

Nutrition Information Management, Surveillance and Monitoring in the Context of COVID-19

Brief No. 2

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BACKGROUND & INTRODUCTION

To support implementers to prepare for and respond to the COVID-19 pandemic, a series of evidence-based guidance briefs are produced and updated as new information and evidence emerges. The first brief on nutrition information, surveillance and monitoring in the context of COVID-19 was released in April¹ 2020. Building on recommendations from brief 1, this brief provides priority actions and recommendations for undertaking nutrition situation analysis and estimating its magnitude, monitoring impacts of COVID-19 including a proposed list of indicators, and alternative ways of data collection.

MAINTAIN PHYSICAL DISTANCING AND USE ALTERNATIVE WAYS FOR DATA COLLECTION

In line with global recommendations on curbing the spread of COVID-19², it is recommended to continue to **suspend all primary data collection activities (i.e. population-based surveys e.g SMART, MICS, DHS, etc, and mass screenings) involving in-person contact, unless deemed essential after critically weighing harms and benefits and until operational guidance on minimum criteria to restart population-based surveys³ is released**. Even when mobility restrictions have been lifted and governments deem it safe to proceed with primary data collection activities, key ethical issues in relation to undertaking evidence generation in the context of COVID-19 should be considered:⁴

- a) **Weighing harms and benefits** – Determine clear justifications for the *urgency and necessity* for in-person data collection activities vs direct benefits for programming. A robust harm-versus-risk analysis should be undertaken to recognize the moral imperative to ‘**do no harm**’; determine:
 - the urgency and absolute necessity of the data for decision-making despite the risk;
 - the process to ensure the health and safety of the community and enumerators;
 - the resources required for recruitment, training, data collection, quality assurance and follow-up while ensuring adequate IPC⁵ measures;
 - the sensitization of the community on the objectives of data collection at this time. Consider how COVID-19 restrictions and messaging may affect community participation and engagement.
- b) **Ensure privacy, confidentiality and consent** during and after the pandemic, when gathering data and appropriate communication of findings.

1 https://www.nutritioncluster.net/resource_NISandCOVID19

2 <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public>

3 Ongoing work is currently being done led by SMART, CDC, MICS, NHANES and DHS teams.

4 UNICEF (2020) [Ethical considerations for evidence generation involving children on the COVID-19 pandemic](#).

5 Infection Prevention and Control (IPC)

Table 1. Ethical Considerations for undertaking evidence generation on COVID-19 involving children (emergency and recovery phase) – adapted table⁶

TYPES OF EVIDENCE GENERATION	HARMS AND BENEFITS	PRIVACY, CONFIDENTIALITY, AND CONSENT	COMMUNICATION OF FINDINGS
FACE-TO-FACE: Population-based surveys (i.e. SMART, MICS, DHS, etc.), Mass screenings, assessments that involve in-person interaction.	DO NOT PROCEED UNTIL OPERATIONAL GUIDANCE ON MINIMUM CRITERIA TO RESTART POPULATION-BASED SURVEYS IS RELEASED⁷ CONSIDER: <ul style="list-style-type: none"> The potential spread of the virus. Upcoming <i>Operational guidance on minimum criteria to restart surveys</i>⁷ Justification based on harm vs. benefits analysis (see above) 	DO NOT PROCEED UNTIL OPERATIONAL GUIDANCE ON MINIMUM CRITERIA TO RESTART POPULATION-BASED SURVEYS IS RELEASED⁸ CONSIDER: Upcoming <i>Operational guidance on minimum criteria to restart surveys</i> ⁷	
FACE-TO-FACE: Critical emergency response and programming, including Community Health Worker surveillance systems, household visits, facility-based assessments	PROCEED WITH EXTREME CAUTION LIMIT THE RISKS BY: <ul style="list-style-type: none"> Maximizing the use of secondary data sources and minimizing face-to-face approaches in favor of phone or virtual interactions, etc. Ensuring enumerators and the community are protected. This includes personal protective equipment, enhanced training, more on-site supervision, and symptom monitoring and testing. Maintain standards of data privacy, limitations on access to raw data, data security, etc. 	LIMIT THE RISKS BY: <ul style="list-style-type: none"> Ensuring data confidentiality and security during collection, transfer, sharing, storage, communication. Ensuring that data are exclusively and solely for supporting emergency programmes 	LIMIT THE RISKS BY: <ul style="list-style-type: none"> Data and findings are limited to stakeholders that need the information for service delivery; Findings are used to inform emergency/ critical interventions.
REMOTE DATA COLLECTION: Data Collection activities that are done using mobile phones, tablets, online surveys etc.	PROCEED WITH CAUTION CONSIDER: <ul style="list-style-type: none"> Access to connectivity maybe limited for some populations Avoid sensitive questions, long surveys and ensure appropriate online support. Ensure appropriate online support. 	PROCEED WITH CAUTION <ul style="list-style-type: none"> It is important to ensure that the privacy, confidentiality and consent of the respondents is maintained. 	PROCEED WITH CAUTION <ul style="list-style-type: none"> Be clear on the limitations and representation of the data. Clearly articulate any potential missing groups Flag that data may exclude the vulnerable and special considerations must be put in place for these groups.

PRACTICAL CONSIDERATIONS FOR REMOTE DATA COLLECTION

Remote data collection includes data collection done by phone surveys or using online surveys and methods. Identify data needs and determine if the information can be collected remotely. Engage with the Ministry of Health, national sector/cluster or coordination bodies and assess the required resources e.g. infrastructure, capacity, training, operational costs, etc. and possibilities of leveraging on existing digital platforms and systems.

When undertaking remote data collection, the following recommendations should be considered (See further details for mobile phone data collection in *Annex 1*):

- Adequate phone or network coverage, of at least 50%;
- Clearly defined concise survey objectives;

6 UNICEF (2020) [Ethical considerations for evidence generation involving children on the COVID-19 pandemic](#).

7 Ongoing work is currently being done led by SMART, CDC, MICS, NHANES and DHS teams.

8 Ongoing work is currently being done led by SMART, CDC, MICS, NHANES and DHS teams.

- Incorporate considerations for data protection (e.g. telephone number of surveyed/beneficiaries);
- Mitigate against potential bias by correctly defining the sampling method and sample size and providing adequate training and supervision.
- Choose the appropriate sampling method depending on the context, and availability of resources:
 - For survey areas with suspected heterogeneity between neighborhoods, districts or villages, cluster sampling is recommended.
 - For survey areas within a single district, neighborhood or village, refugee/IDP camp or where the inclusion of several districts is challenging, simple random sampling method can be used.

UNDERTAKE A NUTRITION SITUATION ANALYSIS WITH EXISTING DATA AND INFORMATION AND ESTIMATE THE NUMBER OF PEOPLE IN NUTRITIONAL NEED

To determine the current nutrition situation and programme performance and coverage, countries should map out existing data sources and conduct analysis using the most recent available data, historical trends to support analysis of projections. As part of this process, also identify the critical data gaps and explore potential practical and innovative ways to expand existing systems and capacities to meet data needs.

The following steps to conduct a situation analysis are in alignment with the recently released **Nutrition Humanitarian Needs Analysis guidance**⁹ for planning or revising the nutrition response plan in the context of COVID-19:

1. **Consolidate latest in-country data available** and identify indicators relevant for nutrition situation analysis and the estimation of the number of people in need of nutritional support. Work closely with all members of the national nutrition information working group¹⁰ (or equivalent structure) in collaboration with the Ministries of Health and national sector/cluster coordination bodies;
2. **Coordinate with relevant sectors** i.e. Food Security, Health, WASH, Education and Social Protection to understand the impacts of COVID-19 on these sectors and to utilize existing nutrition-related data relevant for the situation needs analysis;
3. **Review existing secondary data** of primary indicator(s) recommended in the nutrition humanitarian needs analysis guidance. Keep in mind the following reliability considerations¹¹ in order of preference at country-level:
 - a) Recent population-based surveys (e.g. National Nutrition Surveys, MICS, DHS, SMART, etc.) representative at the unit of analysis with adequate precision and validated by an authority in the country;
 - b) Population-based surveys that are either outdated or representative at a higher administrative unit;
 - c) Data collected from sentinel sites or routine systems;
 - d) Facility-based screening data;
 - e) Qualitative data and information.
4. **Review recent data on contributing factors**¹² that may have changed since the start of the pandemic;
5. **Analyze recent performance data from programmes and routine systems** (i.e. CMAM data, IYCF counselling and sessions, growth monitoring, immunization, micronutrient supplementation, social protection, etc.) and compare to previous years to identify any changes in trends other than seasonal changes;
6. **Based on this secondary data analysis, discuss assumptions on how COVID-19 will affect relevant malnutrition outcomes** (prevalence of wasting, stunting, overweight, micronutrient deficiencies etc.) and relevant

9 Global Nutrition Cluster (2020) [Nutrition Humanitarian Needs Analysis Guidance](#) released in June 2020.

10 Nutrition Information System Technical Working Group [NIS TWG Generic ToRs](#).

11 In alignment with IPC Global Partners (2019) [Integrated Food Security Phase Classification Technical Manual Version 3.0. Evidence and Standards for Better Food Security and Nutrition Decisions](#).

12 Includes but not limited to: infant and young child feeding practices, dietary intake (Minimum Dietary Diversity, Minimum Meal Frequency) for children, morbidity, access to health and WASH services, household food security, feeding and care practices, poverty etc.

contributing factors depending on the context, and mobility restrictions¹³. For humanitarian contexts that rely heavily on the IPC Acute Malnutrition Analysis, please see latest guidance from the [IPC Global Support Unit for assumptions relating to the COVID-19](#).

7. **Using those assumptions, consider the following recommendations when preparing/revising the latest nutrition situation analysis and subsequent PiN estimation** while considering seasonality, context-specific differences (e.g. urban and rural, host vs refugee/IDP, mobility restrictions) due to COVID-19:
 - a) If *minimal/no increase* is expected on the prevalence of malnutrition outcomes, consider taking similar estimations from last year based on primary indicator(s) used;
 - b) If an *increase* is expected on the prevalence of malnutrition outcomes, consider taking the **upper confidence limit** from the confidence interval from the latest survey as a starting point, particularly in contexts where GAM is $\geq 5\%$ ¹⁴. If the latest national-level data is being used that does not provide confidence intervals, look at historical trends and estimate the likely prevalence;

Only in cases where the above approach is not feasible, liaise with regional and global colleagues on the use of interim guidance (UNICEF HQ's *Estimating number of children with severe wasting accessing treatment in the context of COVID-19*)¹⁵, particularly for supplies' planning. For additional guidance or support, [contact the GTAM and GNC-CT mechanisms](#) to discuss how to overcome given challenges.

8. **Discuss amongst the national nutrition working group a range of plausible point prevalence per malnutrition outcome** depending on the situation outlined in points A, or B with the Ministry of Health and national sector/cluster coordination bodies;
9. **Identify the most plausible point prevalence to use from this range for the subsequent estimation of PiN** given all relevant and existing data reviewed;
10. **Apply this plausible point prevalence to the PiN formula to identify the number of people in nutritional need.**
11. **Document all assumptions** made to derive this estimation that considers the foreseen impacts of COVID-19.
12. **Frequently revisit the nutrition situation analysis given emerging evidence** along with any information on potential disruption of nutrition services to ensure the most appropriate and effective responses in the face of this pandemic.

13 Global Nutrition Cluster (2020) [Nutrition Humanitarian Needs Analysis Guidance](#) released in June 2020.

14 *Ibid.*

15 In situations where a deterioration is expected in the prevalence of wasting and there is no recent survey, consider in the interim, the following estimated acute malnutrition PiN increases, based on an incremental increase by quarter: April-June with a 10% increase, July-September with a 15% increase, and October-December with a 10% increase.

MONITOR THE NUTRITION SITUATION AND PROGRAMMES IN THE CONTEXT OF COVID-19

1. **Determine indicators for monitoring and reporting of nutrition programmes based on requirements outlined in the nutrition monitoring framework and response plans.** The specific purpose of indicators to be collected should be relevant for decision-making avoid collecting data, indicators and information that will not be used or is already being collected by other sectors.
2. **Determine the data collection methods and the required resources.** Map out existing digital platforms and data systems, including connectivity and existing capacities. Initiate efforts to build capacity of relevant personnel to collect this data using agreed methods;
3. **Leverage existing systems for data collection**, including from relevant sectors such as Food Security, Health, WASH, Education, Social Protection;
4. **Consider the use of 'proxy or tracer' indicators**, these indicators can be used either to draw assumptions in changes in the situation or service delivery or monitor changes that will require investigation;
5. **During analysis and reporting, review the indicators' quality, availability, and relevance; make any necessary adjustments as needed.** Once the selection of indicators has been done, it is recommended to avoid frequent changes, as it becomes difficult to monitor trends and can be burdensome on the system and data collection process.
6. If possible, **report disaggregated data** (age, sex, disability status etc.).

Table 2 provides a generic list of proposed indicators that can be used to monitor the impacts of COVID-19 on nutrition programmes presented under the thematic areas listed below. It does not intend to be exhaustive and should be adapted to the country's needs and evolving context.

The indicators in this document are presented for reporting at district- and country level for nutrition; however, some indicators may be aggregated also at the regional or global level. The frequency of collection depends on the country's context and monitoring objectives (e.g. weekly, monthly, quarterly, bi-annually, etc):

- a) Coordination and Response
- b) Continuation of Services
- c) Infant and Young Child Nutrition
- d) Nutrition of School Age Children and Adolescents
- e) Maternal Nutrition
- f) Treatment of Acute Malnutrition

Table 2: Proposed list of Nutrition Programme Indicators for Monitoring Impacts of COVID-19 on Nutrition

A. Coordination and Response Planning:

Title	Description	Notes
Nutrition interventions considered as essential health and nutrition services that should continue as part of the national COVID-19 response plan	<p>The nutrition interventions may include:</p> <ul style="list-style-type: none"> • Protection, promotion and support of breastfeeding programmes • Protection, promotion and support of appropriate complementary feeding • Vitamin A supplementation • Deworming prophylaxis • Home fortification with multiple micronutrient powders • Nutrition programmes for school-age children • Nutrition programmes for adolescent girls and boys • Nutrition support for pregnant and lactating women • Early detection and treatment of children 6-59 months with wasting • Nutrition services previously provided through schools • Nutrition information monitoring systems 	<p>This indicator aims to monitor which nutrition interventions are considered as part of the essential health and nutrition services that should continue as part of the COVID-19 national response plan. Indicate which nutrition interventions are considered as essential as part of the national COVID-19 response plan, the list provided is not exhaustive.</p> <p>Example: <i>Early detection and treatment of children 6-59 months with wasting is as an essential health and nutrition service that should continue as part of the national COVID-19 response plan</i></p> <p>Example at regional/ global level: <i>Number of countries with Early detection and treatment of children 6-59 months with wasting is as an essential health and nutrition service that should continue as part of the national COVID-19 response plan</i></p>
Activation/strengthening of the nutrition cluster mechanism or sectoral coordination in response to COVID-19 and its impacts	The country has activated/strengthened the nutrition cluster mechanism or sectoral coordination in response to COVID-19 and/or its impacts	<p>This indicator can be aggregated per region, global</p> <p>Example at regional/ global level: <i>Number of countries that have activated the nutrition cluster mechanism in response to COVID-19 and/or its impacts</i></p>
Submission of a revised humanitarian response plan (HRP) that includes nutrition response in the context of COVID-19	The country has submitted a revised HRP that includes a nutrition response plan in the context of COVID-19	<p>This indicator can be aggregated per region, global</p> <p>Example at regional/ global level: <i>Number of countries that have submitted a revised HRP that includes a nutrition response plan in the context of COVID-19</i></p>
Existence of nutrition information system	A nutrition information system exists; with a mechanism to collect nutrition information data on nutrition programme performance, nutrition surveillance and nutrition outcomes, this may also include relevant multisectoral data that informs on contributing factors affecting nutrition e.g. health, WASH, food security etc.	<p>The system should be able to collect data and information relevant to determine the nutrition situation and inform response and programme needs. In addition to monitoring continuation of services and programme performance</p> <p>Example at regional/ global level: <i>Number of countries that have a functioning nutrition information system</i></p>

B. Continuation of Nutrition Services

Title	Description	Notes
<p>Delivery of key nutrition services <i>significantly</i> disrupted by social impacts of COVID.</p>	<p>The nutrition interventions may include:</p> <ul style="list-style-type: none"> • Protection, promotion and support of breastfeeding programmes • Protection, promotion and support of appropriate complementary feeding • Vitamin A supplementation • Deworming prophylaxis • Home fortification with multiple micronutrient powders • Nutrition programmes for school-age children • Nutrition programmes for adolescent girls and boys • Nutrition support for pregnant and lactating women • Early detection and treatment of children 6-59 months wasting • Nutrition services previously provided through schools • Nutrition information monitoring systems 	<p>Disruption can include, but is not limited to, any of the following reasons: closure of facilities, suspension of service worker or community health worker activities, reduction in availability of personnel, disruption of supply chains, suspension of routine services, suspension of community engagement/communication for behaviour change, and limited access by people given mobility restrictions.</p> <p>Examples to quantify disruptions directly or indirectly due to COVID-19 may include the following categories:</p> <ul style="list-style-type: none"> • No Disruption • Low level of disruption-less than 10% drop in use • Medium >10% but <25% drop in use • High>25% drop in use
<p>National response plan includes alternative/ simplified approaches to provide nutrition services during COVID-19</p>	<p>Alternative, expanded or simplified approaches are planned or being implemented to continue delivery of the following nutrition services:</p> <ul style="list-style-type: none"> • Protection, promotion and support of breastfeeding programmes • Protection, promotion and support of appropriate complementary feeding • Vitamin A supplementation • Deworming prophylaxis • Home fortification with multiple micronutrient powders • Nutrition programmes for school-age children • Nutrition programmes for adolescent girls and boys • Nutrition support for pregnant and lactating women • Early detection and treatment of children 6-59 months wasting • Nutrition services previously provided through schools • Nutrition information monitoring systems 	<p>If regular delivery of nutrition services has been interrupted and alternative or simplified approaches have been designed and implemented to continue service delivery e.g. simplified approaches for treatment of wasting, family MUAC for detection and treatment of wasted children etc.</p>

C. Infant and Young Child Nutrition

Title	Description	Notes
Presence of violations of the International Code of Marketing of breast milk substitutes (BMS) in relation to the COVID-19 response are monitored	<p>The violations of the Code include:</p> <ul style="list-style-type: none"> • Donations of the BMS/bottles/teats from agencies, government, donors, etc; • Accepting unsolicited donations of BMS/bottles/teats; • Blanket distribution of unsolicited or free supplies of BMS/ bottles/teats; • Provision of infant formula that does not align with Operational Guidance IFE 2017 standards and recommendations; • Donations of complementary foods to children 0-5, 6-23 months; • Distribution of milk products (incl. dried milk) that can be potentially used as BMS to general population; • Inadequate labelling (no health hazard warning, inappropriate language, no statement on BF superiority, no info on safe preparation, etc.) • Promotion of BMS at the distribution point (displays, logos, etc); • Other (specify) 	Code violations may occur in health facilities, communities, through food baskets distributed during the emergency response and through social media.
Programmes and services to protect, promote and support optimal breastfeeding (early, exclusive and age-appropriate) and safe complementary foods and feeding practices should remain a critical component of the programming and response for young children in the context of COVID-19.	Number of caregivers of children 0-23 months who receive key messages that protect and promote appropriate breastfeeding practices in the context of COVID through radio, television, print media and other mass communication channels including social media.	Estimate the total number of caregivers of children 0-23 months in the areas targeted with communication campaigns (radio, television, print media etc.) with key messages on appropriate breastfeeding practices in the context of COVID.
	Number of (community) health workers trained in the promotion, protection and support of breastfeeding during the context of COVID-19	
	Number of people reached with messages on breastfeeding and young child diets in the context of COVID-19, (through various channels, including social media, mass communication channels, health facility, community). It can be measured through audience reach methods of mass and social media, or through rapid remote surveys or polls.	It can be measured through audience reach methods of mass and social media, or through rapid remote surveys or polls. <i>This indicator is the nutrition indicator reported as in the global humanitarian response plan (GHRP).</i>
	Number of caregivers with children 6-23 months receiving cash transfers or vouchers for breastfeeding support and complementary foods	
Vitamin A supplementation for children 6-59 months	Number of children aged 6-59 months who received (a) vitamin A supplements in semester 1; (b) vitamin A supplements in semester 2	This is defined as the number of girls and boys aged 6-59 months who received vitamin A supplement in semester 1 and semester 2. Distribution mechanisms of vitamin A supplements include routine systems national immunization days.
Micronutrient supplementation for children 6-59 months	Number of children aged 6-59 months that received micronutrient powders (MNPs)	This is defined as the absolute number of children, according to the specific target group, as per programme design, who received micronutrient powders (home fortification). The focus target group are children aged 6 59 months, but can focus on a narrower age group 6-11 months, 6-17 months, 6-23 months, 6-35 months, 6-59 months, 12-23 months, etc
Unhealthy foods are not provided for young children as part of the food relief/ distribution of COVID-19 response	Unhealthy foods are not provided for young children as part of food relief/food distributions in response to the COVID-19 pandemic	Unhealthy foods are defined as nutrient-poor foods high in saturated fats, free sugar, and/or salt and are not provided as part of the food relief/ distribution of COVID-19 response

D. Nutrition of School Age Children and Adolescents (liaise with Education Cluster/Sector)

Title	Description	Notes
Schools providing nutrition services despite school closures	Proportion of schools providing nutrition services despite school closures	Numerator: Total number of schools providing nutrition services despite school closures Denominator: Total number of closed schools Can be disaggregated by school level, by gender
Children receiving nutrition services through schools despite school closure	Proportion of children receiving nutrition services through schools despite school closure	Numerator: Total number of children receiving nutrition services despite school closures Denominator: Total number of children enrolled in schools Can be disaggregated by school level, by gender.
Adolescents receiving nutrition services through schools despite school closure	Proportion of adolescent receiving nutrition services through schools despite school closure	Numerator: Total number of adolescents receiving nutrition services despite school closures Denominator: Total number of adolescents enrolled in schools Can be disaggregated by school level, by gender.

E. Maternal Nutrition and Social Protection

Title	Description	Notes
Women receiving essential nutrition services	Number of pregnant women who have received IFA supplementation	If the denominator is available, report the proportion of women who received IFA supplementation
	Number of women who have received routine ANC services	If the denominator is available, report the proportion of women who have received routine ANC services
	Number of pregnant and lactating women who have received multiple micronutrient supplementation	If the denominator is available, report the proportion of pregnant and lactating women who have received multiple micronutrient supplementation
Women receiving nutritional support	Number of pregnant or lactating women receiving supplementary food or cash and vouchers assistance	If the denominator is available, report the proportion of pregnant or lactating women receiving supplementary food or cash vouchers
Measures are in place to support access to nutritious and affordable food as part of the COVID-19 response	Number of social protection beneficiaries who received nutrition messages, food vouchers or in-kind nutritious foods (e.g. vegetables, nutrition supplements, ready to use foods etc)	This may include social protection programmes, food distributions etc.
Unhealthy foods are not provided as part of the food relief/ distribution of COVID-19 response	Unhealthy foods are not provided as part of food relief/ food distributions in response to the COVID-19 pandemic	Unhealthy foods are defined as nutrient-poor foods high in saturated fats, free sugar, and/ or salt and are not provided as part of the food relief/ distribution of COVID-19 response

F. Treatment of Acute Malnutrition

Title	Description	Notes
Children receiving treatment for MAM or SAM ¹⁶	Total number of children admitted for SAM treatment	<i>This indicator is the nutrition indicator reported as in the global humanitarian response plan (GHRP).</i>
	Total number of children admitted for MAM treatment	To be disaggregated by sex and age groups: 0-5 months, 6-23 months, 24-59 months at a minimum
	Number of SAM children admitted for inpatient SAM treatment	To be disaggregated by sex and age groups: 0-5 months, 6-23 months, 24-59 months at a minimum
	Number of MAM children admitted for inpatient MAM treatment	
Children screened for wasting	Number of children 6-59 screened for wasting by mothers or CHW	To be disaggregated by sex and age groups: 6-23 months, 24-59 months at a minimum This can be reported as a percentage if denominator is clearly defined.
Stock outs of commodities for the management of SAM or SAM	Stock outs of commodities for the management of SAM reported;	The country has experienced stock out of commodities in a defined period of time. This can be reported at facility-, administrative-, sub-national and national-levels.
	Stockouts of commodities for the management of MAM reported	
	Percentage of facilities that have reported RUTF stock outs; percentage of facilities that have reported RUSF stock outs Numerator: The total number of facilities that have reported stock outs related to impacts of COVID-19 for products for the management of SAM or MAM Denominator: All facilities that are providing services for the management of SAM or MAM	The country has experienced stock out of commodities in a defined period of time. This can be reported at sub-national and national-levels.
	Stock outs of MUAC tapes used for the management of SAM reported	The country has experienced stock out of commodities in a defined period of time. This can be reported at facility-, administrative-, sub-national and national-levels.
	stock outs of MUAC tapes for the management of MAM reported	

¹⁶ Continue to monitor regular programme performance indicators (i.e. cured, defaulted, death, etc.).

UPDATED RESOURCES AND GUIDANCE

Relevant COVID-19 related resources	Guidance and Tools for programmatic adaptations – Global Technical Assistance Mechanism for Nutrition	https://gtam.nutritioncluster.net/node/34
	Berman, G – UNICEF, Innocenti Discussion Paper	Ethical considerations for evidence generation involving children on the COVID-19 pandemic
	Impact on Food Security by the Food Security Cluster	https://fscluster.org/sites/default/files/documents/2020-03-19._impact_of_covid-19_on_fsn_-_hlpe_-_final_draft.pdf
	Keeping food and agricultural systems alive – Analyses and solutions in a period of crises – COVID-19 Pandemic – FAO (live document)	http://www.fao.org/2019-ncov/analysis/en/
	Food and Agriculture Policy Decisions Analysis (FAPDA) – a database of the latest food system policy decisions in response to COVID-19 – FAO (live document)	http://www.fao.org/in-action/fapda/fapda-home/en/
	SMART COVID-19 guidance	https://smartmethodology.org/about-smart/smart-news/
	IPC Tools and Classification for Acute Malnutrition	http://www.ipcinfo.org/ipcinfo-website/resources/resources-details/en/c/1129311/
	Impacts/factors to follow - IFPRI	https://www.ifpri.org/blog/covid-19-nutrition-crisis-what-expect-and-how-protect
Other considerations for data collection	RapidPro	https://www.unicef.org/innovation/rapidpro
	Demographic Household Survey (DHS)	https://dhsprogram.com/Who-We-Are/News-Room/COVID-19-Response-DHS-Program-Fieldwork-Activities-on-Hold.cfm
	Digital contact tracing and surveillance during COVID-19. General and child-specific ethical issues – Innocenti	https://www.unicef-irc.org/publications/1096-digital-contact-tracing-surveillance-covid-19-response-child-specific-issues-iwp.html https://www.unicef-irc.org/publications/1098-digital-contact-tracing-surveillance-covid-19-response-child-specific-issues-irb.html
	Conducting Mobile Surveys Responsibly – WFP	https://documents.wfp.org/stellent/groups/public/documents/manual_guide_proced/wfp292067.pdf
	Nutrition in DHIS – UNICEF	https://mcusercontent.com/fb1d9aabd6c823bef179830e9/files/30f39535-4930-4351-9afa-f548d79a9403/Nutrition_in_DHIS2_LA_Report_April2020.pdf

To contribute to this list of resources, please contact the GNC NIS Helpdesk at vsauveplane@unicef.org

ANNEX 1: SAMPLING METHODS FOR PHONE SURVEYS (taken from Action Against Hunger-France Guidance)

To avoid bias in estimation of an observation measure of a targeted population, efforts should be made to correctly define a sampling method and the size. This document presents the two main sampling methods, and a step-by-step process to calculate the sampling size for each of them. It also present common phone survey bias and how to avoid them.

The sampling method may be considered according to the context of the survey, its costs and the availability of resources. For survey areas with suspected heterogeneity between neighbourhoods, districts or villages, a cluster sampling method is recommended. For missions with a single district, neighbourhood or village, or where the inclusion of several districts is challenging, the simple random sampling method can be used.

1. Cluster sampling

Several parameters should be considered when calculating the sample size: expected prevalence of the measured indicator, acceptable margin of error, design effect and confidence level.

- a) The expected prevalence can vary depending on the indicator studied. It could be assessed based on previous study estimates or in the absence of literature on the subject, expert assumption. When the survey aims to estimate the prevalence of several indicators and that resources are limited, the sampling calculation should be based on the prevalence of the most important indicator to ensure that sufficient statistical power will be achieved to estimate it correctly. If several indicators are of equal importance, base the sampling calculation on the prevalence of the indicator with the lowest prevalence expected can be a strategy to ensure that the sampling will be large enough to estimate every indicator of interest.
- b) Concerning the margin of error, the recommendations of the Integrated Food Security Phase Classification (IPC) should be followed, i.e. a maximum margin of error of 8.5%⁸. However, a lower margin of error will result in a better sampling design.
- c) For the effect of the sample design⁹, recommendations of the IPC should also be followed; however, this parameter can be easily calculated only after the survey. It is often unknown before the survey, unless surveys on the same variables have been conducted previously. An effect of 1.5 as suggested by the IPC sample design could be used as well as a confidence level between 90 or 95%.

Before selecting districts for conducting telephone surveys, it is important to know the level of telephone coverage in the study area. This coverage rate can be estimated via service provider data, national statistics or previous studies. Areas not covered by the telephone network must be excluded before sampling.

The IPC's recommendations for sample sizes are:

- For an area where more than 75% of households have phone access: select at least 150 households (with at least 25 clusters).
- For an area where more than 60% of households have phone access: choose a sample size of 90 households, with 5 clusters.
- For an area with less than 50% coverage, it is not advisable to use a phone survey, as more than half of the population would be excluded. A way to remedy this, would be to complete the part not covered by phone by face-to-face study with key informants but this wouldn't be feasible in all contexts.

The parameters used to calculate the IPC recommendation for sample size exclude the non-response rate and assume a 90% confidence level.

Based on the parameters listed above for the minimum standard sample size qualified, 5 clusters, and considering a zero rate of non-response, the sample sizes according to prevalence and confidence level can be find in this Table:

Expected prevalence	N (Confidence level 90%)	N (Confidence level 95%)
10%	55	75
15%	75	105
20%	90	130
25%	105	150
30%	120	170
35%	130	185
40%	135	195
45%	140	200
50%	145	200
55%	140	200
60%	135	195
65%	130	185
70%	120	170
75%	105	150
80%	90	130
85%	75	105
90%	55	75

This can be considered here as the smallest possible sample size to ensure prevalence estimates with sufficient reliability

2. Simple random sampling

For simple random sampling methods, sample sizes are presented in the following Table depending on the expected prevalence. Note that we have kept the maximum margin of error recommended by IPC.

Expected prevalence	N (Confidence level 90%)	N (Confidence level 95%)
5%	18	25
10%	34	48
15%	48	68
20%	60	85
25%	70	100
30%	79	112
35%	85	121
40%	90	128
45%	93	132
50%	94	133
55%	93	132
60%	90	128
65%	85	121
70%	79	112
75%	70	100
80%	60	85
85%	48	68
90%	34	48

This can be considered here as the smallest possible sample size to ensure prevalence estimates with sufficient reliability

3. Potential bias and how to avoid it

Potential biases can be observed:

- **Geographic coverage bias:** Some areas are not covered by any mobile phone network. Rural areas are often poorly covered and network coverage may completely fail during times of conflict as well. Hence these areas may be entirely excluded from a survey.
- **Selection bias:** some households may have multiple phones, while others may have only one, and some may not even have one. It is well documented that respondents to computer assisted telephone interview (CATI) surveys tend to be more urban, wealthier, more educated, younger, and more frequently male than female.
- **Intra-household bias:** when the same household is monitored over time (i.e. panel design), having different respondents answering the survey at different rounds also creates a bias in the result.
- **Non-response/self-selection bias:** compared to face-to-face (F2F), it is far easier for a potential respondent to ignore an unknown phone number than an enumerator physically present near their dwelling.

To avoid and control these biases, some solutions can be considered:

- To avoid intra-household bias, it is important that the survey protocol ensures consistency in reaching the same respondent in every survey round.
- In contexts where a phone-survey is likely to exclude certain areas or groups of people due to a lack of phone ownership or network coverage, those areas and/or groups are interviewed via F2F interviews instead.
- It is recommended that a minimum of five demographic indicators are compared stratum-by-stratum with another surveys: respondent age, respondent sex, head of household sex, whether respondent lives in an urban or rural area, and a socioeconomic indicator such as the highest level of education within the household or roof/toilet type. Any demographic indicator can be chosen as long as they were measured consistently (i.e. questions and options for response are phrased in the same way) with little error and low non-response across both surveys.
- As with F2F survey data, weights can be applied to phone-survey data to correct for potential biases.

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