UNHCR Operational Guidance on the use of Fortified Blended Foods in Blanket Supplementary Feeding Programmes

AN ADDENDUM TO THE 'UNHCR 2011 OPERATIONAL GUIDANCE ON THE USE OF SPECIAL NUTRITIONAL PRODUCTS TO REDUCE MICRONUTRIENT DEFICIENCIES AND MALNUTRITION IN REFUGEE POPULATIONS'

UNHCR
The UN Refugee Agency

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Cover Page: Thailand / Refugees from Burma (Myanmar) at Mae La Refugee Camp / UNHCR / R. Arnold / January 2008

Graphic Design: A. Mannocchi / Rome

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ACRONYMS AND ABBREVIATIONS

ANC	Ante-Natal Care
BCC	Behaviour Change Communication
BSFP	Blanket Supplementary Feeding Programme
CSB	Corn-Soy Blend
EFA	Essential fatty acids
FBF	Fortified Blended Food
FGD	Focus Group Discussion
GAM	Global Acute Malnutrition
GFD	General Food Distribution
GFR	General Food Ration
IFRC	International Federation of the Red Cross/Crescent Societies
IYCF	Infant and Young Child Feeding
KAP	Knowledge, Attitude and Practice
KI	Key Informant
LNS	Lipid-based Nutrient Supplements
MAM	Moderate Acute Malnutrition
M&E	Monitoring and Evaluation
MNP	Micronutrient Powder
MoU	Memorandum of Understanding
MUAC	Mid-Upper Arm Circumference
PDCAAS	Protein Digestibility Corrected Amino Acid Score
PDM	Post Distribution Monitoring
PLW	Pregnant and Lactating Women

RNI	Reference Nutrient Intake
RSB	Rice-Soy Blend
RUSF	Ready-to-Use Supplementary Food
SAM	Severe Acute Malnutrition
SENS	Standardised Expanded Nutrition Survey
TSFP	Targeted Supplementary Feeding Programme
UCL IGH	University College London, Institute for Global Health
UNHCR	United Nations High Commissioner for Refugees
WASH	Water Sanitation and Hygiene
WHZ	Weight-for-Height z-score
WFP	World Food Programme
WHO	World Health Organisation
WSB	Wheat-Soy Blend

UPDATED ONLINE REFERENCE MATERIALS AND TOOLS

A number of reference materials and tools are available to assist when using UNHCR's 2011 'Operational Guidance on the use of Special Nutritional Products to Reduce Micronutrient deficiencies and Malnutrition in Refugee Camps'. A number of additional materials and tools have been added to this 'tool kit' focusing on blanket supplementary feeding programmes (BSFP) using fortified blended foods (FBF) and can be accessed from the following *new* web address: http://www.unhcr.org/pages/52176e236.html. This replaces the address referred to in the 2011 Operational Guidance - http://info.refugee-nutrition.net/operation-guidance-on-use-of-fsp.

For information on the World Food Programme's (WFP) Food Safety and Quality Management System (FSQMS), and food specifications see http://foodqualityandsafety.wfp.org/. Note that WFP is currently in the process of developing a harmonised BSFP toolkit for data collection. Please contact Kinday Samba for further information - kinday.samba@wfp.org.

A number of tools to assist with planning, implementation and reporting are also available from the Save the Children Blanket Supplementary Feeding Programme (BSFP) guidance (not specific to refugee contexts). This can be accessed from http://www.unicef.org/nutritioncluster/files/Blanket_Supplementary_Feeding_Programme_Guidance_07_May_2013_VF.pdf or contacting j.frize@savethechildren.org.uk or sbutler@savechildren.org.

Comments, feedback, and requests for further guidance should be directed to **HQPHN@unhcr.org**.

AUTHORS

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ACKNOWLEDGEMENTS

We gratefully acknowledge the contributions made by all who provided content, reviewed, and commented on this guidance.

We would like to acknowledge staff from the UNHCR Burkina Faso Branch and Field Offices, with special thanks to Yuve Guluma and Antoinette Gandema for supporting all field work, and development of the monitoring and evaluation guidance. Thanks also to Md Mezanur Rahman from UNHCR Bangladesh for input.

We would also like to acknowledge all key informants for sharing their learning and experiences of implementing blanket supplementary feeding programmes using fortified blended foods.

Thank you to the following reviewers who contributed valuable feedback on this Addendum:

Action Contre la Faim: Lawubah Gubely

Centers for Disease Control and Prevention: Leisel Tally

Emergency Nutrition Network: Carmel Dolan and Marie McGrath

Independent: Victoria Sibson and Gloria Kisia

International Medical Corps: Daniel Takea

Save the Children: Jemal Seid Mohammed

UNHCR: Mélody Tondeur, Ellen Andresen, Allison Oman, Yuve Guluma, Caroline Wilkinson and Terry Theuri

WFP: Natalie Aldern, Lynnda Kiess, Kinday Samba, and Saidou Magagi.

INTRODUCTION

UNHCR and WFP first published joint guidance on selective feeding programmes in 1995[1]. These guidelines were subsequently updated and the latest version was released in 2011[2]. The World Health Organisation (WHO) has also published guidance on selective feeding in emergencies, including Blanket Supplementary Feeding Programmes (BSFP), that is relevant to refugee operations (WHO, UNHCR, IFRC, WFP, (2000)). The UNHCR Operational Guidance on the use of Special Nutritional Products[3] (referred to as the 2011 Operational Guidance) was developed to provide additional detailed guidance on the implementation of BSFP. It describes the expanded scope of BSFP, which may now be used in refugee operations to prevent micronutrient deficiencies and stunting, in addition to preventing acute malnutrition, using a wider range of special nutritional products.

The 2011 Operational Guidance focuses on the use of lipid based nutrient supplements (LNS) and micronutrient powders (MNP) in these programmes. If your programme uses MNP or LNS, please refer to the 2011 Operational Guidance which can be downloaded from http://www.unhcr.org/pages/52176e236.html.

This current document is an Addendum to the 2011 Operational Guidance and provides updated information and additional guidance on the use of fortified blended foods (FBF), such as Super Cereal (i.e. FBF+) and Super Cereal Plus (i.e. FBF++), in selective feeding programmes for children (and pregnant and lactating women (PLW)). Whilst Super Cereal Plus is the recommended FBF for young children in BSFPs, Super Cereal, oil, and sugar mixes are still being used in many contexts at the time of writing. A number of sources were used for the development of this Addendum including a review of the current literature, stakeholder interviews, and results from the pilot testing of materials in Burkina Faso.

This guidance should be used when designing, implementing, or monitoring BSFP that use FBF in refugee operations. It is aimed at UNHCR health and nutrition field staff and partners. Note that while this guidance focuses on children (6-59 months), PLWs[4], the elderly, and other vulnerable groups should not be excluded.

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1 UNHCR/WFP. (1995) Guidelines for selective feeding programmes in emergency situations.

2 UNHCR/WFP. (2011) Guidelines for Selective feeding: The Management of Malnutrition in Emergencies.

3 UNHCR/UCL/ENN. (2011) UNHCR Operational Guidance on the Use of Special Nutritional Products to Reduce Micronutrient Deficiencies and Malnutrition in Refugee Populations.

4 For guidance on breastmilk substitutes (BMS) please refer to UNHCR Standard Operating Procedures for the Handling of Breastmilk Substitutes in Refugee Situations. Version 1.0, October 2013.

HOW TO USE THIS ADDENDUM

The process of needs assessment, planning, and implementing a BSFP using FBF can be described in 6 stages: 1) define the problem; 2) identify the solution; 3) assess risks and challenges; 4) test special nutrition product acceptability and adherence; 5) design the programme and distribute the product; 6) monitor and evaluate. These stages are described in detail in the 2011 Operational Guidance.

FBF supplied by WFP is generally labelled as Super Cereal or Super Cereal Plus therefore these terms will be used throughout this guidance[5]. Collectively, these products will be referred to as FBF.

The format of this Addendum follows that of the 2011 Operational Guidance. In general, information provided that is relevant for MNP, LNS *and* FBF are not repeated here.

- ***Specific references to the 2011 Operational Guidance can be recognised by bulleted italic font such as shown here. Page references refer to the print ready PDF version and not the Word document.***
- **Reference materials and tools can be identified by the following icon**

5 Note that in some cases, FBF may be produced locally using WFP specifications.

ORIENTATION

WHAT IS FORTIFIED BLENDED FOOD (FBF)?

FBF is a mixture of a cereal (e.g. corn, rice, or wheat), a pulse such as soya beans, and other ingredients which may include dried skimmed milk (DSM), sugar and /or oil, and is fortified with vitamins and minerals. The food ingredients are milled, blended, and pre-cooked, and resemble porridge when cooked[6].

Unlike MNP or LNS, FBF requires cooking for up to 10-15 minutes, therefore it is important to ensure that caregivers will have time for cooking, access to firewood / fuel, clean water, and utensils before planning a BSFP using FBF.

For up-to-date WFP specification sheets on the different types of FBF currently available see http://foodqualityandsafety.wfp.org/en/specifications.[7]

WHAT IS A BLANKET SUPPLEMENTARY FEEDING PROGRAMME?

Emergency affected populations often face limited access to diversified diets or livelihood opportunities and are therefore frequently reliant upon food-aid. The General Food Ration (GFR) provided is often not ideal for younger children and other vulnerable groups, therefore selective feeding programmes are frequently introduced as a 'safety net' to help bridge the nutrient gap between the bulk macronutrients supplied by the GFR and the specific physiological needs of at risk groups by providing a special food supplement for these individuals. **Figure 1** illustrates the different types of selective feeding programme.

BSFPs are a type of selective feeding programme. The primary objective of BSFPs is to *prevent* deterioration in nutritional status and related morbidity and mortality in members of at risk groups (for example children 6-23 months, 6-59 months and PLWs)[8].

6 UNHCR/WFP (2011). Guidelines for Selective feeding: The Management of Malnutrition in Emergencies.

7 Note that mixing instructions provided in WFPs specification sheets are not the suggested preparations for consumption, but are the ratios of FBF: water for carrying out the Bostwick analysis. Please see Stage 4 and 5 of this addendum and associated FBF information sheets for guidance on preparation of FBF for consumption.

8 UNHCR/WFP (2011). Guidelines for Selective feeding: The Management of Malnutrition in Emergencies.

In addition to the guidance provided in Stage 1 of the 2011 Operational Guidance for when a BSFP may be appropriate, BSFP may also be suitable in the following contexts[9, 10]:

1) At the onset of an emergency if a reliable pipeline for a general food distribution (GFD) is not in place, to prevent acute malnutrition in young children

2) Where there is a clear seasonal 'hunger period' during which children cyclically descend into malnutrition due to food shortages and/or increased rates of ill health/disease

3) When the population is difficult to reach due to logistical and/or security problems and where more frequent and targeted SFP (for treatment of moderate acute malnutrition (MAM)) is not feasible due to time, access, or partner capacity limitations

4) Where there are (or there are risks of) micronutrient deficiency outbreaks and BSFP is given to support the overall response through the provision of micronutrient-rich foods, fortified commodities, or micronutrient supplementation to the target population

5) When there is a need to provide nutritional support to other at-risk groups, such as people living with AIDS or TB, or the disabled or elderly.

Unlike Targeted Supplementary Feeding Programmes (TSFPs) for treatment for MAM, BSFPs provide a special food supplement to all members of these at risk groups regardless of nutritional status. Note that FBF should be withheld from children being treated for severe acute malnutrition (SAM) and MAM and malnourished PLWs under treatment up until recovered. They may be transferred to the BSFP after discharge.

The 2011 Operational Guidance and this Addendum reflect the extended scope of BSFP programmes, which now also include the prevention of anaemia (used as a proxy indicator for poor micronutrient status) and stunting, as well as acute malnutrition[11]. This shift in approach by UNHCR and partners comes from the identified need to improve the management and prevention of these forms of undernutrition and the availability of specialised nutritional products for targeting them.

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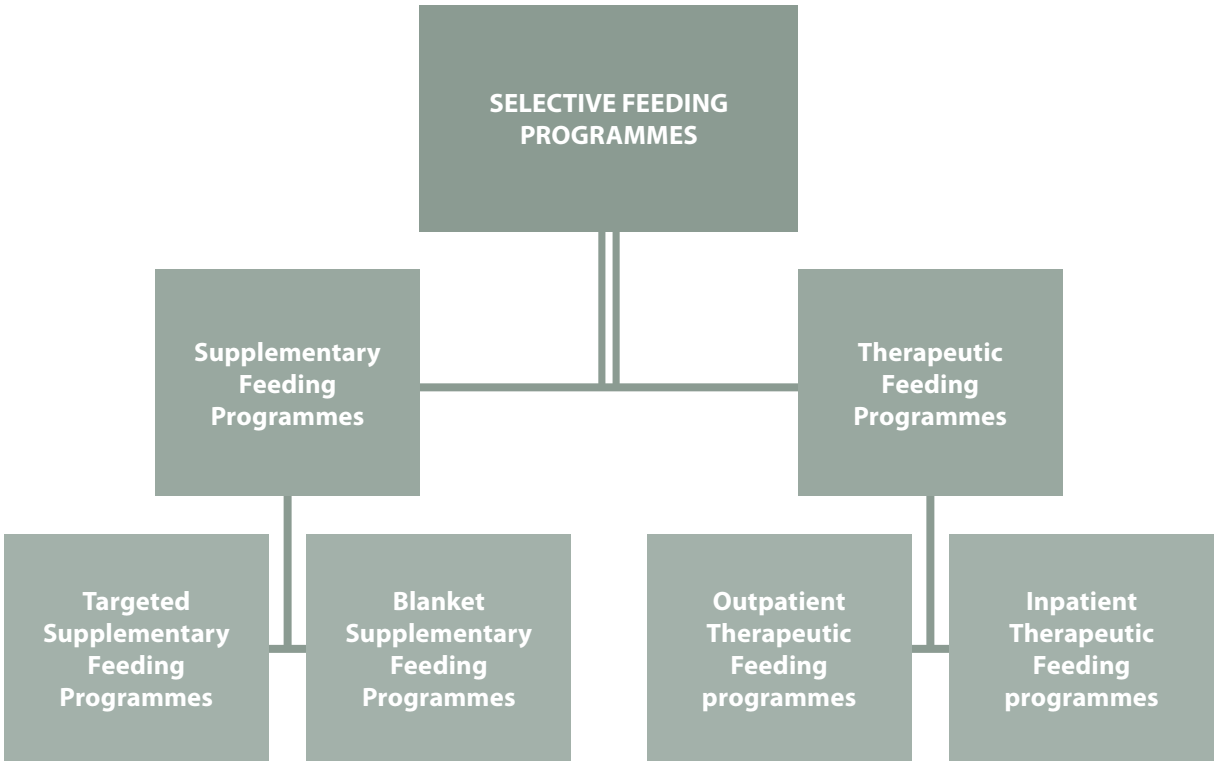
9 UNHCR/WFP (2011). Guidelines for Selective feeding: The Management of Malnutrition in Emergencies.

10 UNHCR-RSH Clarifications on Blanket Supplemental Feeding Programs (BSFP) – Who, When and Why.

11 Style S, Tondeur M, Wilkinson C, Oman A, Spiegel P, Spiegel P, Kassim I.A.R, Grijalva-Eternod C, Dolan C, Seal A. (2013) Operational Guidance on the use of Special Nutritional Products in Refugee Populations. Food Nutr Bull 34(4): 420-428.

FIGURE 1. SELECTIVE FEEDING PROGRAMMES TO ADDRESS MAM AND SAM (WFP/UNHCR (2011) GUIDELINES FOR SELECTIVE FEEDING: THE MANAGEMENT OF MALNUTRITION IN EMERGENCIES).



STAGE 1 – DEFINE THE PROBLEM

- *Refer to the 2011 Operational Guidance **Stage 1 (pg.20-27)** for further guidance on using nutritional indicators (GAM, stunting, and anaemia) as criteria for making decisions on when to implement a BSFP.*

STAGE 2 – IDENTIFY POSSIBLE SOLUTIONS: PRODUCT SELECTION AND TARGET GROUPS

- ***Refer to the 2011 Operational Guidance Stage 2 (pg. 28-39) for guidance on scenarios in which Super Cereal (FBF+/oil/sugar) or Super Cereal Plus (FBF++) may be a suitable product.***
  - ***For further product information, see Table 3 - Summary of Newly Developed Fortified Blended Foods and Food Supplementation products for use in Children aged 6-59 months (pg. 30-31).***

PRODUCT SELECTION

Selecting FBF as a suitable product may be driven by stock availability, pipelines and funding. However further to this, FBF is likely to be the product of choice in contexts where the community can cook the FBF (i.e. firewood/fuel is available), it is culturally acceptable, or where Governments restrict the use of certain products such as LNS. LNS tend to be more costly, and therefore may be best used in certain circumstances e.g. emergencies, where cooking possibilities are limited, or where FBF is not accepted[12]. Where FBF is chosen as a suitable option, the most appropriate blend (corn, wheat, rice) should be selected based on the local context and cultural preferences.

Any decision on product selection should involve discussion and consultation between key stakeholders that will include, but not necessarily be limited to, UNHCR, WFP, nutrition, health, and food assistance partners and representatives of the refugee population.

Super Cereal and Super Cereal Plus are improved versions of FBF containing a modified vitamin and mineral content. Both are currently available in corn, wheat and rice blends (see **Table 1**).

12 Follow-up meeting of the joint WHO/UNICEF/WFP/UNHCR consultation on the dietary management of moderate malnutrition. 23rd February, 2010, WHO HQ, Geneva.

TABLE 1. SUPER CEREAL AND SUPER CEREAL PLUS BLENDS AND TERMINOLOGIES.

BLEND	SUPER CEREAL (FBF+)	SUPER CEREAL PLUS (FBF++)
Corn Soya Blend (CSB)	CSB+	CSB++
Wheat Soya Blend (WSB)	WSB+	WSB++
Rice Soya Blend (RSB)	RSB+	RSB++

Super Cereal Plus e.g. CSB++ is the recommended FBF for programmes which target children 6-23 months with the objective of preventing acute and/or chronic malnutrition. Super Cereal Plus is further improved with a more comprehensive micronutrient vitamin and mineral mix, improved processing and the addition of milk powder, sugar and oil i.e. it is specially adapted to suit the additional nutrient requirements of infants and young children aged 6-23 months. Compared to Super Cereal e.g. CSB+, Super Cereal Plus has improved nutrient density, higher bioavailability of nutrients, animal source protein, and reduced anti-nutrient properties.

The 2011 Operational Guidance and this Addendum also include Super Cereal (FBF+/oil/sugar) as a potential option to consider for children 6-59 months and PLWs[13]. Whilst this is not the recommended FBF for children it reflects the reality of many contexts where Super Cereal is still frequently used due to a lack of funding and/or when problems with product availability prevent the use of Super Cereal Plus[14].

WFP considers locally produced FBF to be Super Cereal because all manufacturers use a premix that meets WFP specifications. No local equivalent exists for Super Cereal Plus. Super Cereal is available with or without sugar. It is usually mixed with 20g oil and 15g sugar per 200g before distributing, however if Super Cereal with sugar is ordered, only oil needs to be added before distribution (oil is only premixed in Super Cereal Plus).

13 PLW are only briefly considered here. This includes pregnant women verified by either a health card or visible pregnancy, or lactating women with a child <6months, verified by mothers health card, or child's birth certificate or health card. Contextual considerations for inclusion of this group include; low birth weight rates, sub optimal infant and young child feeding (IYCF) practices and whether effective treatment for PLWs is in place (Save the Children, 2013).

14 Note that in contexts where Super Cereal (e.g. CSB+) is provided in both the General Food Distribution (GFD) *and* BSFP, experience indicates that recipients may not perceive the added value of the BSFP since the commodity is already in the GFD. This should be considered when raising awareness and developing the Behaviour Change Communication (BCC) strategy.

TARGET GROUPS

Acute malnutrition

It is recommended that the default target group for the prevention of acute malnutrition is children 6-23 months, however this should be extended to children 6-59 months when one or all of the following scenarios apply. It should be noted that these exceptions are highly likely among refugee populations:

- Extremely high global acute malnutrition (GAM) i.e. GAM critical (≥15%), or serious (10-14%) with aggravating factors[15, 16] including extreme food insecurity
- Treatment of MAM is limited
- Prevalence of GAM is high in all age groups between 6-59 months, or higher in the older children e.g. 24-59 months than the younger children within this group
- National guidelines specify this age group.

Any decision to restrict BSFP to the 6-23 month age group should be justified using acute malnutrition prevalence data from the latest nutrition survey, of children 6-59 months of age.

Stunting

Programmes aiming to prevent stunting should target children 6-23 months (or 6-35 months in rare cases where specified by national guidelines). Although stunting may also be high in older age groups, greater catch up growth is possible when prevention is focused on children under 2 years of age.

Anaemia

In the absence of high GAM and/or stunting, FBF would not normally be considered a suitable product for tackling high anaemia prevalence due to the large daily quantity provided, in terms of energy, which may be unnecessary for reductions in anaemia. However, using FBF for prevention of GAM and stunting is likely to have an effect on anaemia.

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15 Aggravating factors (UNHCR/WFP, 2011): Nutritional situation deteriorating; GFD below minimum energy, protein and fat requirements; crude mortality rate>1/10,000/day; measles or whooping cough epidemic; high prevalence of respiratory or diarrhoeal diseases.

16 It should be noted that the 2011 operational guidance recommends the use of LNS where GAM is serious and persistent; i.e. above 10% but stable. Refer to pg.32-38 Section 2.2 'Scenarios for product selection'.

STAGE 3 – ASSESS RISKS AND CHALLENGES

- *Refer to the 2011 Operational Guidance **Stage 3 (pg. 40-51)** for guidance on assessing risks and challenges. This includes information on:*
  - *Risk 1 - Adverse effects on other programmes*
  - *Risk 2 - Excessive micronutrient consumption*
  - *Risk 3 - Adverse effects on feeding practices and child health*
  - *Risk 5 - Delays in importing and obtaining permission for product use*
  - *Risk 6 - Deterioration of stock*
  - *Risk 7 - Environmental pollution*
- *See below for supplementary information.*

RISK 4 – SAFE AND ACCEPTABLE DURATION AND FREQUENCY OF USE

There is limited evidence to date to guide recommendations on the frequency[17], and especially duration of use of FBFs in BSFP. Key factors to bear in mind are highlighted in the **Operational Guidance (pg. 47)**.

The duration of a BSFP should depend on the current or expected food security context. As a guide, programmes for the prevention of stunting and micronutrient deficiencies (usually implemented over 12-18 months), tend to be longer than those designed to prevent acute malnutrition (usually 3-6 months)[18]. With longer term programmes, children should exit once they reach the upper age limit, whereas for shorter-term programmes, it is more beneficial and easier for programme management for children to remain in the programme for its duration.

17 For information on suggested frequency of distribution, see the 2011 Operational Guidance pg. 74. Note that frequency of distribution is nearly always monthly.

18 WFP (2013). Managing the Supply Chain of Specialized Nutritious Foods.

Some indications that a BSFP may be stopped are[19]:

- Decreased Global Acute Malnutrition (<10%)
- Decreased mortality rates
- Stabilisation in any population movements (for example if there has been significant influx of refugees which may initially overwhelm camp services)
- No nutritional deterioration is expected (although if seasonal deterioration is expected in relation to the hunger gap, closure should be delayed)
- When an improvement in food accessibility and availability (quantity, quality and equity) is expected.

Compared to products like MNP and LNS, FBF provide a larger proportion of a child's daily food intake. Due to the small stomach size of infants and young children, the daily ration should therefore be provided in a minimum of 2 portions per day.

19 MSF (2013). MSF Nutrition Guideline (adapted from)

STAGE 4 – TEST SPECIAL NUTRITIONAL PRODUCT ACCEPTABILITY

- ***This section provides updates on testing acceptability of an FBF and replaces the corresponding Stage in the 2011 Operational Guidance (pg. 52-65)***

Many refugee populations are already familiar with blended foods, therefore an in-depth investigation into beneficiary/community acceptability of and adherence to FBF protocols, as described in the 2011 Operational Guidance, may not be required (adherence is defined here as the extent to which product consumption conforms to the recommendations provided to the caregivers). This need should be assessed on a case by case basis.

At the current time there is no field friendly way of measuring adherence to FBF protocols. In households with more than one child registered in the BSFP, caregivers are likely to feed all registered children from one packet / bag of FBF before opening the next, therefore it is difficult to assess how much an individual child may have eaten. Additionally, where sharing with household members not registered in the BSFP occurs, adherence is likely to be over-estimated. While these challenges apply when assessing adherence to any special nutritional product, they are more problematic with FBF as the product is consumed from the same packet over a number of days, rather than one sachet being consumed per day.

To help address this challenge, before implementing a BSFP using FBF, a well implemented **'Rapid Acceptability Assessment'** based on participatory cooking demonstrations and nutrition and hygiene education sessions is recommended.[20] This will facilitate the understanding of context specific nutrition related beliefs and behaviours, local consumption preferences, and which key factors for encouraging acceptance and correct use of the product are essential, particularly where little is known about the context. If the product is not used as intended, the nutrient gap in the beneficiaries' diet will not be filled.

20 This need should be balanced against the need to distribute the product to beneficiaries as quickly as possible (WFP (2013). Managing the Supply Chain of Specialized Nutritious Foods).

This assessment can help to ensure that the messages and activities developed during planning and implementation of the intervention are tailored to existing health beliefs and knowledge gaps in the population, and will be easily understood (see **Stage 5** of this document for further information on essential Behaviour Change Communication (BCC)).

Some benefits of conducting a Rapid Acceptability Assessment are as follows:

- Aids in the development of context specific key messages and in identifying important considerations for programme planning (see **Stage 5**)
- Provides an opportunity to address the communities' questions
- Helps identify local names for the FBF to use during BCC and awareness campaigns
- Provides an on-the-job training opportunity for staff who will participate in the camp wide cooking demonstrations (see **Stage 5**)
- Where possible, competent and motivated caregivers participating in the assessment can be identified and recruited to conduct the camp wide cooking demonstrations.

Whilst acceptability assessments should be undertaken during the planning phase there may be situations where the product is already in-country, or the FBF needs to be distributed to beneficiaries as quickly as possible. In such cases it may be necessary to conduct the assessment in parallel to implementation (ideally during the first 2 months) and the findings can be used to refine key messages and BCC strategies where necessary[21].

RAPID ACCEPTABILITY ASSESSMENT: COOKING DEMONSTRATIONS ACCOMPANIED BY NUTRITION AND HYGIENE EDUCATION

The Rapid Acceptability Assessment should include the following key components:

1) Stakeholder meetings with partners and key members of the community (where demonstrations will be held) e.g. parents, community leaders, elders and health staff, to discuss and raise awareness of the proposed cooking demonstrations
2) Staff recruitment and training; 1-2 trained staff per cooking demonstration will be needed (where possible a capable and motivated caregiver can be trained to conduct the demonstration)
3) Cooking demonstrations accompanied by nutrition and hygiene education sessions
4) One post-demonstration focus group discussion per cooking demonstration to investigate community acceptability, perceptions of the product and potential challenges etc.

21 In these cases, information collected during a Rapid Acceptability Assessment can still be used to help design a culturally appropriate, context-specific BCC to help ensure proper use of the product.

Important!!

- **In camps where different types of FBF are used for different target groups, it is essential for mothers/caregivers to be made aware of the difference between the products in terms of their content, purpose, target group and any different cooking methods required. Note that Super Cereal Plus looks slightly different from Super Cereal due to added milk powder.**
- **Cooking demonstrations and assessments of acceptability should be carried out using samples of the product being used in the BSFP. For example, using Super Cereal (often more easily available, and provided in the General Food Distribution (GFD) for all members of a household) in place of Super Cereal Plus may cause confusion and misunderstanding of the different purpose and target groups of both products. If it is not possible to obtain Super Cereal Plus samples from the product manufacturer, samples should be sought from neighbouring operations. As a last resort, verbal instructions should be used.**
- **Ensure cooking demonstrations are conducted in an accessible location and a time convenient for caregivers to attend i.e. avoid conducting during the GFD or other important distributions or activities.**

Super Cereal and Super Cereal Plus product information sheets for guidance on conducting a cooking demonstration are available at http://www.unhcr.org/pages/52176e236.html, in the Addendum folder. These can be adapted according to need and context.

A summary of the key objectives and requirements to conduct a Rapid Acceptability Assessment are provided below, and **Table 2** summarises the activities involved. This information can be used for planning and report writing.

Objectives of a Rapid Acceptability Assessment:

- To assess community acceptance of the FBF provided in BSFP
- To identify key challenges, barriers, and enablers for the BSFP
- To answer participants questions regarding the product and its use
- To clarify differences with FBF provided from other sources e.g. GFR (if applicable)
- To stimulate positive experiences and perceptions of the FBF and the BSFP
- To identify from the above, key concepts for inclusion in the BSFP BCC strategy (**Stage 5**)
- To increase participant's knowledge and understanding of optimal Infant and Young Child Feeding (IYCF), nutrition and hygiene practices.

Sample size required:

- **The minimum number of cooking demonstrations to conduct for the Rapid Acceptability Assessment is 3.** These should be manageable for most operations, whilst also allowing the necessary information to be extracted. However, more may be needed in diverse populations
- As a guide, each cooking demonstration should have no more than 10-12 adult participants present plus participants' children in the target age range, as this should be a manageable number for subsequent focus group discussions.

How to select a sample for inclusion:

- Participants can be selected randomly or by actively seeking interested participants from individual camp blocks. However the following should be included where possible:
  - Caregivers e.g. mothers, grandmothers, siblings, and other persons in charge of cooking and feeding children (of the target age range) should form the majority of participants
  - Children of all age ranges in the target group should be represented
  - Key community leaders e.g. block leaders, opinion leaders etc.
  - Men e.g. fathers, household heads
  - Individuals from all geographic areas of the camp
  - Individuals from all ethnic groups (where applicable).

Materials needed for cooking demonstrations:

- Safe drinking water
- Clean cooking utensils (spatulas, spoons etc.)
- Large pot
- Bowls and small spoons for participants to taste the FBF
- Fuel e.g. firewood[22]
- Sufficient samples of FBF
- A bowl to wash the pots and utensils after use
- Washing detergent
- BCC materials for education sessions

How to run the Focus Group Discussions

Focus group discussions should be conducted at the end of each cooking demonstration to investigate participants' perceptions of the product and key factors mentioned above (see also **Table 2**). Depth of questions should depend on the extent of existing knowledge of the population and culturally specific feeding habits. Where little is known about the context, it may also be necessary (where feasible) to conduct interviews with health workers and other key stakeholders to investigate further.

22 Feedback received highlighted that for large cooking demonstrations, considerable quantities of firewood would be required in order to prepare sufficient FBF for participants; gas burners may therefore be preferable as they require considerably less fuel. As long as there is no difference between how the FBF is prepared between firewood and gas, either fuel may be used depending on what is considered easiest.

TABLE 2. KEY ACTIVITIES IN THE RAPID ACCEPTABILITY ASSESSMENT

ACTIVITY	COMMENTS
Stakeholder meetings	The purpose of the activity should be explained clearly, and consent obtained from all participants.
Nutrition, IYCF, and hygiene education	A brief education session should be provided to all participants focusing on the following. - The product, its purpose and proper use - Possible side effects and what to do if side-effects occur - Appropriate breastfeeding and complementary feeding practices - Information on proper hygiene practices e.g. hand washing with soap prior to cooking, using clean utensils, not storing the FBF after cooking. FBF information sheets can be used to develop these sessions available at: http://www.unhcr.org/pages/52176e236.html.
Cooking demonstration & taste tests	See online FBF Information Sheets. Cooking demonstrations should be overseen by existing trained community workers (usually refugee staff) or partner staff, and have a maximum size of 10-12 adult participants and their children in the target age range. Ideally, demonstrations should be conducted by refugees (caregivers) seen as 'good examples' in the community, with healthy children who (in some cases) may have previously used the FBF properly i.e. a 'positive deviant'* approach. Key messages should accompany all cooking demonstrations. Allow all participants to taste the FBF.
Focus Group Discussion	A discussion should be facilitated at the end of the cooking demonstration to investigate questions (that will depend on existing knowledge of the context and cultural preferences) such as: - Common child caring practices (e.g. how / when children are fed, common complementary foods used etc.) - Perception of the FBF, including its appearance and taste - Challenges and potential barriers to implementation and uptake (e.g. do caregivers have sufficient time for preparation, access to cooking utensils and firewood/fuel, knowledge of malnutrition and its causes) - Suitable names for the product - Local views on malnutrition etc.

*See http://www.positivedeviance.org/about_pdi/index.html for further information on positive deviance.

- ***Refer to the 2011 Operational Guidance acceptability and adherence tools for further information on conducting FGDs and KI interviews, and potential questions to include:***
  - ***Tool 2 – Acceptability test protocol (pg. 9-11)***
  - ***Tool 3 – Acceptability test tools (pg. 5-14)***

STAGE 5 – DESIGN THE PROGRAMME AND DISTRIBUTE THE PRODUCT

- ***Refer to the 2011 Operational Guidance*** *Stage 5 (pg. 66-75)* ***for guidance on designing the programme and distributing the product. This includes information on:***
  - ***Coordinating programme implementation***
  - ***Logistics***
  - ***Training health workers and staff***
  - ***Developing a communication plan***
  - ***Distributing the product and frequency of distribution.***
- ***See below for supplementary information.***

DEVELOP A COMMUNICATION PLAN

- ***The following information supplements* *Section 5.4 (pg. 70-73)* *of the 2011 Operational Guidance. Please refer to this section for further details.***

Key Messages / Sensitisation

Similarly to BSFPs that use LNS / MNP products, it is essential to develop an effective communication plan, including a significant public education campaign and BCC strategy. It is essential for refugees themselves to be involved in the process of sensitisation. The 2011 Operational Guidance (pg. 70-73) provides information on BCC and designing key messages. Findings from the Rapid Acceptability Assessment should inform the development of key messages, which can also be refined during programme implementation should problems arise, as illustrated in the case study below.

FBF BCC materials including key messages are provided for help, and may be translated as necessary (FBF information sheets and WHO Food Safety Poster are available at http://www.unhcr.org/pages/52176e236.html).

FBF is more likely to be shared with other children than Ready-to-Use Supplementary Food (RUSF)[23, 24] and while there are many reasons that this may happen, this should be considered in the key messages and education provided.

Experience indicates that BCC messages and activities are greatly compromised in contexts where, due to shortages, Super Cereal Plus has been replaced with Super Cereal / oil / sugar, or conversely, the target age range has been expanded due to the availability of excess product. This sends mixed messages to caregivers as to whom different products are intended. It is therefore important to ensure that the pipeline is carefully planned and, when supply problems do occur, BCC messages are adapted to reflect the change in programme operations.

Case Study – Camp A – BSFP providing Super Cereal Plus (CSB++) to children 6-23 months.

Key informant interviews were conducted to assess a number of problems encountered during implementation. Key informants included caregivers of children registered in the BSFP, community workers and other key stakeholders. Interviews investigated stakeholders' knowledge of Super Cereal Plus and its correct use, barriers to consumption, and methods of storage etc. The following findings were identified, which were then used to refine key messages, and the BCC strategy:

- Many participants weren't aware of the differences between Super Cereal (provided in the General Ration for the whole household) and Super Cereal Plus i.e. that Super Cereal Plus contains added milk powder (which is a better source of protein), is more easily digestible, has a better nutrient density and is therefore more nutritious for infants and young children greater than 6 months of age than Super Cereal
- Many caregivers were reporting that their child had diarrhoea after consuming CSB++ and were therefore attributing it to the product. Many caregivers were also allowing their children to eat the product dry which might cause stomach problems
- Caregivers were not clear on the correct cooking method and the ratio of Super Cereal Plus to water that should be used, nor how long the product should be cooked for. This may have contributed towards children disliking the product, side effects such as diarrhoea, and reduced nutrient value if overcooked
- Even after months of BSFP distribution, caregivers were observed boiling 4 cups of water, and then adding the CSB++ which resulted in lumpy porridge which is likely to be less palatable, rather than pre-mixing a small amount of flour with water beforehand
- Some caregivers did not know dates of the BSFP distribution
- The Super Cereal Plus was provided in one month rations, however many households had none left at the time of the interview which took place 1.5 weeks after distribution. Whilst the product may have been shared, further investigations indicated that households frequently empty the contents of the FBF packets for selling but retain the packet in order to hand it in at the next distribution, a mandatory requirement to receive further rations.

23 Wang RJ et al. Investigation of Food Acceptability and Feeding Practices for Lipid Nutrient Supplements and Blended Flours Used to Treat Malnutrition. J Nutr Educ Behav 2013; Vol 45, 3:258-263.

24 Take home ration sizes are generally increased in order to account for sharing at the household level.

Camp Wide Cooking Demonstrations

For BSFP using FBF, cooking demonstrations are an essential component of any BCC strategy; while caregivers may be familiar with porridge, they may be unfamiliar with FBF, its purpose, and how to prepare it. Experience suggests that regions with a higher rate of correct use tend to have better knowledge about the product. They also report higher attendance to sensitisation sessions, indicating that audience-appropriate and product specific sensitisation can increase knowledge, and therefore correct use of products[25]. After the population have been informed about the BSFP, cooking demonstrations should be planned in collaboration with block/community leaders, to cover the entire camp and all caregivers of registered children. Note that this activity is different from the Rapid Acceptability Test mentioned above which only involves around 3 cooking demonstrations in selected households, to investigate acceptability.

The duration of this activity will depend on the camp's population however, as a guide, around **1 cooking demonstration per 25 households** is recommended, so as to achieve a reasonable coverage of the population. Demonstrations should ideally be conducted at the block level, or at the smallest level of segmentation used in the camp, as often this is where similar ethnic groups reside.

Ensure that the planned dates for cooking demonstrations and the importance of attending are well communicated to the refugee population. A single cooking demonstration is unlikely to be sufficient for a household to properly cook FBF, therefore household level follow up involving direct observations and necessary corrections of cooking methods used should be organised within 2 weeks of completing the cooking demonstrations. These should be conducted by refugee outreach / community health workers who live in the block.

As previously mentioned, FBF information sheets providing guidance on FBF preparation can be found at http://www.unhcr.org/pages/52176e236.html. These should be adapted according to need and context when planning cooking demonstrations, in addition to guidance from **Stage 4**.

25 GroundWork LLC. (2013). Report on the Monitoring and Evaluation Results: WFP's Emergency Nutrition Response to the 2012 Sahel Crisis: Blanket supplementary feeding – operational performance and effect on acute malnutrition.

The objectives of the camp cooking demonstration should be as follows:

Objectives:

- To introduce the FBF to the camp population, particularly caregivers of children in the target age range of the BSFP
- To inform participants on the purpose of the FBF and that it is a special food for the target age group
- To inform caregivers how to prepare the FBF and to share key messages
- To increase caregiver's knowledge of the role of the FBF in the prevention of malnutrition
- To provide an opportunity for the community to taste the product
- To answer participants questions, and address concerns.

Secondary objectives:

- To clarify differences with FBF provided from other sources (if applicable)
- To increase caregiver's knowledge and understanding of optimal IYCF, nutrition and hygiene practices.

Expected outcomes are as follows:

- The safe preparation of FBF is known and understood
- Participants understand the role of FBF in prevention of malnutrition
- Participants have improved understanding of key hygiene and IYCF practices
- Households accept, and target children adhere to the FBF during the intervention life-cycle.

FIGURE 2. COOKING DEMONSTRATION

ORDER THE PRODUCT

- *The following information supplements **Section 5.2.3 (pg. 68)** of the 2011 Operational Guidance. Please refer to this section for further details.*

It is important to regularly revise planning and supply chain documents in order to avoid excesses or shortages of food[26]. As mentioned, where excess occurs, the target age group is frequently expanded to avoid wastage; however experience from the field indicates that this causes considerable confusion and scepticism to caregivers on the BCC messages of importance, if they have previously been sensitised that the FBF is a special commodity for a specific age group and shouldn't be shared with older children.

26 Regarding procurement, the UNHCR/WFP MoU (2011) states that 'WFP is responsible for mobilizing cereals, edible oils and fats…and fortified blended foods for general, selective and school feeding programmes', and that 'WFP will ensure the provision of improved fortified blended foods, such as corn-soya blend (CSB+ and CSB++), or other fortified food items... for targeted and blanket supplementary feeding interventions that address moderate acute malnutrition, stunting and micronutrient deficiencies'. 'When WFP is unable to provide these items, UNHCR, in consultation with WFP, will explore other possibilities for their provision until WFP is able to provide them.' See http://www.unhcr.org/53465c929.html.

Ration Sizes

BSFP rations are generally intended to supplement the daily diet and meet the nutrient gap i.e. between nutrient requirements and nutrient intake. Standardised guidance for the minimum daily energy, protein and fat provided from Super Cereal and Super Cereal Plus, summarised from WFP's Specialised Nutritious Foods sheet, are provided below[27].

TABLE 3. ADAPTED EXCERPT OF WFP SPECIALIZED NUTRITION FOODS SHEET: SUPER CEREAL PLUS AND SUPER CEREAL FOR THE PREVENTION OF STUNTING AND ACUTE MALNUTRITION.

ITEM	SUPER CEREAL PLUS	SUPER CEREAL AND LOCAL EQUIVALENTS
Main ingredients	Corn/wheat/rice, soya, vitamins and minerals, milk powder, sugar, oil	Corn/wheat/rice, soya, vitamins and minerals, **with added sugar and/or oil**
Daily ration	100-200g (200g includes provision for sharing)	100-200g (200g includes provision for sharing)
Nutrient profile	394-787 kcal, 16-33g protein (17%), 10-20g fat (23%). Contains EFA, meets RNI and PDCAAS[3]	376-752 kcal, 15-31g protein (16%), 8-16g fat (19%). Meets RNI and PDCAAS With added sugar and oil[1]: 613-989 kcal, 15-31g protein, 28-36g fat.
Shelf life	12 months	12 months[2]
Packaging details	Primary: 1.5kg (net) bag; Secondary: 15kg (net) carton has 10 bags; or 18kg sack has 12 bags	25 kg (net) bags

% refers to the percentage of energy supplied by protein or fat

[1] Calculated in NutVal version 3.0

[2] This refers to pre-packaged Super Cereal, or Super Cereal with sugar.

[3] EFA = Essential fatty acids; RNI = Reference nutrient intake; PDCAAS = Protein digestibility corrected amino acid score

Note that the above nutrient profiles differ slightly from those provided in the WFP/UNHCR (2011) selective feeding guidance (pg. 53), which state that Supplementary Feeding Programme (SFP) on site rations should provide between 500-700kcal, but take home rations should provide from 1,000 to 1,200 kcal per person per day, and 35-45 grams of protein to account for sharing at home. This is likely to be partly because the need to increase rations to such an extent to account for sharing

27 WFP. (2013). Managing the Supply Chain of Specialized Nutritious Foods. Pg. 38-41. http://documents.wfp.org/stellent/groups/public/documents/manual_guide_proced/wfp259937.pdf

has been questioned whilst commodities are getting more expensive because of their better nutritional quality[28].

Contact UNHCR HQ / Regional Offices for further advice on the recommended daily ration for Super Cereal with added oil and/or sugar[29].

DISTRIBUTE AND STORE

Super Cereal Plus is currently pre-packaged into weekly rations of 1.5 kg packets, and pre-mixed with oil and sugar, thus facilitating distribution. Empty packets should be retained by caregivers and returned at each distribution as a pre-requisite to receive further rations. Note that while this may encourage correct usage, it is not proof that the product has been consumed by the target beneficiary.

Super Cereal is usually packaged in 25kg bags; sugar can be premixed in the bags, mixed at-site prior to distribution (to avoid sale or exchange of the individual commodities), given separately, or not included at all. Oil also needs to be added during preparation. Ensure pre-packaging takes place under appropriately hygienic conditions.

Containers or bags should be provided for transportation and storage of the product at the household level (see **Figure 3** below). This helps to separate the BSFP food from food intended for the whole household, as well as to reduce contamination as long as containers/bags are kept clean. Bowls, spoons and cooking pots should also be distributed to beneficiaries where necessary.

It is important to ensure that sufficient staff are present during distributions, as long delays or queues may discourage caregivers from attending. In some contexts, particularly where the organisation registering beneficiaries is different from the organisation distributing the product, the use of tokens may facilitate distribution; caregivers are only given a token which can be redeemed for the ration once their child is fully registered.

Appropriate distribution sites are considered to be health/nutrition centres, child friendly spaces and general distribution site (but not on the same day as the GFD). Distribution sites that are *not* appropriate include breastfeeding tents or other baby friendly spaces working on breastfeeding

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28 de Pee S, Bloem MW. Current and potential role of specially formulated foods and food supplements for preventing malnutrition among 6- to 23-month-old children and for treating moderate malnutrition among 6- to 59-month-old children. Food Nutr Bull 2009;30(3 suppl):S434-63

29 As an example, contexts using pre-mixes have provided the following ration per day (rations given in g/p/d):

Refugee context:

- Bangladesh (2011): Children 6-23 months – WSB+ pre-mix: 180g WSB+; 40g fortified vegetable oil, 20g dried skimmed milk; and 40g sugar (**1,272 kcal**)

Rural contexts:

- Kenya (2010): Children 6-59 months (and PLW) - 250g CSB, 25g oil (**1,225kcal**).
- Kenya (2011-2012): Children 6-59 months (and PLW) - 200g CSB, 20g oil (**977kcal**).

promotion, support and protection. Ideally, FBF for PLWs should be distributed through the Ante-Natal Care (ANC) sites to encourage follow up during and after delivery.

Where feasible, brief product education sessions should be held with recipients at the distribution site, including information on proper hygiene, complementary feeding practices, and cooking methods. However, BCC activities should also be delivered at the household level, as distribution sites may not be the optimal location for education sessions if they are overcrowded, and recipients have queued for long periods. Defaulters (i.e. registered children who have missed 2 consecutive distributions) should also be followed up through home visits, and re-entry to the BSFP facilitated if possible.

FIGURE 3. STORAGE CONTAINERS FOR BSFP FOOD

1) Bucket for collection and household storage of FBF; 2) Bad practice example - recipient's dirty/ contaminated bucket; 3) Members of the distribution team at work; 4) Collection of empty Super Cereal Plus packets at distribution site.

SCREENING AND SYSTEMATIC TREATMENTS

In refugee contexts where malnutrition levels are high, the BSFP can provide a good opportunity for:

- On-site anthropometric screening, allowing the monthly monitoring of at-risk children, and those with SAM or MAM to be referred for treatment (a screening and referral summary template which can be adapted to individual contexts and needs is available at: http://www.unhcr.org/pages/52176e236.html)
- Systematic health treatments e.g. vitamin A and iron supplementation, vaccinations and deworming
- Linkages with other nutrition activities for example, growth monitoring and promotion, and baby friendly centres providing IYCF counselling to support appropriate growth of young children.

In such cases, planning for additional staff and anthropometric equipment (for measuring weight-for-height z-score and/or MUAC) is needed in order to provide a comprehensive service.

Note that many refugee contexts implement routine quarterly mass MUAC screenings, and vitamin A, measles, de-worming campaigns etc. therefore it is important not to duplicate efforts. Please refer to other guidance[30] for further details on health treatment as this is outside the scope of this document.

HUMAN RESOURCES

The following list of key personnel required for BSFP distributions is provided as a guide. The numbers of staff needed will depend on the activities undertaken and the population size served.

- Programme manager – accountable to deliver the programme
- Supervisor – to oversee all activities on a day to day basis
- Logistics staff – to manage the procurement, storage and movement of FBF
- Registration staff – to register/identify eligible beneficiaries on arrival
- Distribution staff – to distribute commodities
- Screeners and tally sheet registrars – to conduct anthropometric measurements, record anthropometric measurements and numbers of SAM/MAM children / PLW and to make referrals
- Verification staff – to conduct finger inking for beneficiaries
- Community health workers / volunteers – to conduct onsite education
- Crowd controllers – to maintain safety and security.

30 Save the Children. (2013). Blanket Supplementary Feeding Programming (BSFP). A Save the Children Guidance Note. Version 1.0.

STAGE 6 – MONITORING AND EVALUATION

- ***This section replaces the 2011 Operational Guidance LogFrame and section '6.2.1 on Indicator Descriptions'***
- ***Please refer to the 2011 Operational Guidance for information on:***
  - ***Overview of setting up M&E systems***
    - ***Adapting the M&E system***
    - ***Costs and budget***
  - ***Evaluation***

LOGFRAME

The UNHCR LogFrame for BSFP using FBF (see below) outlines the requirements for M&E. Please note that this LogFrame is specifically for use with BSFP using FBF and differs from the 2011 Operational Guidance LogFrame, which is aimed at BSFP using MNP or LNS.

The overall responsibility for conducting M&E lies with programme managers and staff members. While the UNHCR recommendations on M&E are presented here, within each operational setting efforts should be made to harmonise reporting requirements and indicators between partners.

MONITORING INDICATORS

Descriptions for all indicators specified in the LogFrame are provided, including whether they are 'Core', or 'Desired'.

- A *Core indicator* is regarded by UNHCR as being essential to allow the assessment of programme performance
- A *Desired indicator* is one that is useful for understanding factors that affect programme performance. It should be reported if data collection and analysis is feasible.

Indicator results should be summarised on the 'Reporting Form for BSFP Monitoring Data' provided in **Appendix 2**, which also includes the formulas required for calculating all indicators.

Note that most monthly indicators should be simple to collect and record during the BSFP distribution day, thus facilitating regular monthly monitoring. The collection of other indicators may require the organisation of specific activities.

UNHCR LOGICAL FRAMEWORK FOR THE MONITORING AND EVALUATION OF BLANKET SUPPLEMENTARY FEEDING PROGRAMMES USING FORTIFIED BLENDED FOODS (FBF)							
	Narrative Summary	**Indicator**	**Target**	**Core / Desired**	**Means of Verification**	**Remedial actions**	**Tool[a]**
1. Goal	1.1 To control and prevent micronutrient deficiencies and malnutrition among vulnerable refugee population group(s)[b]	1.1.1 GAM prevalence	<10% in the presence of aggravating factors[c]	**Core**	▪ GAM measurements in annual nutrition surveys	–	**UNHCR SENS**
		1.1.2 Anaemia prevalence	<40%[d]	**Core**	▪ Haemoglobin measurements in annual nutrition surveys	–	**UNHCR SENS**
		1.1.3 Stunting prevalence	<30%[e]	**Core**	▪ Stunting measurements in annual nutrition surveys	–	**UNHCR SENS**
2. Objective	2.1 Increased intake of micronutrients and nutritious foods in vulnerable refugee population group(s)	2.1.1 Product consumption by target group	>70%	**Core**	▪ Nutrition survey: IYCF questionnaire 24 hour recall for children 6-23 months[f] ▪ PDM report	▪ Assess barriers to poor consumption using FGD/KIs and/or mini-KAP, and target with BCC as appropriate	**UNHCR SENS PDM**
3. Output	3.1 Supply FBF to target group(s)	3.1.1 Product received by target group	>90%	**Core**	▪ Distribution list ▪ Monitoring report ▪ ProGres registration database ▪ Coverage measurement during nutrition surveys[g]	▪ Assess barriers to uptake and distribution using FGD/KIs and/or mini-KAP ▪ Target defaulters[a] with BCC messages as appropriate	**Appendix 2&3**
4. Activities	4.1 Procure and appropriately transport, store, and distribute FBF	4.1.1 Sufficient stock at distribution site(s)	100%	**Core**	▪ Order records ▪ Delivery slips	▪ Address issues with appropriate staff member of responsible organisation	**Appendix 2&3**
		4.1.2 Product wastage	<5%	**Core**	▪ Order records ▪ Delivery slips	▪ Review transportation, storage and handling procedures	**Appendix 2&3**
		4.1.3 Distributions undertaken on time	>90%	**Core**	▪ Distribution lists and dates	▪ Investigate and address distribution issues ▪ Distribute FBF to missed recipients by other means	**Appendix 2**
	4.2 Screen and refer recipients identified with MAM or SAM	4.2.1 Beneficiaries screened during distributions	>90%	**Desired**	▪ Screening report ▪ Beneficiary report	▪ Recruit more trained staff ▪ Procure additional anthropometric equipment ▪ Increase number of distribution sites / days to reduce queues	**Screening template**
	4.3 Train staff on FBF and programme systems (including nutrition/anaemia; FBF; distribution system; M&E system)	4.3.1 Necessary staff trained and available	>90%	**Core**	▪ Training attendance records	▪ Implement more trainings ▪ Recruit more staff ▪ Set this as priority activity for staff	**Appendix 2**
		4.3.2 Trained staff pass post-training test[h]	>90%	**Desired**	▪ Test results	▪ Review and improve training in problem areas ▪ Provide re-fresher training	**OG tool 1 Appendix 2**
	4.4 Implement BCC activities for target group(s)	4.4.1 Required FBF cooking demonstrations held (1 demonstration required /25 households)[i]	>90%	**Core**	▪ Education session attendance/implementation lists	▪ Increase availability of staff ▪ Order additional product where necessary	**Appendix 2**
		4.4.2 Adequate BCC materials (e.g. posters / pictures / flyers / radio / TV messages) are available[j]	Yes/No	**Core**	▪ BCC strategy	▪ Modify/improve BCC strategy / materials as appropriate	**Appendix 2**
	4.5 Follow up recipients to ensure proper understanding and usage	4.5.1 Recipients reporting sharing of FBF	<25%	**Desired**	▪ Nutrition surveys ▪ PDM	▪ Assess problem areas using FGD/KIs and/or mini-KAP, and target with BCC as appropriate ▪ Ensure key messages about usage are provided at distribution and during home visits	**Appendix 2**
		4.5.2 No selling of FBF on market	Yes/No	**Desired**	▪ Market visits ▪ PDM report		**PDM**
		4.5.3 FGD/KIs/ mini-KAP assessment (via HH visits or at distribution) completed during the first two months of implementation[k]	Yes/No	**Desired**	▪ Assessment and/or KAP report		**Appendix 2**
5. M&E	5.1 Implement nutrition surveys	5.1.1 Annual nutrition survey completed according to UNHCR Standardised Expanded Nutrition Survey (SENS) Guidelines[l]	Yes/No	**Core**	▪ Survey reports	▪ Allocate time and resources for survey ▪ Encourage staff/survey coordinator to produce and use reports	**UNHCR SENS**
	5.2 Monitor programme and alter as necessary to maintain proper function	5.2.1 Monitoring reports produced monthly[m]	Yes/No	**Core**	▪ Monitoring report	▪ Encourage staff to produce and use reports	**Appendix 2**
		5.2.2 All remedial action points in the previous monitoring report are addressed	Yes/No	**Core**	▪ Monitoring report		**Appendix 2**
	5.3 Implement additional evaluation activities if appropriate [m]	5.3.1 Additional evaluations are planned and undertaken if necessary[n]	Yes/No	**Desired**	▪ Evaluation reports	--	--

ACRONYMS AND ABBREVIATIONS

BCC	Behaviour Change Communication
FGD	Focus Group Discussion
GAM	Global Acute Malnutrition
IYCF	Infant and Young Child Feeding
KAP	Knowledge Attitude and Practice
KI	Key Informant
OG	2011 Operational Guidance
PDM	Post Distribution Monitoring

a. M&E Tools (see **Appendix 1** of this Addendum for full list of all tools and reference / training materials):
   Appendix 2 – Example monitoring reporting form for BSFP using FBF
   Appendix 3 – Cooperating partner distribution report
   Screening and referral summary template
   OG Appendix 3 – Tool 1: Nutrition worker post-training test.

b. Target groups as defined as:
   - Children 6-59 months
   - Women – especially pregnant and lactating women (PLW) (not covered in the current version of this guidance)
   - Adolescent girls (not covered in the current version of this guidance).

c. **10%** is the WHO cut-off for prevalence of GAM of serious public health significance. Aggravating factors (UNHCR/WFP, 2011): Nutritional situation deteriorating; GFD below minimum energy, protein and fat requirements; crude mortality rate>1/10,000/day; measles or whooping cough epidemic; high prevalence of respiratory or diarrhoeal diseases.

d. **40%** is the WHO cut-off for anaemia prevalence of high public health significance (The Management of Nutrition in Major Emergencies 2000).

e. **30%** is the WHO cut-off for prevalence of stunting of serious public health significance (The Management of Nutrition in Major Emergencies 2000).

f. Note that consumption assessments in nutrition survey IYCF 24 hour recalls do not capture children 24-59 months.

g. Note that due to small sample sizes nutrition survey results for the assessment of programme coverage (% of beneficiaries who actually received the FBF) in children 6-23 months will not be precise, however should provide a useful indication for monitoring purposes. A defaulter is defined as a registered individual missing 2 distributions, with the exception of those having left the camp or legitimately exited the programme for another reason.

h. Staff tests should be administered immediately after training (and ideally again during the programme e.g. every 6 months), to ensure adequate staff knowledge.

i. FBF cooking demonstrations should include behaviour change communication (BCC) sessions with target groups on nutrition, proper complementary feeding, breastfeeding, anaemia, micronutrient deficiencies and FBF usage prior to the intervention starting; FBF cooking demonstrations should be prioritised to households with children in the target age group for the intervention.

j. Regular community BCC meetings in all sections/blocks of the camp(s), and individual/group BCC for new arrivals to the camp that are eligible for the FBF programme should be conducted, using available BCC materials.

k. Focus group discussions (FGD) and key informant interviews (KI) can be conducted to gather the information adapting the tools provided in the 2011 Operational Guidance Stage 4 as a guide, or using the mini-KAP questionnaire. If feasible, the mini-KAP survey provided in the 2011 Operational Guidance **Appendix 5** should be undertaken during the first two months of the programme, and again as required (for example if coverage, or consumption levels fall below target) in order to assess acceptance of the programme after implementation, and identify any problem areas that the programme needs to address. This can be undertaken as a house-to-house survey, or as exit interviews at distribution sites.

l. Annual nutrition surveys, including the Anaemia Module from the UNHCR Standardised Expanded Nutrition Survey (SENS) Guidelines, to be undertaken at the same time each year to ensure comparability and minimise seasonal fluctuations.

m. Desired frequency: suggestions are provided in **Appendix 2.**

n. See **Evaluation** section below and in the 2011 Operational Guidance for advice on further evaluations to undertake according to context.

OUTCOME MONITORING INDICATORS

Indicator 2.1.1 – Product consumed by >70% of target group (CORE)

This **consumption indicator** assesses whether the FBF is being consumed by the targeted child. Note that it does not provide any information on the extent to which the product consumption conforms to the recommendations provided to the caregivers i.e. adherence. Information on product consumption can be obtained from the following sources:

- ✓ **Children 6-23 months**: UNHCR's **Standardised Expanded Nutrition Survey (SENS) IYCF questionnaire** (see http://www.sens.unhcr.org) includes a 24 hour recall for children 6-23 months including questions on the consumption of FBF. When interpreting this information, be aware that sample sizes for this age group are small resulting in imprecise estimates with wide confidence intervals. Also, if children are not eating the product daily, the 24 hour recall may underestimate the proportion of children 6-23 months consuming the product. Additionally, in most contexts nutrition surveys are completed annually, and this may not coincide with the BSFP implementation unless planned accordingly, which is not always feasible.
- ✓ **Target groups including children ≥24 months:** WFP Post Distribution Monitoring (PDM) is sometimes used to collection information on consumption and use of the BSFP food in addition to or separately from PDM concerning General Food Distribution (GFD), through counting sachets or a proportional piling method. PDMs are usually conducted between 7 and 21 days after the monthly distribution. There are challenges associated with this method that should be considered during interpretation of the results. For example, households may not want to disclose that they do not eat the product for fear of rising losing their food entitlement. Thus, it is important for interview teams to be well trained to introduce questions on utilisation properly, and reassure households that the PDM results will not be used to inform a change in assistance entitlement. Care should be taken if the PDM is combined for the GFD and the BSFP to differentiate between the FBF distributed in the GFD and the FBF distributed in the BSFP.

PROCESS MONITORING INDICATORS

Indicator 3.1.1 – Product received by >90% (in each target group) (CORE)

This **coverage indicator** assesses whether intended recipients are attending distributions and collecting the FBF. Information on the proportion of recipients actually collecting the product can be recorded in **WFP's Cooperating Partners distribution report** (available in **Appendix 3** and online at: http://www.unhcr.org/pages/52176e236.html) or other UNHCR reporting formats where available. Additionally, in UNHCR administered camps, lists detailing registered individuals in population groups eligible for FBF are sometimes available from the ProGres database. These lists of eligible recipients can be compared to actual recipients attending each distribution and programme coverage estimated. Where ProGres is not available or up to date and a nutrition survey is being conducted at an appropriate time during BSFP implementation, UNHCR or partners may include relevant questions to assess coverage in the survey. The following key points should also be considered:

- ✓ Coverage should be calculated as the **number of actual beneficiaries / number of planned beneficiaries x 100.**
- ✓ Where coverage falls below 70%, barriers to programme uptake should be assessed using appropriate participatory methods including FGDs and KIs and / or by conducting a mini-KAP survey. BCC campaigns should be conducted to address the barriers identified.
- ✓ Defaulters may also be targeted individually, to address any concerns they may have.

▪ *Refer to the 2011 Operational Guidance **Appendix 5 (pg. 120-132)** for an example KAP questionnaire which can be adapted for BSFP using FBF.*

Indicator 4.1.1 - Sufficient stock at 100% of distribution site(s) (CORE)

This is a **logistics indicator**, and information on FBF quantities available in stock at the distribution site(s) can be found from **WFP's Cooperating Partners distribution report** (**Appendix 3**) by comparing the quantity received, to the quantity distributed. If this report is not available, information should be readily available from storekeepers or logistics managers in the form of delivery notes, waybills, or similar. **This indicator should be checked at each distribution site; the quantity of FBF available in stock before the distribution should be equal to or greater than the quantity of FBF distributed.** The following key point should also be considered:

- ✓ If sufficient stock at distribution site(s) falls below 100%, the reasons for this should be assessed, and issues addressed with the UNHCR/partner logistics manager at the appropriate stage of the supply chain, who should in turn check with the manufacturer, transport organisations, local partners, logistics departments, or check the orders placed by the distribution sites. Reasons should be documented on the monthly monitoring report.

Indicator 4.1.2 - Product wastage <5% (CORE)

Another **logistics indicator**, product wastage can provide information on whether the FBF is being appropriately transported, stored and handled, and can be found from **WFP's Cooperating Partners distribution report** (**Appendix 3**) by checking the spoilage / loss columns. The following key points should be considered:

- ✓ FBF should be checked for quality (undamaged, unopened, clean packaging, not out of date, unspoiled - no heat, water, animal, insect or other damage) at the time of delivery, and then regularly throughout the programme. This should normally be part of standard store checks.
- ✓ In some cases this may require initiating new checks, and storekeepers should be trained to check for problems and record the amount of product checked and the amount found to be

unfit for distribution, and therefore wasted. If >5% of FBF is found to be unfit for distribution, the reasons for this should be assessed, and issues addressed with the appropriate people (e.g. UNHCR/partner logistics manager, manufacturer, transport organisation).

Indicator 4.1.3 - >90% of distributions undertaken on time (CORE)

This is a **distribution indicator** assessing whether a programme is functioning. If distributions are not being undertaken then the FBF is not reaching its intended recipients, and the programme is not functioning. This indicator also considers the fact that delayed distributions (according to the planned schedule) may affect beneficiary attendance. The following key points should be considered:

- ✓ **Information on dates and locations of FBF distributions can be compared with planning documents to ensure that all planned distributions are going ahead.**
- ✓ If the proportion of intended distributions occurring on time falls below 90%, the reasons for this should be assessed and issues addressed (e.g. lack of FBF availability; lack of staff available to cover distributions; unforeseen events in the camp). FBF from missed distributions should be distributed to intended recipients by other means e.g. household visits, whenever possible.

Indicator 4.2.1 - >90% of beneficiaries screened during distributions (DESIRED)

While BSFPs do not admit beneficiaries according to nutritional status, screening at the BSFP site allows beneficiaries with acute malnutrition (MAM or SAM) to be referred for the relevant treatment. Additionally, programme managers can monitor changes in nutritional status, which may also be necessary for accountability to donors. Screening can most easily be carried out using MUAC and every child should also be checked for bilateral pitting oedema. It is important for staff to be sufficiently trained and supervised when taking measurements. In addition to reporting on the percentage of beneficiaries screened, other important screening data to report on includes:

- ✓ Percentage of children (according to sex) with: MUAC <11.5cm (SAM); MUAC ≥11.5 & <12.5cm (MAM); bilateral pitting oedema.
- ✓ Percentage of PLWs with MUAC <21cm[31].
- ✓ Total number of referrals to treatment for SAM and MAM (these should be verified with the relevant health provider / treatment programme to see if beneficiaries referred are attending).

Note that there is currently no threshold available for the number / proportion of cases that might be considered serious, however any increases in the number of cases identified should be investigated. A screening and referral summary template which can be adapted to individual contexts and needs is available at: http://www.unhcr.org/pages/52176e236.html.

31 Or according to national protocol.

Indicator 4.3.1 - >90% of necessary staff trained and available (CORE)

This **training indicator** relates to the implementation section of the **2011 Operational Guidance - Stage 5 (pg. 66-75)**, including staff recruitment and training. Staff and community volunteers should be trained on relevant nutrition, optimal complementary feeding and breastfeeding, anaemia, micronutrient deficiencies and the FBF in use in the refugee operation(s), according to their level of responsibility. The following key points should be considered:

- ✓ Planning documents specifying human resource requirements should be developed prior to implementation, including a calculation of the number of staff / volunteers required in each role. This should be compared to actual levels of fully-trained individuals available to the programme in each reporting period.
- ✓ If <90% of required, fully-trained staff / volunteers are available to run the programme properly, reasons for this should be assessed (e.g. suitable staff / volunteers unavailable in camp area; staff available but untrained so far, staff turnover), and issues addressed in order to make the required fully-trained staff available.

Indicator 4.3.2 - >90% of trained staff pass post-training test (DESIRED)

Another **training indicator**, this assesses whether knowledge gained in training sessions is understood and retained. The following key points should be considered:

- ✓ **This test should be administered immediately after the training session and again after the intervention has been running for some time** (refer to Reporting form in **Appendix 2** for suggested frequency).
- ✓ The test can be administered orally for community volunteers who may be illiterate.
- ✓ If a staff member / volunteer does not pass the test **(pass mark 75%)**, any weak areas should be addressed until understanding is achieved. If many individuals are not passing the test, the training curriculum should be reviewed and improved based on the areas of weakness identified.
- ✓ Where feasible, trained staff should be followed up at the field level to ensure theory is being correctly applied in practice.

- ▪ ***Refer to the 2011 Operational Guidance Appendix 3 (pg. 108-111) for the basic BSFP test of knowledge which can be adapted accordingly.***

Indicator 4.4.1 - >90% of required FBF cooking demonstrations held (CORE)

This **BCC indicator** assesses whether beneficiaries are receiving sufficient practical guidance on how to properly cook and feed the FBF as well as education on key hygiene and IYCF messages. Incorrectly cooked FBF can result in reduced nutrient content and changes to taste, as well as side effects including diarrhoea and stomach ache if the product is consumed raw. Poor hygiene practices during cooking or storage may also result in illness being wrongly attributed to the FBF. This can contribute to selling of the product, low consumption, or low attendance and defaulting. Please note the following:

- ✓ The number of camp wide cooking demonstrations required should be planned prior to BSFP implementation and these figures compared to the actual number held. Information on planning and conducting cooking demonstrations can be found in **Stage 5** above.
- ✓ Around 1 demonstration / 25 households should be held and prioritised to households with children in the target age group for the intervention.

Indicator 4.4.2 - Adequate BCC materials (e.g. posters / pictures / flyers / radio / TV messages) are available (CORE)

This **BCC indicator** along with indicators *4.4.1,* and *4.5.1 - 4.5.3* will help indicate the appropriateness and availability of the different BCC tools and strategy as a whole, to ensure proper understanding of the key messages among the refugee community.

Indicator 4.5.1 - <25% of recipients reporting sharing of FBF (DESIRED)

This **usage and knowledge indicator** assesses whether the FBF is being shared. This information can be assessed during monthly PDM specifically looking at the BSFP.

- ✓ **The number of recipients reporting any sharing should be compared to the number of recipients interviewed**. If more than 25% of recipients are found to be sharing, reasons for sharing, and amounts shared should be investigated using FGD / KI interviews etc., and BCC messages emphasising reasons for not sharing should be strengthened.

Indicator 4.5.2 - No selling of FBF on market (DESIRED)

This **usage and knowledge indicator** assesses selling of the FBF by the recipient. Significant selling of the product indicates that beneficiaries are not consuming adequate amounts and that households have other important needs that are not being met. Please note the following:

- ✓ Market visits should be conducted regularly to assess whether the products are being sold. It should be noted that in some contexts, recipients have been found to empty the contents of FBF packets for selling, or to accumulate the product from several distributions as larger quantities can be easier to sell.

- ✓ If it seems that a significant amount of FBF is being sold on the market KI interviews with the camp community should be conducted to investigate the reasons why the product is being sold. This may be an acceptability issue, which will require a change in the strategy.

Indicator 4.5.3 - FGD / KIs / mini-KAP survey completed as needed (DESIRED)

If problems are identified during the first two months of implementation e.g. low coverage, an assessment of the problems encountered is required. This **usage and knowledge indicator** shows whether necessary assessments are being conducted. FGDs, KI interviews or a mini-KAP assessment should be conducted to aid in the evaluation of problems encountered, including barriers to implementation, so that these can be addressed. KAP assessments should preferably be administered to a sample of FBF recipients early on in the programme (**suggested minimum sample size is 105** (see 2011 Operational Guidance)), and then again, if core indicator targets are missed. The questionnaire should be utilised as follows:

- ✓ Randomly select a sample of recipients from a full list of recipients in the BSFP. If no list is available and random selection is not possible, the recipients should be selected purposefully in each camp section, making sure that recipients of all ages and ethnic groups are represented.
- ✓ If the KAP is being used to assess a particular problem that is only present in a certain camp or a certain target group, the sample should only be drawn from this camp or group to allow for assessment of the problem (**suggested minimum sample size is 50**).
- ✓ Administer the questionnaire in the homes of the recipients or at distributions (e.g. exit interview).

- ▪ ***Refer to the 2011 Operational Guidance Stage 4 Acceptability and Adherence tools for FGD and KI guides, and Appendix 5 for an example mini-KAP questionnaire that can be adapted and used for BSFP using FBF.***
- ▪ ***Appendix 4 of this document provides example questions specific to FBF which may be used in the mini-KAP questionnaire.***

Indicator 5.1.1 - Annual nutrition survey completed according to UNHCR SENS Guidelines (CORE)

The prevalence of GAM, stunting, and anaemia should be assessed through annual cross-sectional nutrition surveys. Surveys are usually implemented at the same time every year in order to avoid seasonal differences and allow comparisons to be made between years. Factors such as insecurity and poor planning may inhibit the timely implementation of surveys. Survey planning should be initiated at least 3 months in advance. See UNHCR SENS Guidelines for further information on conducting a nutrition survey http://www.sens.unhcr.org.

Indicator 5.2.1 - Monitoring report produced monthly (CORE)

Monitoring data should be collected throughout the programme and needs to be summarised and incorporated into monitoring reports. An example monitoring reporting form has been provided in **Appendix 2** and includes the suggested frequency of reporting for different indicators. The majority of core indicator results can be collated from nutrition surveys and the Cooperating Partners distribution report if used (**Appendix 3**). **Where targets are missed, action points should be generated on the monitoring report**. Please note the following:

- ✓ The frequency of reporting should be decided upon before implementation, and monitored throughout the programme. Reporting of monitoring data 'upwards' will follow usual reporting structures.
- ✓ Partners should report summarised programme data to the in-country UNHCR health / nutrition division.
- ✓ Reports including summarised data on each indicator and a brief analysis should then be forwarded to the Branch Office health / nutrition co-ordinator and the UNHCR Regional Office / HQ in the standard format (see **Appendix 2**).
- ✓ Feedback of monitoring findings must also flow 'downwards', back to the field: one-page summaries of monitoring information (page one of the monitoring report), including action points to address missed targets, must be regularly given to staff in the field (both UNHCR and partners, as appropriate) to increase ownership of the project and ensure that improvements to the programme are made where necessary.

Indicator 5.2.2 - >90% of action points in the previous monitoring report addressed (CORE)

Action points are generated on the monitoring report when any targets are missed. Action points should be followed up at the next reporting period and the number of actions completed compared to the number of actions generated in the report. When developing action points please state:

- ✓ WHAT is to be done to ensure that the target is achieved in the next reporting period
- ✓ WHO is to carry out the action
- ✓ WHEN the action should be completed.

EVALUATION

The minimum required impact evaluation of the FBF interventions will be the assessment of GAM, stunting, and anaemia prevalence in the target group through annual cross-sectional surveys, taken in conjunction with monitoring data such as coverage, consumption, and other indicators.

It is important to bear in mind that there are many factors that can improve GAM, anaemia, and stunting levels and that the BSFP is only one contributing factor. Therefore, it will not be possible to conclude that any observed impact in the target population is *directly* attributable to the FBF intervention. Furthermore, in some cases, target groups for FBFs aimed at decreasing GAM, anaemia and / or stunting will be children aged 6-23 months or 6-35 months and not the whole 6-59 months age group. This complicates the impact evaluation through a simple cross-sectional survey due to the limited sample size of these age groups out of the 6-59 months age group sampled. It is hoped that as a greater evidence base is accumulated more guidance will be provided in the future. In operations where BSFP includes specific age groups e.g. children 6-23 or 6-35 months, the SENS report should present findings on prevalence of GAM, anaemia and stunting for the relevant age group, in addition to children 6-59 months.

There is currently limited evidence available as to the extent of the change in GAM, anaemia and stunting that would be expected when using FBF. Nevertheless, a reduction in the prevalence of these indicators in the target group would be hoped for when using an FBF aimed at addressing these problems (refer to **Stage 2** of the 2011 Operational Guidance). The following targets have been recommended for situations where high GAM, high anaemia and/or high stunting have been identified as the major nutritional problem (**Table 4** and LogFrame above)[32]. Note that the below targets are not immediate targets and if the reductions presented are not achieved this does not mean that the project has failed, but further work may be required to achieve these targets in the longer term.

TABLE 4. TARGETS FOR THE REDUCTION OF GAM, ANAEMIA, AND STUNTING, IN BSFP USING FBF

PREVALENCE %	TARGET
GAM	<10% (in the presence of aggravating factors)[a]
Stunting	<30[a]
Anaemia	<40[b]

[a] WHO cut off for GAM and Stunting of serious public health significance in children 6-59 months.
[b] WHO cut off for anaemia of high public health significance in children 6-59 months.

32 Note that the targets for anaemia reduction in **Table 4** differ from the 2011 Operational Guidance LogFrame target for reduction of anaemia in BSFP using products such as MNP and LNS, which is based on evidence from iron supplementation and MNP programmes, and is therefore not applicable to programmes using FBF.

APPENDICES

APPENDIX 1. BSFP TOOLS AND REFERENCE MATERIALS

The table below lists all tools currently provided in the 2011 Operational Guidance and this Addendum which can be accessed from http://www.unhcr.org/pages/52176e236.html. Where new tools are not provided specifically for BSFPs using FBF it is assumed that the existing 2011 Operational Guidance tools can be easily adapted using the guidance provided in this document. Note that additional tools may be added to the above website from time to time, therefore this list may not be exhaustive.

OPERATIONAL GUIDANCE ON THE USE OF FORTIFIED BLENDED FOODS IN BSFP (ADDENDUM)	
FBF information sheets / BCC materials	
1	Super Cereal information sheet
2	Super Cereal Plus information sheet
3	WHO Food Safety Poster
4	UNHCR-RSH Clarifications on Blanket Supplemental Feeding Programmes (BSFP) - Who, When and Why.
Monitoring and Evaluation	
5 (Appendix 2)	Example monitoring reporting form for BSFP using FBF
6 (Appendix 3)	Cooperating partner distribution report
7 (Appendix 4)	Example KAP questions for BSFP using FBF
8	Screening and referrals summary template
2011 OPERATIONAL GUIDANCE ON THE USE OF SPECIAL NUTRITIONAL PRODUCTS - REFERENCE MATERIALS AND TOOLS	
Tools	
Tool_01	Checklist for contacting UNHCR
Tool_02	Acceptability protocol
Tool_03	Acceptability tools
Tool_04	Acceptability report
Tool_05	Food Supplementation Product (FSP) quantity calculator
Reference Material	
RM_01	Anaemia strategy
RM_02	Example timeline
RM_03	Classification of SNP
RM_04	Joint statement – WHO Micronutrients
RM_05	Product fact sheet Nutributter®
RM_06	Product fact sheet Plumpy'doz®
RM_07	Algeria NB formulation
RM_08	Yemen MNP formulation
RM_09	UNHCR issues paper
RM_10	Yemen case study malaria
RM_11	FSP approved suppliers
RM_12	Pushtika training manual
BCC materials from countries	
RM_13	Nepal MNP
RM_14	Bangladesh PD
RM_15	Dadaab NB
RM_16	Nutributter booklet (Nutriset)
Monitoring and Evaluation tools	
Tool 1 (Appendix 3)	Nutrition worker post-training test
Tool 2 (Appendix 4)	Adherence, usage and knowledge monitoring form Pot Monitoring Guide
Tool 3 (Appendix 5)	KAP questionnaire
Tool 4 (Appendix 6)	Example monitoring data reporting form (for BSFP using MNP or LNS)

APPENDIX 2. EXAMPLE MONITORING REPORTING FORM FOR BSFP USING FBF

Below is the reporting form for the monitoring of FBF interventions. Monitoring data should be summarised regularly according to the suggested frequency and the full report submitted to the Country Office / HQ. The first page of the report, detailing indicators, targets and remedial actions should also be shared with staff and implementing partners in the field. Action points should detail what needs to be done to improve the programme so as to meet the indicator target next time, who needs to implement the action and by when the action needs to be completed.

Page two of the report has space for additional explanatory notes on a brief context analysis, so that any changes in context can be documented to help explain the performance indicators achieved. Information should also be provided on target groups and coverage; consumption, training and BCC and major challenges, risk assessment follow-up and the way forward. The boxes can be expanded and pages added if more space is required.

This is a generic report, to be adapted for each individual camp context. The name of the specific FBF (e.g. CSB++) in use in the camp(s) should be inserted in place of the generic term 'FBF', and indicators not in use (for example 'desired' indicators that have not yet been phased in) should be removed from the form.

UNHCR Reporting Form for BSFP Monitoring Data

Country	Camp(s)	Date	BSFP Cycle	Author

The following indicators should be calculated and reported regularly. See M&E narrative in Stage 6 for further information.

Indicator		Calculation (*100)	Target	Actual	Suggested Frequency of monitoring
2.1.1	Product consumption	**Nutrition survey:** Number of children 6-23m who ate FBF (from BSFP) in the last 24 hours Total number of children 6-23m **PDM:** Number of caregivers with children enrolled in the BSFP reporting that >70% of FBF is consumed Number of caregivers with children in BSFP interviewed	>70%		Nutrition survey: - Dependent on timing of planned nutrition survey. PDM: - At least after 2 months of implementation and at 6 and 12 months of implementation. - To be repeated, as needed
3.1.1	Product received by target group	Number of actual recipients at each distribution Number of eligible persons registered in the camp(s)	>90%		- Monthly throughout programme implementation.
4.1.1	Sufficient stock at distribution site(s) for full distribution	Number of distribution site(s) with sufficient stock for full distribution Number of distribution site(s) Note: if there is only 1 distribution site, use YES/NO response	100%		- Monthly throughout programme implementation.
4.1.2	Product wastage	Quantity of FBF found to be unfit for distribution Quantity of FBF checked	<5%		- Monthly throughout programme implementation.
4.1.3	Distributions undertaken on time	Number of distributions undertaken on time Number of distribution planned Note: if there is only 1 distribution site, calculate the number of distribution *days* undertaken compared to the number planned	>90%		- Monthly throughout programme implementation.
4.2.1	Beneficiaries screened at each distribution	Number of beneficiaries screened Number of actual recipients at distribution	>90%		- Monthly throughout programme implementation
4.3.1	Staff training and availability	Number of staff fully trained and available Number of staff required	>90%		- Before programme implementation. - Monthly throughout programme implementation
4.3.2	Staff knowledge test	Number of staff passing test Number of staff taking test	>90%		- Before programme implementation. - One refresher training to be done after 6 months of implementation. - To be repeated, as needed.

4.4.1	FBF Cooking demonstrations held	Number of cooking demonstrations held / Number of cooking demonstrations planned	>90%		- Before programme implementation. - To be repeated as needed
4.4.2	Adequacy and availability of BCC materials checked	Yes / No	Yes		- Before programme implementation and during programme roll-out. - To be repeated, as needed.
4.5.1	Sharing of FBF	Number of recipients reporting sharing of FBF / Number of recipients interviewed	<25%		Nutrition survey: - Dependent on timing of planned nutrition survey. PDM: - At least after 2 months of implementation and at 6 and 12 months of implementation. - To be repeated, as needed.
4.5.2	Selling of FBF	Yes / No	No		- At least after 2 months of implementation and at 6 and 12 months of implementation. - To be repeated, as needed.
4.5.3	FGD / KIs and / or mini-KAP survey conducted	Yes / No / Not needed	-		- At least after 2 months of implementation and at 6 and 12 months of implementation. - To be repeated, as needed.
5.2.1	Monitoring report produced during last reporting period	Yes / No	Yes		- If the programme is stable, monthly during first 6 months of implementation and quarterly thereafter.
5.2.2	Action points followed up	Number of action points followed up from last report / Number of action points in last monitoring report	>90%		- When the monitoring report is produced and action points are set.

Adapt and use the form below to *briefly* summarise key monitoring findings from each distribution cycle. For each indicator where the target was not achieved, create an action point to improve the programme for next time. *Refer to the programme Logical Framework in the M&E section for suggested remedial actions.*

Monthly Blanket Feeding Distribution and Activity Report	**Distribution Cycle:**
1) **Summary of activities since last reporting period:**	
2) **Changes in context since last report:**	
3) **Target groups, distributions and coverage (beneficiary numbers):**	
4) **Cooking demonstrations:**	
5) **Training, BCC, and household visits:**	
6) **Staffing:**	
7) **Screening for MAM/SAM:**	
8) **Major challenges, and risk assessment follow-up:**	
ACTION POINTS (who, what, when)**:**	
1. 2. 3. 4. 5. Etc.	

APPENDIX 3. COOPERATING PARTNERS DISTRIBUTION REPORT

WFP
wfp.org/fr

COOPERATING PARTNERS DISTRIBUTION REPORT

1. COOPERATING PARTNER DETAILS

Cooperating partner:	Region and province:	Distribution site:	Protocol no.:	Project no.: Activity: BSFP
Month of report:	Date of distribution :		Date of report:	Report number:

2. STOCK MOVEMENTS / STOCK DETAILS

Commodity	Serial Number	Opening stock	Quantity received	Quantity distributed	Quantity returned	Damaged stock	Loses	Final stock	Reasons for loss and damages
e.g. CSB+									
CSB++									
Sugar									
Oil									
Total		**0**	**0**	**0**	**0**	**0**	**0**	**0**	

Observations:

3. NUMBER OF BENEFICIARIES

	Girls 6-23m	Boys 6-23m	PLW	Total			
Planned							
Actual							
%							

4. CERTIFICATION

CP: Prepared by:	Title :	WFP: Received by :	Title:
Signature……	Date	Signature……	Date

APPENDIX 4. EXAMPLE KAP QUESTIONS FOR BSFP USING FBF

Please see the 2011 Operational Guidance **Appendix 5 (pg. 120-132)** for a full KAP questionnaire and adapt accordingly including the following question examples where needed. Ensure that the correct FBF name (e.g. CSB++, or the local name) is inserted in to questions and responses in place of FBF.

Question	Response
Did you receive FBF?	Yes
	No
What proportion of the FBF did you consume?	All or most
	More than half
	Half
	Less than half
	None
	Don't know
What did you do with the FBF if not consumed fully?	Throw it away
	Exchanged it
	Sell it
	Gave it to animals
	Bartered it
	Other (specify)
If you sold or exchanged the FBF, what did you do with most of the money that you received?	Buy Spices
	Buy vegetables and fruits
	Buy rice
	Buy non-food items
	Saved the money
	Other (specify)
How do you prepare the FBF (in what form)?	Porridge
	Couscous
	Other (specify)
If boiled, please explain how you prepare it (what ingredients you use)?	Water
	Oil
	Sugar
	Salt
	Other (specify)
How long do you cook the porridge / FBF for?	Less than 5 minutes
	Between 5-10 minutes
	More than 10 minutes
Who eats the porridge?	Children
	Pregnant women
	Lactating women
	All of the family


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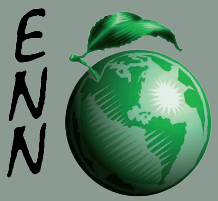
UCL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