

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 (MIYCN) 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 overburdened 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



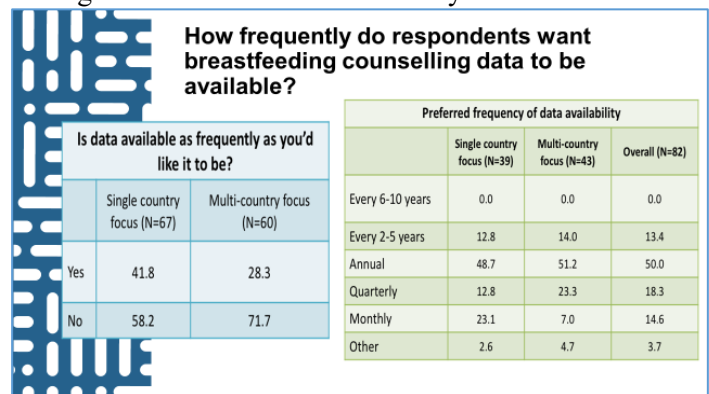
To better understand the nutrition community’s uses and needs for data, an online survey was conducted in the months leading up to this consultation. The results of that survey were analyzed, and the preliminary findings were compiled for use during the WG sessions. There were 235 completed responses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




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.

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.

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"



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.

Nutrition data

DHS	SPA survey	MIS survey
<ul style="list-style-type: none"> • Anemia • Height and weight • Breastfeeding/C complementary feeding • Breastfeeding counselling • Iodized salt in households • Micronutrient supplementation 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Anemia



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)

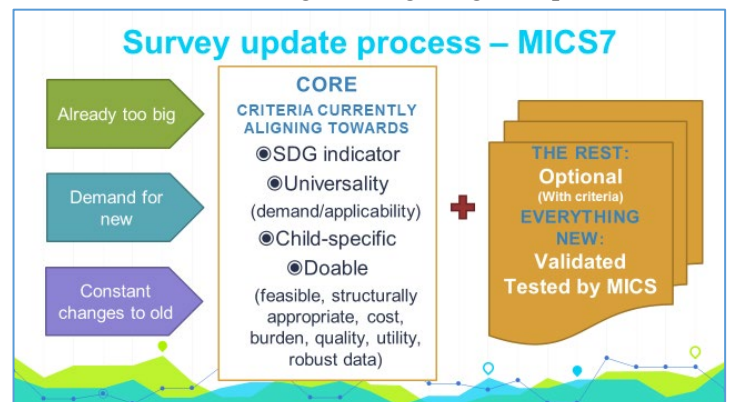


MICS started out as a project intervention to capture very specific data, and began transitioning to a ‘program’ in 2005. MICS and DHS have been collaborating since the start of MICS, and collaboration continues to increase, both formally and informally, each year. The MICS is currently in its 6th round, 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)

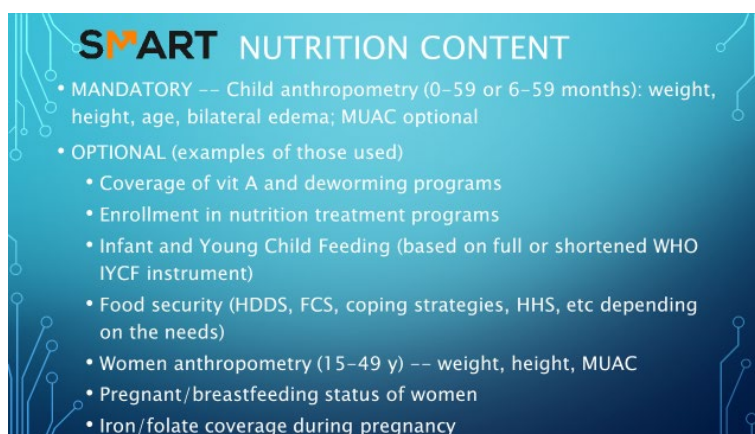


SMART is very different than DHS and MICS. SMART emerged in 2005 as a simplified methodology for field surveys, particularly ones that take place in emergencies. It is designed for a simple, two-stage cluster survey; a simple random survey; or an exhaustive survey that NGO practitioners can easily implement 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/lsm

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.

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 list document.

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 the Power Point Presentation (PPP).

The following WG Resources were provided in four main folders:

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

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)

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)

- 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:

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](#).

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	

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.

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

Overview: surveys with relevant question examples

Intervention	Population	Slide #	DHS*	MICS	PMA2020	NE 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."

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](#).

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](#).

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	8	Yes		Yes	Yes	Yes	Yes	Tanzania SMART; UC Davis (general)
Folic acid supplementation	WRA; AD; PW	8						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	UC Davis
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							UC Davis
Vitamin A supplementation (high-dose)	Child<5y	50	Yes		Yes	Yes	Yes	Yes	UC Davis, 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	UC Davis, 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](#).

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.

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.

Plenary 6: Overview of Nutrition Content in Facility Surveys

Moderator: Chika Hayashi, UNICEF

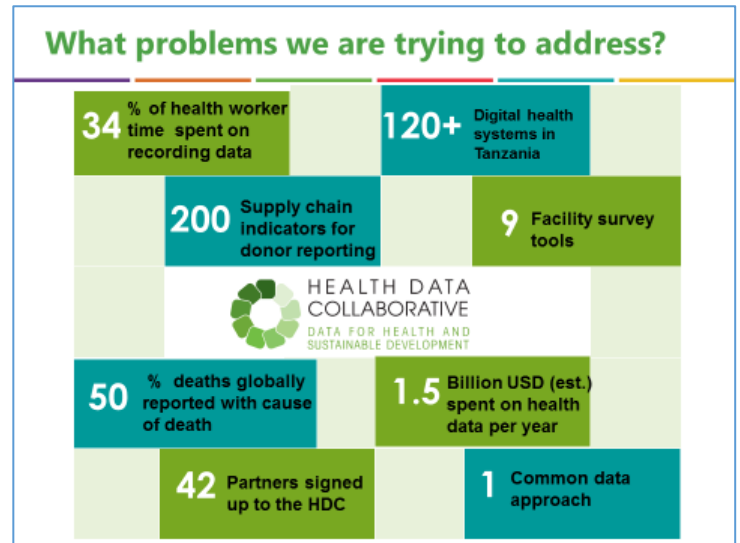
This session is dedicated to reviewing and discussing health facility-based surveys. The participants of this consultation are generally less familiar with this topic, in comparison to PBHSs, so there are likely to be more questions. Amani Siyam (WHO) begins the discussion with an overview of facility-based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



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.

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

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.

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.



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.

Behavior/life stage	Facility audit	Service provider interview	Service observation	Client exit interviews
Maternal nutrition (diet, activity, micronutrient supplements, BF)	Job aids for BCC/counseling	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?] <i>Possible to include exit interviews after delivery (several topics to be covered, including early initiation support)</i>
IYCF	IMCI chartbook (already included) Job aids for BCC/counseling	<i>Included</i> <i>-Consider inclusion of knowledge</i>	<i>Included</i>	- Check on prescriptions or recommendations on formula during sick child exit interview

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?

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.



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.

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

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) <ul style="list-style-type: none"> • 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

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 <ul style="list-style-type: none"> a. MDD/healthy diet b. Unhealthy diet 		X		III
Quantitative dietary assessment	Explore opportunities for piggybacking nutrition survey onto other platforms			X	II



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.

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.

Topic	Proposed Change	1. Where does it belong?			2. Should it be done now? Tier / Priority
		DHS /MICS core	DHS Module	Other PBHS	
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

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 (<i>could be in ANC-current pregnancy or recall to last pregnancy</i>)
	Growth monitoring	• Ask whether child had weight, height, MUAC measured in specified 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 Iron in women of reproductive age	• Add question about whether purchased or received. • 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 Health 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.

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

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

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 Fabric, 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.

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
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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