. Most of our recommendations did wind up resulting in additions or modifications to the DHS Core or Module, however a few exceptions were as follows:

- Coverage of management for moderate and severe acute malnutrition was deemed problematic for a DHS or MICS survey, particularly due to the difficulty in attaining an accurate denominator, therefore the Working Group thought that small scale surveys or facility-based surveys that assess the presence and quality of services offered would be preferable.
- Measuring cash transfers would be particularly useful where programs are designed to be nutrition-sensitive. Survey questions may inquire about whether women have received specific programs, however it may still be difficult to attain an accurate denominator. Administrative data from these programs themselves may be more appropriate to assess coverage.

3. For data gap intervention or practices amenable to a) DHS/MICS or b) other PBHS – prioritize order in which they will be addressed by your group (consider dividing into sub-groups to facilitate review).

As mentioned, we proceeded in the order provided in the list and we did not have pre-conceived ideas about which interventions would need to be covered in DHS/MICS or other PBHS.

B. Proposed modifications to DHS*/MICS questionnaires (*Core or Modules)

4. For each new question or recommended edit/change to an existing question, please discuss and document

a) the rationale for the addition or change

b) which population it relates to
c) who will answer the question(s)
d) recommended wording of question (to extent possible)
e) provide examples of surveys or studies that have used the recommended question, collected similar data or otherwise support the proposed addition or change[6]
f) recommend how data for any new questions could be summarized/tabulated/presented to facilitate use of in reports (e.g. as means vs. cut-off, by which indicators? by which subgroups/levels?)
g) *Prioritization:* Please classify each proposed change as Tier I, Tier II, or Tier III.
    - Tier I: it is feasible to implement this change in the next ~12 months & it should be prioritized
    - Tier II: it is feasible to implement this change in the next ~12 months but it is not essential / not everyone agrees
    - Tier III: implementing this change in the next 2-5 years will require additional research

Working Group discussion on weight monitoring during pregnancy:

- The Working Group agreed that weight monitoring during pregnancy is a high priority for including in DHS and MICS, which is not included currently – it is linked to birth outcomes and WHO has specific recommendations on multiple weight measurements during pregnancy.
- Of the example questions provided from other surveys, the group preferred the PMA2020 questions, which were a set of four. The first asks whether women were weighed during their last pregnancy, were they weighed once or more than once, did their provider discuss their weight gain, and what did their provider tell them about their weight gain.
- The final question ("What did the provider tell you…") may not be as important for coverage measure, is difficult to code, and may also be subject to recall bias.
- Some members felt it was important to be a little more specific than "did your provider discuss your weight gain with you" – this may lead to overestimates, it should rather ask specifically "did your provider discuss healthy eating with you" which is still not quite as specific as the current options. Others still felt it was enough to ask simply whether a discussion took place. This may require a validation study.
- The group discussed whether questions about weight gain could be combined with DHS questions about antenatal care – currently there are questions on number of visits and whether certain interventions (blood pressure, urine test) were received once. The option could be added on whether weight was also measured (the first question). However, we do not know whether it should be restricted to antenatal care – whether this would leave many women out.
- This was initially flagged as Tier I.

Working Group discussion on food supplementation during pregnancy:

- This intervention is not currently included in DHS or MICS.
- This is an important intervention, recommended by WHO in undernourished populations, but it may be difficult to assess the quality of the transfer (balanced protein and energy) and may be difficult to establish an accurate denominator that includes only the women who need food supplementation.
- Despite the caveats, in some contexts, it is still valuable to know what proportion of the population of pregnant women are receiving food supplementation.
- There is risk that obese mothers will also receive food supplementation.
- There was support from the Working Group to consider this as part of a DHS Module, rather than core, due to the context-specific nature of countries.
- This was initially flagged as Tier II.

Working Group discussion on growth monitoring – GMP:

- This is also not part of the DHS or MICS surveys, but it has been included in DHS India and Nepal.
- GMP consists of two separate components – monitoring and promotion – and just because a provider can accurately monitor, it does not mean they can do promotion. Still, this is an issue of quality, and our main goal is to focus on indicators for coverage.
- PMA2020 questions were preferred by the group, they consisted of three questions: was your child measured (height, weight or MUAC), what was told to you about your child's growth, and were they referred.
- The second question in PMA, what were you told, does not concern itself with the exact coding, but is rather used to measure whether any discussion took place at all. However, some members of the Working Group felt that this type of coding increases cognitive burden for the interviewer and the training required. It is not clear what the benefit is over asking more generically whether any discussion took place about child's growth.
- It may not be the place of population-based surveys to assess quality of counselling – this may be better in a facility-based survey; however, those too are subject to bias.
- The Working Group recognized that many countries are doing growth monitoring and spending a lot of money on it, however the evidence does not show that it is effective. If measurement is stopped, however, we won't know anything about coverage and there will be no opportunity to interpret whether it is worth the investment where malnutrition prevalence remains high. Even where these data are available, we don't know if the interpretation of results will play out that way.

- The group also discussed the reference period of 30 days. Some members stated that this will be country-specific, because some countries are now having protocols that are less frequent (making 30 days too short), while others felt that 30 days makes sense because that is the global recommendation. It should be between 1 and 3 months, but further investigation is needed.
- Tentatively flagged as tier I.

Working Group discussion on screening for acute malnutrition (MUAC):

- There was some concern among Working Group members of overloading the DHS with too many program-specific interventions.
- This is important, but some members felt it could be better assessed in health facility-based surveys, including direct observation and inventory checklist (are scales available, protocols, etc.)
- Similar to Growth Monitoring, screening for MUAC can often be an entry point for other interventions.
- However, if including this question with the other questions about growth monitoring is the only way that makes sense (the way the PMA2020 question asks about height, weight, and MUAC), it may be difficult to extract what is specifically screening of acute malnutrition. Some countries screen using height and weight, however MUAC is really the only practical way of screening and most countries are moving in this direction.
- Initially labeled as Tier I, because it is embedded in the child growth monitoring questions.

Working Group discussion on food supplementation for complementary feeding in food insecure populations:

- There are DHS core questions about whether children have received RUTFs or RUSFs, however these are more narrowly focused on therapeutic interventions, rather than supplementary food more broadly speaking, which could also include blanket supplementation and food commodities other than LNS.
- A program like WIC in the US or take-home rations in India would not be captured by these questions in the DHS.
- Many countries provide additional foods to children in food insecure populations, but the specific food support can vary.
- PMA2020 asks questions in a more general way, have you received and food or cash support and if it was food, what type of food (then there is a list of food commodities).
- Similar to the women's food supplementation, it will be difficult to attain a denominator that consists of only those women who are eligible, where programs are not blanket. This is also the case with the current DHS questions.

- Despite it being difficult to establish eligibility, we may still be able to narrow it down by presenting the data stratified by rural versus urban or by administrative zone when we know the programs are being implemented in specific regions.
- There was support among the group for replacing question 525a in the DHS with something closer to the PMA2020 questions.

Working Group discussion on management of moderate and severe acute malnutrition:

- Questions for these two interventions are included in DHS core module question 525a, however, these only ask whether RUTF or RUSF was received – if we want to capture the full continuum of care that is part of management of acute malnutrition, often including both therapeutic and preventative measures, these questions may not be enough. Additionally, many countries may begin adopting the same food commodity for both treatment of moderate and severe (just different dosages), so we may need to be prepared for that.
- Specific products used may also depend on supply chains, donors, and time of the year. It can flip back and forth between LNS and Supercereal+.
- We will once again have a hard time attaining an accurate denominator to measure coverage of SAM treatment. The surveys are also only conducted every 3 or 4 years. SAM prevalence is also so low, the denominator may not be enough to estimate coverage. DHS and MICS may not be ideal for this purpose. Smaller surveysare nimbler and more capable of doing this.
- At the same time, some members did not want to remove these questions from the DHS and MICS completely. Treatment coverage is a major gap in our data. There will also be demand from countries for these questions and some countries still have higher GAM rates.
- We can alter the question to be more along the lines of the PMA2020 question (416a-c), but it still won't get us to treatment, it will only provide a proxy of what is being done. There is also some language that needs to be adapted – "program" related language and the way 416c narrows down to food delivered specifically for treatment at health facilities.
- The reference period needs to be examined. 7 days seemed not ideal to the group – too short – but the correct reference period may need more thinking (possibly 3 months). This is asked to mothers of all children under 5.
- PMA2020 question can be adapted to include different food items – but it is still difficult to associate these products with specific treatment programs. For this reason, it will be important for facility-based surveys to assess availability of services.
- Other diseases (diarrhea) inquire about symptoms to establish eligibility for treatment (ORS), but studies show that it doesn't work well.
- Working Group felt the best option was to combine these management of acute malnutrition questions in the same questions about food supplementation for children, with a food list

that includes different food commodities (which could be for blanket/preventative, or for treatment). It may also be possible to add micronutrient powders/Sprinkles to this list.
- Guidance would need to be provided on how to analyze this raw data in a way that tells you about specific programs.

Working Group discussion on cash transfer programs:

- MICS has this in core questions, but it is very general and is part of the household questionnaire. It needs to be modified based on the specific names of the programs. Some members felt that women might not remember the names of all the programs they participated in, others thought it wouldn't be a problem.
- PMA2020 embeds the cash question with the question about whether food support was received.
- Again, like some of the other interventions, it is difficult to establish eligibility, and we are unable to take into consideration targeting criteria.
- Countries also have multiple programs running that provide cash or other benefits (e.g. Bangladesh) – they may not all have a specific link to nutrition. It can require a lot of questions to untangle these.
- Programs are widely prevalent and there is still a more upstream conversation ongoing about nutrition-sensitive social protection. If a program is designed to be nutrition-sensitive and has been shown to have relevance for certain outcomes that are important for nutrition, then it may be more straightforward to ask about coverage of the program. This would also have relevance for nutrition, rather than just being about coverage of social protection (which may be the case for a generic cash transfer that is more related to poverty).
- Follow up action might be to look across countries with MICS surveys who also have nutrition-sensitive social protection and assess whether these questions are enough to assess coverage.
- The Working Group tentatively identified this as Tier III, in need of more work before it is ready to include in any large-scale population-based surveys.

5. ***Are there any nutrition-related questions from the current DHS/MICS core questionnaires that are not deemed useful (from experience and/or online survey results) and can be dropped? What is the rationale for this?***

See the discussion above on the DHS core questions 525a – which the Working Group felt should be replaced. It is not fit for purpose to assess coverage of SAM and MAM treatment and is also so narrow that it will not capture blanket/preventative supplementary food that is provided to children

in food insecure populations. The recommendation was to add questions related to RUTF and RUSF foods to the PMA2020 questions.
Additionally, the Working Group thought that the question about sprinkles for children under the age of 3 (question 606 could be removed), if these are instead combined with the food list that is part of supplementation during complementary feeding. However, this also depends on the recommendations of the micronutrient group.

C. For coverage data gaps better addressed in other types of PBHS

6. For each new or modified question proposed, please discuss and document:
   a) the rationale for the addition or change
   b) the type(s) of population-based HH survey it is recommended for [7]
   c) which population it relates to
   d) who will answer the question
   e) recommended wording of question (to extent possible)
   f) provide examples of surveys or studies that have used the recommended question, collected similar data or otherwise support the proposed addition or change[7]
   g) *Prioritization:* Please classify each proposed change as Tier I, Tier II, or Tier III.
   - Tier I: it is feasible to implement this change in the next ~12 months & it should be prioritized
   - Tier II: it is feasible to implement this change in the next ~12 months but it is not essential / not everyone agrees
   - Tier III: implementing this change in the next 2-5 years will require additional research

The Working Group did not have a separate discussion about non DHS or MICS surveys. In the course of our conversation, the only thing that was specifically mentioned was that coverage of SAM and MAM treatment may be better conducted through smaller scale surveys. They may also be important to assess at facility level.

Session 1 Notes:

[1] Groups should briefly review list to ensure completeness. We recognize that nutrition-sensitive interventions are limited - most are out of scope for DHS-type surveys and so we recommend prioritizing discussion of indicators with more information. A summary of all interventions under review across groups is available under WG Resources Folder

[2] DataDENT team will provide background slide summarizing this information that WG can modify for use in report out.

[3] *A "data gap" could be completely missing information, incomplete information (e.g. a question is asked about receipt but does not account for a minimum dose) or inappropriately-captured data (e.g. particularly question has been shown not to be valid or there is a "better practice" known)*

[4]*proposals should focus primarily on questionnaire wording changes. Changes to other aspects such as sampling, training, data quality checks, etc should be briefly noted/documented for record but will not be addressed in detail.*

[5] *examples of special topical modules are at DHS program website here. It is also possible for a country to add specific questions to the country survey based on national stakeholder request.*

[6] *Examples:* Has there been any documented cognitive testing, validation or other systematic question design work?

[7] Provide most specific description feasible – e.g. if SMART survey; LSMS – but more general descriptions such as "a periodic national nutrition survey" are fine.

Child Growth Working Group Notes

Sessions 3 & 4

Working Group Chair: Edward Frongillo
Note taker: Quinn Marshall

WORKING GROUP SESSION 3: Recommendations to improve the nutrition content of facility assessments (60 MINS)

A. Identifying gaps in nutrition data that are amenable to health facility surveys

Working Group discussion:

- The group first had a general discussion about the purpose of facility-based surveys and the data collection types that they use. It was recognized that facility surveys can tell you about service availability, readiness, and general quality. Meanwhile, household surveys are used to assess whether individuals went to the facility and what interventions they received. By combining these two (e.g. a DHS and a SPA), you may get some idea of the coverage of quality treatment.
- Types of data collection used for facility-based surveys include direct observation, inventory checklists, exit interviews among others. Of these, Working Group members generally felt that the inventory checklists and exit interviews are the most objective, while the direct observation can be influenced by the Hawthorne effect. Record reviews are also objective measures, but they do not provide a lot of detail.
- One obvious limitation of facility-based surveys is that they do not capture community-based programs.
- Training of data collectors is also a challenge – these are not nutrition-specific, but are rather meant to assess a broad range of domains in the health facility.
- The Working Group noted that within the current SPA questions, weight monitoring of pregnant women and growth monitoring of children were generally covered, while there was a gap around management of acute malnutrition.

B. Proposed modifications to SPA core questionnaires

1. For each new question or change to an existing question proposed, please discuss and document:
    a) the rationale for the addition or change – including how the data are likely to be used (e.g. for quality adjusted coverage; for systems improvement, etc)
    b) which intervention(s) it relates to
    c) how (& by whom) the question will be answered (e.g. inventory; exit interview, etc)
    d) recommended wording of question (to extent possible)
    e) provide examples of surveys or studies that have used the recommended question, collected similar data or otherwise support the proposed addition or change (to extent possible)
    a) *Prioritization:* Please classify each proposed change as Tier I, Tier II, or Tier III.
    - Tier I: it is feasible to implement this change in the next ~12 months & it should be prioritized
    - Tier II: it is feasible to implement this change in the next ~12 months but it is not essential / not everyone agrees
    - Tier III: implementing this change in the next 2-5 years will require additional research

Working Group discussion of weight monitoring of pregnant women in facility-based surveys:

- Currently SPA includes inventory checks for scales to weigh and direct observation of whether providers discussed weight with pregnant women.
- Health provider interview inquires whether providers have received training on how to counsel women with regards to quantity and quality of food.
- The Working Group discussed whether there should also be questions directed towards ascertaining provider's ability to monitor and provide counselling on excess weight gain and obesity. However, some members pointed out that very few countries have training protocols on this and we don't know if those that do reflect current best practices.

Working Group discussion of management of acute malnutrition in facility-based surveys:

- The Working Group recognized this as the biggest current gap in SPA – it is also a key issue we identified the first day for the need to complement household surveys with facility-based information.
- There is a question on whether services for child malnutrition are available (Inventory – Child Curative Services - question 1202), but this is not specific enough – we want to ask about acute malnutrition as a specific service. Two questions could be: 1) Does the health facility screen for acute malnutrition?; and 2) Does the health facility treat or refer children with acute malnutrition?

- For those facilities that provide management of acute malnutrition, there should also be a separate list in the basic supplies section of the inventory checklist that includes: RUSF and RUTF supplies (taking consideration of both stock-outs and expiration dates); guidance documents; and job aids.
- In the health worker interview, questions are directed towards training in micronutrient deficiencies and nutrition assessment generically speaking; however, the Working Group recommended asking about country's specific CMAM protocols and follow-ups.

WORKING GROUP SESSION 4: Revisiting prioritization and Tier III research priorities (60 MINS)

A. Revisiting Prioritization of Proposed Changes

See the attached templates (at the end of this document) on proposed modifications to DHS/MICS for a more detailed discussion of each intervention area, the changes requested, and prioritization. In general, the priorities were as follows:

- Weight monitoring during pregnancy: Tier 1 for the DHS Core. There is no global indicator but there is specific guidance that it is important for preventing low birthweight, birth complications, and excess weight gain. It can be used for both undernutrition and obesity.
- Growth monitoring and screening of acute malnutrition: Tier I for the DHS Core. The Working Group felt that screening of acute via MUAC was a high priority interventions and it makes the most sense to combine this question with others about assessment of weight and height, even though those do not have the same evidence base. Where countries have low GAM prevalence, they can opt to remove these questions (similar to malaria).
- Food supplementation during pregnancy: Tier 2 for the DHS Modules. These programs will be context-specific in terms of the specific foods, so it is better in an optional module. Further work may be needed to understand the extent to which questions should be tied to specific programs (we may look to Mexico's National Nutrition Survey).
- Food assistance for complementary feeding in food insecure populations: Tier II for an optional DHS module. This is recommended in food insecure areas, but the current questions are narrowly focused on LNS foods. The current questions can be modified to be more flexible (offering a list of food items that would include both non-LNS supplementary foods as well as LNS supplements) and sent to a module due to the country-specific nature.

B. Specifying Research Agenda

1. For each Tier III recommendation, please discuss and document:
   a) the questions that need to be addressed through further research

b) recommended methods for addressing (e.g. secondary analysis of existing data, types of new data collection)
c) scale of research required (e.g. single small pilot; testing across multiple cultural contexts, etc)
d) researchers or institutions that are working in related areas
e) opportunities / recommended contexts (e.g. upcoming large surveys)

Working Group discussion on research:

Throughout the two days, a few areas of potential research came up:

- For cash transfers, we can look at countries that have social protection programs that are designed to be nutrition-sensitive to see how these programs are/are not addressed in MICS surveys (since MICS has generic questions on cash transfers that are meant to be adapted to specific programs).
- There is a major gap in management of acute malnutrition coverage across the continuum of care, at population level. While screening may be possible in DHS or MICS, the Group did not feel they were adequate to estimate coverage of treatment. It is still not clear from where this should come– SQUEC and SLEAC do not seem like promising options either.
- The group discussed whether questions about food supplementation during pregnancy should prompt women to recall what they were told about their weight gain, or whether they should just recall yes/no did any discussion take place. Though asking the simple yes/no question would reduce cognitive and training burden on interviewers, there was the possibility it could lead to over-reporting. This could be an issue for a validity study.

Note taking template for proposed modifications to DHS/MICS questionnaires

Intervention or practice	**Weight monitoring during pregnancy**
Type of change (new; modification of existing question; remove)	New addition
If DHS – for core or module?	Core
Describe change	Add questions 228a – 228c from the PMA2020 Female Child Questionnaire to DHS/MICS, which does not currently include any questions related to weight monitoring. These three questions ask whether a mother was weighed during pregnancy, whether this occurred more than once, and whether information was given regarding weight gain.
Rationale	Weight monitoring during pregnancy is important for preventing low birthweight of children, birth complications, as well as excess weight gain during pregnancy. For these reasons, as well as the evidence base (see below), the group felt that while three questions would take up a lot of real estate, they are worth including.
Population being asked about	Pregnant women
Respondent for question	Women who have been pregnant
Recommended wording	• During that pregnancy with [CHILD NAME] did your health provider or community health volunteer/worker ever weigh you? • Were you weighed once or more than once? • Did your health provider or community health volunteer/worker discuss your weight gain with you?
Evidence supporting recommendation	Routine weight monitoring should inform dietary counseling provided to pregnant women, which is a recommended action in WHO's Antenatal Care Guidelines for women to stay healthy and prevent excess weight gain during pregnancy.
Recommendations for data tabulation or display	The working group recognized that there is no globally accepted indicator to measure weight monitoring, so this may still need to be decided.
Other comments (including about methods, quality, etc)	The Working Group discussed whether to include another question included in the PMA2020 questionnaire, 228d, which asks women to identify what type of information was given by their provider with regards to their weight. Enumerators must then categorize their response according to the options

	provided. The group noted that while this could provide some information regarding the quality of counseling, it is subject to recall. Additionally, there is a cognitive burden placed on interviewers to correctly categorize the response, which requires extensive training.
Priority Tier – I, II, III	Tier I
Other comments / notes	The Working Group identified two separate options for how to include the questions in DHS: • Embed the three new questions in question 413 of the DHS Women's Questionnaire (pg. 21), which asks women which assessments they received during their *current* pregnancy. • Add the three questions to a different part of the DHS and relate them to *last* pregnancy. The group left the decision on these two options still to be decided, but did note that it would have implications on the number of women who would be captured (fewer are currently in antenatal care) as well as extent of recall bias.

Intervention or practice	**Food supplementation during pregnancy**
Type of change (new; modification of existing question; remove)	New addition
If DHS – for core or module?	Module
Describe change	Adapt questions 232a-d from the PMA2020 Female Child Questionnaire for DHS/MICS, which does not currently have any questions on food supplementation. These questions ask whether a woman received food assistance during pregnancy and if so, what type.
Rationale	The group discussed some challenges with this indicator, especially related to the difficulty in attaining an accurate denominator (which should focus on food insecure women and not include obese women), as well as in attaining information related to the nutrient composition of the transfer (if provided in the form of food), i.e. balanced energy and protein. Despite these limitations, if the numerator (pregnant women receiving a supplement) could be accurately estimated and the context was food

	insecure, the group would still see value in collecting this indicator in an optional module. In such a context, food supplementation could improve birth outcomes.
Population being asked about	Pregnant women who are food insecure
Respondent for question	Women who have been pregnant
Recommended wording	The PMA2020 questions, which would need to be adapted to context, include the following: • During your pregnancy with [CHILD NAME}, did you receive any kind of food or cash assistance from the government, an NGO, or other groups? • What type of assistance did you receive – cash transfer or food? • What kind of food did you receive? *(Read list of country-specific supplementary foods)* • For how many months during your pregnancy did you receive this cash or food in the health facility where you went for prenatal care? The adaptations required would relate to: the specific food supplements that are commonly given to women during pregnancy (the third question); the national programs that are in place to reach women with these supplements; and the location where supplementation is provided (see reference to health facility in the fourth question).
Evidence supporting recommendation	There is evidence that balanced energy and protein supplements can reduce risk of small for gestational age and still births. For this reason, the WHO Antenatal Care Guidelines provide a context-specific recommendation that applies to settings with high prevalence of undernourished pregnant women.
Recommendations for data tabulation or display	If there are questions about food insecurity or wealth in the questionnaire, the Working Group recommended reporting results by levels of food insecurity or wealth quintiles.
Other comments (including about methods, quality, etc)	As mentioned previously, these questions will need to be adapted to national contexts (types of assistance and programs available). Quality of the supplementation in terms of specific nutrient composition may be difficult to measure.
Priority Tier – I, II, III	Tier II

Other comments / notes	A possible follow up action would be to look at Mexico's National Nutrition Survey questionnaire to see if/how they reference specific programs.

Intervention or practice	**Growth Assessment – GMP**
Type of change (new; modification of existing question; remove)	Add new questions to the core, but with the option of removal (this is similar to the way malaria questions can be removed in survey countries where it doesn't exist)
If DHS – for core or module?	Core
Describe change	Add questions based on PMA2020 Female Child Questionnaire 415a – c. These relate to whether or not a child had an assessment, what type (height, weight, MUAC), information that was provided based on growth, and referrals.
Rationale	The Working Group placed importance in MUAC assessment, in particular, and thought it made sense to combine MUAC with the other types of assessment (height and weight) in the same question, as is the case with the PMA2020 questions. While the height and weight monitoring do not have a strong evidence base, the interventions are implemented by many countries, and it does not cost much to keep them in the question.
Population being asked about	Children 0 – 59 months old
Respondent for question	Women with children 0 - 59 months
Recommended wording	Three questions as follows: • In the last 30 days*, has a health provider or community health volunteer/worker measured [CHILD NAME]'s height, weight or arm (MUAC)? *(Respondents would need to indicate yes/no for each of these options)* • Did the health provider or community health worker/volunteer discuss your child's growth with you?** • After [CHILD NAME] was measured, were they referred to another facility or health worker? * The reference time period of 30 days is context-specific. **Similar to the case of weight monitoring during pregnancy, the group was concerned that inquiring about the specific contents of the counseling/promotion given

	("what did the provider tell you about your child's growth?"), as the PMA2020 question does, may add cognitive burden to the enumerators and may be subject to recall bias. There seemed to be agreement that it would be preferably to make this a yes/no response, asking whether or not a discussion took place. Even when it doesn't matter which option an interviewer chooses from a list (i.e. the purpose is just to check whether any conversation took place), it may not be worth the training and mental burden.
Evidence supporting recommendation	The Working Group recognized that there is not evidence supporting the effectiveness of monitoring height and weight growth in health centers. However—see below—there is evidence based rationale behind screening of acute malnutrition, and we would recommend combining these questions.
Recommendations for data tabulation or display	
Other comments (including about methods, quality, etc.)	Regarding the quality of the promotion/counseling, the Working Group suggested that this may be better measured at facility level. This may generate more accurate data than asking mothers to recall what they were specifically told about their child's growth.
Priority Tier – I, II, III	Tier I, for countries where screening of acute malnutrition is applicable. Countries where it is not applicable could still choose to keep the questions in if they want to measure coverage of growth monitoring.
Other comments / notes	There was concern from some Working Group members that the interpretation of growth monitoring survey results may also need to improve. For example, a country could be investing a lot of resources in monitoring weight and height, though stunting could still remain high. How should these results inform the government's actions?

Intervention or practice	**Screening for Acute Malnutrition**
Type of change (new; modification of existing question; remove)	New (though note that this question is embedded in the questions adopted as part of the Growth Monitoring interventions). These questions can be removed in countries where screening for acute malnutrition is not applicable.
If DHS – for core or module?	Core

Describe change	The same change that was described for Growth Monitoring applies here as well. Add questions based on PMA2020 Female Child Questionnaire 415a – c. These relate to whether or not a child had an assessment, what type (height, weight, MUAC), information that was provided based on growth, and referrals.
Rationale	In contrast to growth monitoring, screening of acute malnutrition is most practical using MUAC and many governments have included MUAC in their treatment protocol. The group felt that while mothers may not be able to recall whether their child was "screened for malnutrition", but they may remember whether their arm was measured. The best option seems to be to embed this question in the other questions about measuring height and weight.
Population being asked about	Children 6 – 59 months
Respondent for question	Women with children 6 - 59 months
Recommended wording	Same as the Growth Monitoring questions above: • In the last 30 days, has a health provider or community health volunteer/worker measured [CHILD NAME]'s height, weight or arm (MUAC)? *(Respondents would need to indicate yes/no for each of these options)* • Did the health provider or community health worker/volunteer discuss your child's growth with you? • After [CHILD NAME] was measured, were they referred to another facility or health worker?
Evidence supporting recommendation	Screening of acute malnutrition with MUAC is strongly recommended by the WHO in their guidance on management of severe acute malnutrition. Studies show the risk of death is significantly increased below the MUAC cutoff of 115 mm.
Recommendations for data tabulation or display	Proportion of children 6 – 59 months who have had a MUAC measurement in the last 6 months
Other comments (including about methods, quality, etc.)	Some countries may have a protocol that allows for the option of screening for acute malnutrition with weight and height in the health centers. However, the group agreed that MUAC is the direction most countries are headed in, so the number of children receiving only weight for height measurement in a health center would be small and unlikely to affect a coverage of screening estimate.

Priority Tier – I, II, III	Tier I, for countries where screening of acute malnutrition is applicable.
Other comments / notes	Asking mothers about screening at the household level rather than health workers at the facility level will also have the benefit of capturing screening that takes place outside of the health center (e.g. community campaigns).

Intervention or practice	**Food supplementation for complementary feeding in food insecure populations**
Type of change (new; modification of existing question; remove)	Modification of existing question in DHS Core, 525a
If DHS – for core or module?	Module
Describe change	The current DHS Core question in the Female Child Questionnaire, 525a, should be replaced with the questions articulated below, which are adapted from the PMA2020 questions 416a and 416c.
Rationale	Question 525a in DHS is narrowly focused on RUSF/RUTF for treatment of AM and micronutrient supplementation. There may be blanket provision of other types of food or supplements, based on government programs, delivered to children in food insecure populations, for example (e.g. India's take home ration program or WIC in the US). These wouldn't be captured under the current DHS questions, so there is value in asking this question in a more open way. The PMA2020 questions are framed in a way could capture food provided as part of treatment of acute malnutrition or these more general/blanket types of support. The group also did not agree with the 7-day reference period used in DHS question 525a.
Population being asked about	Children aged 6 – 59 months
Respondent for question	Women with children aged 6 – 59 months.
Recommended wording	Two questions: • Has [CHILD NAME] received food or a food supplement in the last [recall period to be determined]? • What type of food or food supplement did [CHILD NAME] receive? *(context-specific list of items)*

	The list of food items that would be included in the list would depend on the programs in place, however, may include LNS, fortified blended foods (e.g. Supercereal+), other foods, etc. The groups also discussed whether micronutrient powders should be included and decided that this should be left up to the Micronutrient Interventions Group.
Evidence supporting recommendation	WHO guidance on complementary feeding recommends fortified or micronutrient supplements for infants as needed in order to meet recommended nutrient intakes.
Recommendations for data tabulation or display	It could be possible to stratify results by urban vs. rural, or by different geographic areas, if programs are known to be implemented in certain regions and not in others.
Other comments (including about methods, quality, etc.)	These questions would work best to estimate coverage for a blanket program. For the therapeutic programs, it is very difficult to get an accurate denominator, especially where prevalence of acute malnutrition is very low. This—in combination with the 7-day recall period—will make it difficult to estimate treatment coverage. See below section on Management of Acute Malnutrition
Priority Tier – I, II, III	Tier II
Other comments / notes	Note that the reference period is still to be decided.

Intervention or practice	**Management of severe acute malnutrition; management of moderate acute malnutrition**
Type of change (new; modification of existing question; remove)	Modification of existing question in DHS Core, 525a
If DHS – for core or module?	Module
Describe change	The current DHS Core question in the Female Child Questionnaire, 525a, should be replaced with the questions articulated below, which are adapted from the PMA2020 questions 416a and 416c, which will include food supplements used for management of acute malnutrition in the list attached to 416c.

Rationale	The group found that question 525a in DHS, with its narrow focus on RUSF/RUTF for treatment of AM and micronutrient supplementation, should no longer be recommended. In addition to it failing to capture general food support that is provided as part of a blanket approach, the questions are not fit for their primary purpose of measuring treatment coverage.
Population being asked about	Children aged 6 – 59 months
Respondent for question	Women with children aged 6 – 59 months.
Recommended wording	See questions above in Food Supplementation for Complementary Feeding in Food Insecure Populations
Evidence supporting recommendation	
Recommendations for data tabulation or display	As mentioned above, while it is still not a perfect way to capture coverage, proportion of children receiving LNS (from the question based on PMA2020 416c) could be stratified by urban vs. rural or by administrative regions depending on where the program is being implemented.
Other comments (including about methods, quality, etc.)	For therapeutic programs, it is very difficult to get an accurate denominator, especially where prevalence of acute malnutrition is very low. This—in combination with the 7-day recall period—will make it difficult to estimate treatment coverage. The group felt that treatment programs would be better assessed at facility level (e.g. are services available?) and through smaller scale surveys rather than the DHS survey.
Priority Tier – I, II, III	Tier II (embedded with GMP)
Other comments / notes	

Intervention or practice	**Cash transfer programs**
Type of change (new; modification of existing question; remove)	No proposed change
If DHS – for core or module?	n/a

Describe change	n/a
Rationale	Several reasons why it is too premature to make recommendation now: • Impossible to include eligibility criteria in coverage estimate • Programs will be highly context specific and in some contexts, there may be multiple programs (e.g. health grant, education grant) • Where social protection programs are designed to be nutrition-sensitive and have been evaluated to have certain impacts on nutrition, then it would make sense to measure coverage of those specific programs, but just measuring receipt of cash does not really tell us much about nutrition.
Population being asked about	n/a
Respondent for question	n/a
Recommended wording	n/a
Evidence supporting recommendation	n/a
Recommendations for data tabulation or display	n/a
Other comments (including about methods, quality, etc.)	n/a
Priority Tier – I, II, III	None
Other comments / notes	As a follow up action: we may look across countries that have social protection programs determined to be nutrition-sensitive and examine the MICS survey results (where names of specific programs are asked about) to see if we can pull this information out from the responses.