

## 1. Budget for the additional 33 months of activities.

The budget requested for the additional 33 months of work starting September 1, 2021 is \$18,096,282. When combined with the \$1,811,140 of the bridge award, the three-year funding total is \$19,907,422.

### 1.1 Burkina Faso

	Bridge Award	Year 1	Year 2	Year 3	TOTAL
Implementation	\$402,281	\$ 1,334,107	\$ 1,004,231	\$ 798,118	\$ 3,136,455
Data Collection		\$ 108,411	\$ 86,293	\$ 78,023	\$ 272,727
ICR		\$ 160,264	\$ 121,157	\$ 97,339	\$ 378,760
TOTAL		\$ 1,602,781	\$ 1,211,681	\$ 973,480	\$ 3,787,942

### 1.2 Chad

	Bridge Award	Year 1	Year 2	Year 3	TOTAL
Implementation	\$365,157	\$ 953,536	\$ 898,286	\$ 648,652	\$ 2,500,474
Data Collection		\$ 30,591	\$ 23,561	\$ 19,573	\$ 73,725
ICR		\$ 109,336	\$ 102,417	\$ 74,240	\$ 285,993
TOTAL		\$ 1,093,463	\$ 1,024,264	\$ 742,464	\$ 2,860,192

### 1.3 DRC

	Bridge Award	Year 1	Year 2	Year 3	TOTAL
Implementation	\$326,269	\$ 1,255,674	\$ 1,251,472	\$ 1,070,220	\$ 3,577,366
Data Collection		\$ 28,055	\$ 24,110	\$ 24,110	\$ 76,275
ICR		\$ 142,622	\$ 141,717	\$ 121,580	\$ 405,919
TOTAL		\$ 1,426,352	\$ 1,417,299	\$ 1,215,910	\$ 4,059,560

### 1.4 Niger

	Bridge Award	Year 1	Year 2	Year 3	TOTAL
Implementation	\$120,000	\$ 881,073	\$ 869,596	\$ 691,322	\$ 2,441,991
Data Collection		\$ 28,336	\$ 26,482	\$ 26,482	\$ 81,300
ICR		\$ 101,035	\$ 99,554	\$ 79,748	\$ 280,338
TOTAL		\$ 1,010,444	\$ 995,632	\$ 797,552	\$ 2,803,628

### 1.5 Somalia

	Bridge Award	Year 1	Year 2	Year 3	TOTAL
Implementation	\$381,301	\$ 624,291	\$ 937,153	\$ 964,755	\$ 2,526,200
Data Collection		\$ 7,380	\$ 68,040	\$ 68,290	\$ 143,710
ICR		\$ 70,179	\$ 111,677	\$ 114,771	\$ 296,627
TOTAL		\$ 701,850	\$ 1,116,870	\$ 1,147,816	\$ 2,966,537

### 1.6 HQ Budget

	Bridge Award	Year 1	Year 2	Year 3	TOTAL
Implementation	\$216,131	\$ 368,483	\$ 313,851	\$ 296,089	\$ 978,423
Data Collection		\$ 168,989	\$ 170,781	\$ 138,402	\$ 478,172
ICR		\$ 59,713	\$ 53,843	\$ 48,272	\$ 161,828
TOTAL		\$ 597,186	\$ 538,475	\$ 482,762	\$ 1,618,423

## 2. IRC's funding history in the region of interest.

*Technical Advisors have provided figures on funding for nutrition in each of the targeted districts over the last 3 years, however it is important to note that these totals include both nutrition prevention and treatment activities. In other words, the budget amounts you can see in the “Funding” tables are likely higher than the actual amount of funding dedicated to GAM treatment. Because grants often combine multiple districts, as well as multiple activities, it is not always easy to distinguish total spending across districts*

*For the list of submitted but not accepted proposals, we have shown roughly 2 years of rejected opportunities from our system. However, our opportunity tracking system is not entirely disaggregated—for instance, in some cases we may have submitted an initial proposal including malnutrition treatment activities, and later been asked by the donor to adapt and re-submit a proposal with different activities or a different geographic scope. These would not show up as “rejected” proposals in our system, although they would be unsuccessful attempts to raise funding for malnutrition treatment in a given area. For example, this is the case in Chad, where our proposal to ECHO was ultimately accepted (and is marked as such in our system), however the donor told us to remove the proposed nutrition treatment activities in Guera before finalization.*

*For proposals which were never awarded, our data systems also make it more difficult to parse out budgeted spending to the level of the sector (as has been possible for actually awarded grants). Therefore, so we have included both the total value of the proposed grant as well as the names of the various sectors of work that would have been covered under that budget. While it does not allow you to precisely estimate the amounts that would have been allocated to nutrition generally, or GAM treatment specifically, this does provide a sense of the many different activities over which fixed pots of funding are typically spread.*

### 2.1 BURKINA FASO

IRC has been working in Burkina Faso since April 2019 in the areas of health, nutrition, water, hygiene and sanitation, protection, and economic recovery. In response to the deteriorating humanitarian situation in the country, IRC has implemented programs in all three regions (Sahel, North, and Boucle de Mouhoun). As of May 2021, IRC had funding from several donors (BHA, MOFA crisis and support center, UNHCR, UNICEF, SIDA and SV).

In the nutrition sector, IRC has BHA funding as part of a consortium with Action Contre le Faim for two years (May 2020-April 2022, 3 million USD), the Sahel, North and Boucle de Mouhoun regions. This project aims to prevent and treat severe acute malnutrition within the framework of rapid response mechanisms<sup>1</sup>. In the regions affected by the security crisis (Sahel, Centre-North, East, Boucle du Mouhoun, North and Centre-East), significant humanitarian funds have been mobilized to respond to the deterioration in the living conditions and the growing displacement. These funds have made it possible to strengthen support to health services for the treatment of malnutrition. However, other areas of the country suffer from a critical lack of investment and capacity for scaling up the treatment of acute malnutrition.

This situation is particularly critical in the peri-urban region of Ouagadougou, and especially in the health districts of Bogodogo, Boulmiougou, and Sig-Noghin, which are densely populated (2,984,972

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<sup>1</sup> Rapid response mechanisms are a commonly used approach to coordinating the assessment of needs and disbursement of assistance in emergency settings. You can see an example or what an RRM looks like in [this overview](#) of a response Central African Republic here.

inhabitants). In these districts, only 90 health centers out of 151 provide any treatment for malnutrition. This low availability of malnutrition treatment resulted in a low number of admissions in 2020, with only 5,003 cases of severe acute malnutrition cases admitted out of an estimated 21,000 cases in these 3 districts (estimate from the Burkina Faso Nutrition Cluster). Malnutrition is also poorly diagnosed, with very little screening being carried out because these peri-urban regions lack community health worker networks or systematized reception procedures in the health centers. This project therefore represents a new area of operations for IRC nutrition programming; no other nutrition projects have yet been implemented by IRC in the Centre region.

FUNDING – CENTRE REGION				
Date	Health District	Type of nutrition activities	Donor	Budget
N/A	Bogodogo, Boulmiougou, Sig-Noghin			\$0

REJECTIONS – CENTRE REGION				
Proposed Dates	Health District	All sectors included in the budget	Donor	Budget
<i>No relevant pots of funding have been available for Centre region for which IRC could submit proposals.</i>				

## 2.2 CHAD

The IRC has been working in Chad since 2004, first in the health sector (maternal and child health care, nutrition and environmental health) in Eastern camps. In 2015 we expanded to begin working safety/protection (prevention and response to gender-based violence), and since 2017 we have offered economic recovery and development programs. IRC’s work in Chad and has been funded by various donors including DG ECHO, UNHCR, WFP, SIDA, BPRM, GAC, OFDA, EuropeAid, AFD, and private donors. For nutrition program specifically, IRC Chad has been providing preventive and treatment for children in five in refugee camps (11 in the East and 1 in Lac province), in one IDP site in Lac province, as well as for the general population in Guera province.

This project will be implemented in the first year in Guera province. From the second year onwards, following a needs assessment budgeted in the first year, we plan also to begin nutrition in Wadi-Fira region in Eastern Chad allowing the IRC to offer nutrition services also to children under five outside of camps. Located between the edge of the Sahelian region and the Sudanian zone, Guera faces persistent food and nutrition insecurity crises. It is often cited as one of the most vulnerable provinces for malnutrition and the latest national [SMART survey \(December 2020\)](#) classified it among eight provinces in a critical situation. Guera province counts a total five health districts (Melfi, Mangalme, Mongo, Baro and Bitkine).

IRC has worked in Guera since 2013 and had nutrition program in all five districts at different times. These have been funded by six awards focused on malnutrition prevention (Infant and young child feeding) and treatment (CMAM), which have targeted children under five and pregnant and lactating women.

FUNDING - GUERA PROVINCE				
Date	Health District	Type of nutrition activities	Donor	Budget

10/2013-12/2016	Mongo, Baro, Mangalme	CMAM IYCF	EuropeAid (DEVCO)	2,480,891 EURO
4/2017 - 3/2018	Mongo, Baro, Mangalme, Melfi	CMAM IYCF	ECHO - DG European Civil Protection and Humanitarian Aid Operations	4,450,000 EURO
4/2017 - 3/2019	Mangalme, Melfi			
1/2019 - 4/2021	Mangalme, Melfi	CMAM IYCF	ECHO - DG	4,700,000 EURO
2021	Melfi	ICCM (health) and screening (nutrition)	LDS	300,000 USD
2020-2025	Bitkine	CMAM IYCF	EuropeAid	4,600,000 EURO

REJECTIONS – GUERA PROVINCE				
Proposed Dates	Health District	All sectors included in the budget	Donor	Budget
01/2019 – 01/2022	Various Districts in Guera, Wadi Fira, and others	Health	EuropeAid (DEVCO)	Not specified
09/2019-09/2024	Wadi Fira	Health	EuropeAid (DEVCO)	\$7,202,593
6/2021 – 6/2022	Guera, Baga Sola, Liwa Districts	Health, Protection	ECHO	\$2,890,621

After the end of our ECHO project which was funded through mid-2021, our proposal for follow-on funding for Guera was not accepted and the IRC was about to end our nutrition program in Mangalme and Melfi HD. Thanks to GiveWell, the IRC has continued its intervention in the HDs of Mangalme and Melfi and is hoping to extend work back into Baro HD. We had previously operated nutrition programs in Baro until December 2018 when our award from ECHO ended.

## 2.3 DRC

In DRC. The IRC has been working in DRC since 1996 in **health** (maternal and child health care, nutrition and environmental health), **in protection** (prevention and response to gender-based violence) and in **economic wellbeing** and in **governance**. To date, IRC Chad has been funded from a dozen donors, including DG ECHO, UNHCR, WFP, SIDA, BPRM, GAC, OFDA, EuropeAid AFD FISONG and private donors. For nutrition programming, the IRC have implemented preventive (Infant and young child feeding) and treatment (CMAM) projects targeting children under five and pregnant and lactating women.

In Tanganyika Province: The IRC has been intervening in nutrition programming only since December 2018 in the Tanganyika Province under SIDA and the Pool Fund project. In the province, the IRC has supported different zones at different periods (see the below table). Currently the IRC has only a limited budget to cover nutrition activities in Nyemba HZ.

FUNDING – TANGANYIKA PROVINCE				
Date	Health District	Nutrition activities	Donor	Budget (all sectors)
12/2018 - 5/2019	Kalemie	CMAM	SIDA	\$1,610,051

		IYCF		(Health + Protection)
7/2019 - 9/2020	Kiambi	CMAM IYCF	Pool Fund	\$2,136,658 (Protectin, Health, Violence Prevention)
8/2019 - 3/2020	Nyemba, Kalemie	CMAM IYCF	SIDA	\$1,078,187 (Protection, Nutrition, Reproductive Health)
5/2020 - 3/2021	Nyemba, Kalemie	CMAM IYCF	SIDA	\$1,089,662 (Health, Protection, Governance)
4/2021 – 3/2022	Nyemba	CMAM IYCF	SIDA	\$600,000 (Protection, Health)

REJECTIONS – TANGANYIKA PROVINCE				
Proposed Dates	Health District	All sectors included in the budget	Donor	Budget
04/2019 – 03/2020	Nyemba, Kalemie	Health	Common Humanitarian Fund (DRC Pooled Fund)	\$1,384,868
06/2021 – 03/2022	Districts across Tanganyika, South Kivu, and Ituri provinces	Health	United Nations Children's Fund (UNICEF)	\$750,000

## 2.4 NIGER

In Niger. The IRC has been working in Niger since 2013 in **health** (maternal and child health care, nutrition and environmental health), **in protection** (child protection, prevention and response to gender-based violence, migration), in **economic wellbeing, and in education**. To date, IRC Niger has been funded from several donors, including DG ECHO, OFDA/BHA, EuropeAid, AFD and private donors. For nutrition programming, IRC Niger have implemented preventive (Infant and young child feeding) and treatment (CMAM) projects targeting children under five and pregnant and lactating women.

Tillabery region covers six. The Tillabery counts 13 health districts, and the IRC intervened in nutrition in 5 of them at different periods (Balleyara, Fillingue Ouallam, Abala, and Banibangou.). In December 2018, the IRC end its support to Balleyara HD (ECHO withdrawal). To date, the IRC through ECHO funding is still supporting Fillingue and Ouallam HD but in July 2021, the support will be reduced to only SC and supporting the Surge Approach. With this project, IRC will continue its full CMAM intervention support in the HDs of Fillingue and Ouallam and then extend in Balleyara HD, previously supported by IRC. To date, no partner has intervened in Balleyara HD for the management of malnutrition, resulting in low functionality of OTP and the absence of SC services.

FUNDING - TILLABERY PROVINCE					
Date	HD	Date	Type of programme	Donor	Nutrition budget
2013 – 7/2020	Balleyara	2013 – 7/2020	CMAM, ANJE	ECHO	EC316 2013 : 950,601€
2013 - Present	Filingué	2013 - Present	CMAM, ANJE		EC330 2014 : 1,600,000€
2013 - Present	Ouallam	2013 - Present	CMAM, ANJE		EC355 2015 : 2,746,180€
					EC388 2016 : 1,200,000€
					EC403 2017 : 750,000€

Present				EC428 2018 : 600,000€ EC461 2019 : 647,500€ EC481 2020 : 422,667€ ECXX 2021 : 464,094€
2013 – 7/2020	Abala	2013 – 7/2020	CMAM, ANJE	
2013 - Present	Banibangou	2013 - Present	CMAM, ANJE	

<b>REJECTIONS – TILLABERRY PROVINCE</b>				
<b>Proposed Dates</b>	<b>Health District</b>	<b>All sectors included in the budget</b>	<b>Donor</b>	<b>Total Budget</b>
04/2019 – 03/2020	Abala, Filingue, Ouallam	Child Protection, Health, WPE	Global Affairs Canada (GAC)	\$770,900
04/2019 – 03/2021	Filingué, Ouallam, Abala, Banibangou, Balleyara	Health	USAID - Office of Food For Peace (FFP)	\$1,484,233
01/2020 – 12/2020	Abala, Filingue	Health, WPE	Global Affairs Canada (GAC)	\$756,788
09/2019 – 05/2020	Filingué, Ouallam, Abala, Banibangou	Health	Tereska	\$55,647
05/2021 – 04/2023	Filingué, Ouallam, Banibangou	Health	Else Kröner Fresenius Stiftung	\$246,519

## 2.5 SOMALIA

In Somalia, IRC has been implementing health and nutrition program since 2013 in Banadir region, with support from UNICEF in outpatient therapeutic program (OTP). From 2016 IRC received funding from SV, ECHO and BHA and implemented nutrition programs targeting under five children with uncomplicated severe acute malnutrition integrated with Infant and Young Child Feeding (IYCF) practices. In 2017, there was a severe drought across Somalia which exacerbated the rates of acute malnutrition in the country and in response to this, the IRC expanded its nutrition intervention into Galgaduud, Mudug and Nugal regions with support from DFID through the Building Resilient Communities in Somalia (BRICS) consortium. With this support, IRC has been implementing a multi-year integrated package of nutrition interventions targeting children with both severe acute malnutrition (SAM) and moderate acute malnutrition (MAM) through 4 mobile teams reaching 27 outreach sites at reach areas in order increase the access and coverage of nutrition services. IRC also set up one health facility with Stabilization Care (SC) services for treating SAM cases with complications.

In addition to the above, with support from ECHO, the IRC is conducting an operational study using the CompAS protocol at the Karaan clinic and at KM8 clinic within the IDP settlement in Deynille district in Banadir region. In 2020, IRC reached 5,660 under five children through the CompAS simplified protocol for treating MAM and SAM cases using reduced dosages of RUTF. For the last two years, the funding for malnutrition treatment and prevention has been unstable with some donors already withdrawing their support for the nutrition program including BHA, SV, and UNICEF.

<b>FUNDING – BANADIR REGION</b>				
<b>Date</b>	<b>Health District</b>	<b>Nutrition activities</b>	<b>Donor</b>	<b>Budget (all sectors)</b>
1/2020 – 12/2020	Puntland (Nugaal), Galmudug (Mudug) and Banadir regions	CMAM	DG ECHO	\$1,312,993 (Health, WPE, Nutrition)

7/2020 - 7/2021	Banadir and Galgadud	CMAM IYCF	Bureau for Humanitarian Assistance (BHA)	\$3,600,000 (Health, Nutrition, Environmental Health, WPE, ERD)
8/2018 - 8/2020	Banadir	CMAM IYCF	United Nations Children's Fund (UNICEF)	\$772,654 (Nutrition)
9/2019 – 3/2020	Galgadud, Mudug, Nugal	CMAM	DfID - Department for International Development UK	Nutrition, Environmental Health, ERD
4/2017 – 12/2017	Banadir	CMAM IYCF	Stichting Vluchteling (SV)	\$375,993 (Nutrition, ERD, Education, Protection)

<b>REJECTIONS – BANADIR REGION</b>				
<b>Proposed Dates</b>	<b>Health District</b>	<b>All sectors included in the budget</b>	<b>Donor</b>	<b>Budget</b>
9/2020 – 12/2021	Goldogob, Mudug region	Health, Nutrition and Environmental Health	United Nations Children's Fund (UNICEF)	\$500,000
1/2019 – 6/2019	Banadir & Hirshabelle	Nutrition	World Food Program (WFP)	Donations In Kind

### 3. Retrospective numbers of cases treated in the specific areas we are proposing to serve.

*It is not possible to identify the spending specifically attributable to SAM/MAM treatment in the specific districts in specific years from our grants data (i.e. the final column in the requested tables). Most information is tracked at the level of awards, which may span multiple provinces, multiple activities, and multiple years. Information has been provided in Question 2, at the greatest level of granularity possible (e.g. in Niger, someone had chosen to track this spending by hand for nutrition programming in the relevant areas so we have included it), about historical spending on nutrition activities as part of larger programs.*

*The difficulty of identifying activity-specific costs, to enable assessments of cost-efficiency and cost-effectiveness, is the reason that the Best Use of Resources team has been budgeted to support this project. In addition to acting as a general counterpart for GiveWell, we will conduct annual cost-efficiency analyses which will identify all relevant costs (i.e. separating data collection costs from implementation costs) attributable to CMAM in order to estimate the cost-efficiency of the project in each country. This addition of 15 cost-efficiency analyses (5 countries for 3 years) to the literature on the costs of CMAM will be another significant contribution of this project, allowing the BUR team to estimate how much cost-efficiency responds to fixed contextual characteristics or time trends.*

#### 3.1 BURKINA FASO

Burkina Faso: Bogodogo, Boulmiougou and Signoghin districts in the Centre Region						
		Cases treated by IRC	Number of cases per child	HF	SC	Budget
Two years ago	SAM	0	0	0	0	
	MAM	0				
Past year	SAM	0	0	0	0	
	MAM	0				

#### 3.2 CHAD

Chad: Guera (Melfi, Mangalme and Baro)						
		Cases treated by IRC	Number of cases per child	HF	SC	Budget
Two years ago	SAM	23,063	N/A	30	3	
	MAM	11,932				
Past year	SAM	6,869	N/A	23	2	
	MAM	N/A				

#### 3.3 DRC

DRC: Niemba district						
		Cases treated by IRC	Number of cases per child	HF	SC	Budget



Two years ago	SAM	0	N/A	0	0	
	MAM	0				
Past year	SAM	400	N/A	2	1	
	MAM	0				

### 3.4 NIGER

Niger: Fillingue and South of Ouallam districts						
		Cases treated by IRC	Number of cases per child	HF	SC	Budget
Two years ago	SAM	15,018	N/A	151	3	
	MAM	0				
Past year	SAM	9,901	N/A	80	2	
	MAM	0				

### 3.5 SOMALIA

Somalia: Banadir, Nugal, Galgadud, and Mudug						
		Cases treated by IRC (i.e. admissions)	Number of cases per child	HF	SC	Budget
Two years ago	SAM	N/A	N/A	N/A	N/A	
	MAM	N/A				
Past year	SAM	3,200	N/A	3	0	
	MAM	0				

#### 4. Projected numbers of cases treated in the specific areas we are proposing to serve.

*The equation typically used to estimate future caseloads is based on prevalence, under-five population, and the known incidence factor throughout the year<sup>2</sup>. However, this equation is widely acknowledged to provide inaccurate results because of the lack of reliable population data or reliable estimates of the known incidence factor. To accurately estimate caseload requires incidence data for the period, gained from longitudinal studies, which are rarely available in low-income settings. In the absence of this data, incidence factors such as 2.6 are widely used, however studies from the Sahel have shown wide variation in incidence factors from Burkina Faso and Mali ranging from 5.7 to 9.4. Given the uncertainty of incidence factor, practitioners often rely on setting their expected admissions based on past years admissions.*

*For example, imagine that the prevalence of SAM is 3.5%, the under-five population is 20,456 and the incidence factor is 2.6. Over a three-year period, the total caseload would be 7,732.*

*Caseload = (Prevalence × Time) + Incidence*

*Prevalence = Under Five Population × Prevalence Rate*

*Time = 3 years*

*Incidence = Incidence Factor, if known (otherwise 2.6)*

*Therefore, in this example Caseload = (20,456 × 0.035) × 3 + (2148 × 2.6) = 7,732*

*If population growth is known, this can also be taken into account, by increasing the estimate of the under-five population for each year. As written, this equation does assume 100% coverage and could technically be further reduced if projected coverage was well understood.*

*All of the caseload projections below, except for Chad, used this calculation given their current under-five population, the latest SMART survey estimates of prevalence, and an incidence factor of 2.6. For Chad we have opted to base caseload estimates on past admissions, given the observed inaccuracy of projections based on this formula in the past.*

#### 4.1 BURKINA FASO

The yearly target number case estimation is calculated on the latest SAM prevalence + yearly increase of population (3.6% yearly increase population). Beneficiary targets projections will be revised every year based on coverage survey results.

The project will target all of the 151 functional health centers in the 3 HDs (52 Bogodogo, 64 Boulmiougou, and 35 Sig-Noghin) for the treatment of severe acute malnutrition at the OTP and SC level. Based on the prevalence of severe acute malnutrition in the area ([SMART 2020](#)), the number of SAM admissions is estimated at:

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<sup>2</sup> For an explanation of incidence factors, and background on why quality estimates of the incidence factor are not common, see [“Incidence Correction Factors for Moderate and Severe Acute Child Malnutrition From 2 Longitudinal Cohorts in Mali and Burkina Faso”](#) or [“Estimating the burden of child acute malnutrition accurately”](#).

DISTRICT	YEAR 1			YEAR 2			YEAR 3			TOTAL		
	OTP	SC	Total	OTP	SC	Total	OTP	SC	Total	OTP	SC	Total
Bogodogo	4,686	827	5,513	4,855	857	5,712	5,030	888	5,918	14,572	2,571	17,143
Boulmiougou	5,207	919	6,126	5,395	952	6,347	5,589	986	6,575	16,192	2,857	19,049
Sg-Nognin	1,743	308	2,051	1,806	319	2,125	1,871	330	2,201	5,420	957	6,377
TOTAL	11,636	2,054	13,690	12,056	2,128	14,184	12,490	2,204	14,694	36,184	6,385	42,569

## 4.2 CHAD

The project will target all the 32 functional health centers in the 3 HDs (12 HDs in Mangalme, 11 HDs in Melfi, and 9 HDs in Baro) for the treatment of severe acute malnutrition (SAM) at OTP and SC level.

The yearly target number case estimation is based on the number of admissions in 2020 in Mangalme and Melfi HD and 2018 admission figures in Baro HD. Estimates from SMART surveys as compared to IRC admissions have underestimated caseload every year (by 39% in 2018, by 41% in 2019 and in 40% in 2020). The estimated caseload based on SMART surveys is 15,967, however IRC treated 29,932 children in the last 3 years suggesting that the equation is not a good predictor of actual admissions. Therefore, our estimate of the 3-year caseload based off of historical admissions (with a slight increase) is estimated to be 30,339. Beneficiary targets projections will be revised every year based on coverage survey results. The number of SAM admissions per year is estimated at:

DISTRICT	YEAR 1			YEAR 2			YEAR 3			TOTAL		
	OTP	SC	Total	OTP	SC	Total	OTP	SC	Total	OTP	SC	Total
Baro	1,804	318	2,122	1,804	318	2,122	1,804	318	2,122	5,412	954	6,366
Mangalme	3,786	668	4,454	3,786	668	4,454	3,786	668	4,454	11,358	2004	13,362
Melfi	3,006	531	3,537	3,006	531	3,537	3,006	531	3,537	9,018	1593	10,611
TOTAL	8,596	1,517	10,113	8,596	1517	10,113	8,596	1517	10,113	25,788	4551	30,339

## 4.3 DRC

The project will target all the 28 functional health centers in the 2 HDs (17 HF in Kalemie and 11 HF in Nyemba) for the treatment of severe acute malnutrition at OTP and SC level.

The yearly target caseload is estimated based on the latest SAM prevalence + and under-five population, also assuming a 3.3% yearly increase population. Beneficiary targets projections will be revised every year based on coverage survey results.

Based on the prevalence of severe acute malnutrition in the area (SMART 2020), the number of SAM admissions is estimated at:

DISTRICT	YEAR 1			YEAR 2			YEAR 3			TOTAL		
	OTP	SC	Total	OTP	SC	Total	OTP	SC	Total	OTP	SC	Total

Kalemie	4,167	736	4,903	4,305	760	5,065	4,447	785	5,232	12,919	2281	15,201
Nyemba	1,893	334	2,227	3,138	554	3,692	3,242	572	3,814	8,273	1460	9,732
TOTAL	6,061	1,069	7,130	7,443	1,314	8,757	7,689	1,357	9,046	21,193	3740	24,933

#### 4.4 NIGER

The project will target all of the 32 functional health centers in the 3 HDs (12 HDs in Mangalme, 11 HDs in Melfi and 9 HDs in Baro) for the treatment of severe acute malnutrition at OTP and SC level.

The yearly target number case estimation is calculated on the latest SAM prevalence + yearly increase of population (3.0% yearly increase population). Beneficiary targets projections will be revised every year based on coverage survey results.

Based on the prevalence of severe acute malnutrition in the area ([SMART 2020](#)), the number of SAM admissions is estimated at:

DISTRICT	YEAR 1			YEAR 2			YEAR 3			TOTAL		
	OTP	SC	Total	OTP	SC	Total	OTP	SC	Total	OTP	SC	Total
Balleyara	1,238	218	1,456	1,274	225	1,499	1,312	232	1,544	3,824	675	4,499
Fillingue	3,457	610	4,067	3,561	628	4,189	3,667	647	4,314	10,685	1885	12,570
Ouallam	3,746	661	4,407	3,858	681	4,539	3,974	701	4,675	11,578	2043	13,621
TOTAL	8,441	1,489	9,930	8,693	1,534	10,227	8,953	1,580	10,533	26,087	4,603	30,690

#### 4.5 SOMALIA

The project targets 5 health facilities (2 in Banadir with one of the facilities providing SC services, 1 Galgadud, 1 Mudug and 1 Nugal) and 27 sites that will be reached through mobile teams in Galgadud, Mudug and Nugal regions. The target projection will be revised annually considering the coverage of the project.

Based on the prevalence of severe acute malnutrition in the area ([SMART 2020](#)), the number of SAM admissions is estimated at:

DISTRICT	YEAR 1				YEAR 2				YEAR 3				TOTAL	S
	OTP	SC	MAM	Total	OTP	SC	MAM	Total	OTP	SC	MAM	Total		
Banadir	851	128	1864	2,843	888	133	1870	2,891	901	135	1872	2,908	2640	3
Galgadud	756	113	1474	2,343	762	114	1479	2,355	769	115	1480	2,364	2287	3
Mudug	578	87	1350	2,015	582	87	1358	2,027	584	88	1359	2,031	1744	2
Nugal	776	116	1907	2,799	778	117	1910	2,805	779	117	1911	2,807	2333	3
TOTAL	2,961	444	6,595	10,000	3,010	452	6,617	10,079	3,033	455	6,622	10,110	9004	13

#### 5. Other providers of malnutrition programs (aside from MoH) and their activities.

## **5.1 BURKINA FASO**

With this project, IRC proposes to support the Ministry of Health in the detection and management of malnutrition in 3 Health Districts of the Guera province: Mangalme, Baro and Melfi. This support will be done in complementarity with other nutrition stakeholders in the area, particularly:

- UNICEF: RUTF supply for all cases served

## **5.2 CHAD**

Within this project, IRC proposes to support the Ministry of Health in the detection and management of malnutrition in three Health Districts of the Guera province: Mangalme, Baro and Melfi. This support will be done in complementarity with other nutrition stakeholders in the area, particularly:

- UNICEF: RUTF supply for all cases served

## **5.3 DRC**

With this project, IRC proposes to support the Ministry of Health in the detection and management of malnutrition in 2 Health Zones of the Tanganyka province: Kalemie and Nyemba. In this area no other stakeholders are present and UNICEF and WFP do not provide any RUTF or RUSF supplies.

## **5.4 NIGER**

With this project, IRC proposes to support the Ministry of Health in the detection and management of malnutrition in 3 Health Districts of the Tillabery region: Balleyara, Fillingue and Ouallam. This support will be done in complementarity with other nutrition stakeholders in the area:

- UNICEF: RUTF supply for all cases served

## **5.5 SOMALIA**

- Concern World Wide (CWW) - support stabilization centre (SC) focusing on the treatment of complicated cases in one district in Banadir.
- CWW also have nutrition centres focusing on treatment of MAM and SAM cases.
- SCI is providing nutrition services targeting MAM and SAM cases in some of the proposed areas
- Norwegian Refugee Council (NRC) –provide SAM and MAM service.
- ACF-has also nutrition activities
- UNICEF- provide RUTF supplies to IRC for SAM treatment.
- WFP- provide RUST supplies for MAM treatment – IRC does not get any supplies from WFP
- CESVI –provide nutrition interventions in some of the proposed areas.

## 6. The types of programmatic activities to be undertaken in the targeted regions.

*GiveWell has asked whether IRC does post-discharge chemoprevention as follow-up treatment for children who receive services through stabilization centers. When children are discharged from SCs back to OTP sites, and any child who is positive for malaria is treated. In the Sahel specifically, the WHO recommends seasonal malaria chemoprevention, and our staff will be implementing that in accordance with national guidelines.*

### 6.1 BURKINA FASO

#### **Children under 5 have access to good quality treatment services including in hard-to-reach area**

##### 1. At the hospital level (SC):

- Training of at least 10 health workers per SC by MoH (national level) and IRC agents.
- Continuous mentoring adapted to the specific needs of health workers by the IRC agents. This mentoring will be on a sliding scale throughout the project and will be linked to the empowerment of the health agents in the management of medical complications.
- Provision of materials, equipment, medicines, additional human resources, referral system and rehabilitation in the 3 SC (located in the HD hospitals).
- Rehabilitation of SC ward.

##### 2. At the health center level (OTP):

- Training of at least 2 health workers per health center by MoH and IRC agents.
- Continuous mentoring adapted to the specific needs of health workers by the IRC agents. This mentoring will be on a sliding scale throughout the project and will be linked to the empowerment of the health agents for CMAM.
- Provision of materials, equipment, and medicines for the management of malnutrition according to the needs of each health facility.

#### **Caregivers of children seek prompt treatment and adopt household practices for the appropriate management of acute malnutrition**

- Regular and continuous malnutrition screening through Family MUAC approach, which aims to train and equip each household on malnutrition screening. For that, community health volunteers (CHVs) from each village will be trained on Family MUAC by a local partner (CORAB) and then will replicate the training at household level.
- Mass screening by CHVs in areas with low SAM admission rate by trained CHVs.

#### **Services are effectively planned, managed, and delivered in partnership with MoH and national actors including determining increased support during peak surges.**

- Quarterly joint supervision by regional MoH officials and IRC to evaluate the quality and coverage of nutrition treatment services at health facility and community level with priority given to facilities with low performance indicators.
- Monthly joint supervision by local MoH to evaluate the quality of nutrition treatment services at health facility and community level with priority given to facilities with low performance indicators.

#### **Learning questions**

- Coverage survey planned each year by IRC agents with the support of external consultant for the qualitative portion.
- Routine data collected and analyzed through Commcare by the IRC agents.

## 6.2 CHAD

### **Children under 5 have access to good quality treatment services including in hard-to-reach areas.**

#### 1. At the hospital level (SC):

- Training of at least four (4) health workers per SC by MoH (national level) and IRC agents.
- Continuous mentoring adapted to the specific needs of health workers by the IRC agents. This mentoring will be on a sliding scale throughout the project and will be linked to the empowerment of the health agents in the management of medical complications.
- Provision of materials, equipment, medicines, additional human resources, referral system and rehabilitation in the 3 SC (located in the HD hospitals).

#### 2. At the health center level (OTP):

- Training of at least two (2) health workers per health center by MoH and IRC agents.
- Continuous mentoring adapted to the specific needs of health workers by the IRC agents. This mentoring will be on a sliding scale throughout the project and will be linked to the empowerment of the health agents for CMAM.
- Provision of materials, equipment, and medicines for the management of malnutrition according to the needs of each health facility.
- Establishment of a RUTF buffer stock to respond to any possible stock out.

#### 3. At village level – in hard-to-reach area through advanced vaccination strategy

- Provision of materials, medicines and transportation means to integrate SAM treatment within the treatment the advanced vaccination strategy.
- Continuous mentoring adapted to the specific needs of health workers responsible of the advanced vaccination strategy, by the IRC agents. This mentoring will be on a sliding scale throughout the project and will be linked to the empowerment of the health agents for CMAM.

### **Caregivers of children seek prompt treatment and adopt household practices for the appropriate management of acute malnutrition.**

- Regular and continuous malnutrition screening through Family MUAC approach, which aims to train and equip each household on malnutrition screening. For that, community health volunteers (CHVs) from each village will be trained on Family MUAC by IRC and then will replicate the training at household level.
- Mass screening by CHVs in areas with low SAM admission rate by CHVs already trained.

### **Services are effectively planned, managed, and delivered in partnership with MoH and national actors including determining increased support during peak surges.**

- CMAM Surge implementation to enable programs and MoH to plan for and predict changes in malnutrition caseloads and access the capacity to manage. For that, at least 2 health workers per health center workers will be trained and monitored by IRC on CMAM Surge approach.
- Quarterly joint supervision with MoH and IRC to evaluate the quality and coverage of nutrition treatment services at health facility and community level, with priority given to facilities with low performance indicators.

### Learning questions

- Coverage survey planned each year in each HD by IRC agents with the support of external consultant for the qualitative part.
- Routine data collected and analyzed through Commcare by the IRC agents

## 6.3 DRC

### Children under 5 have access to good quality treatment services including in hard-to-reach area

#### 1. At the hospital level (SC):

- Training of at least 4 health workers per SC by MoH (national level) and IRC agents.
- Continuous mentoring adapted to the specific needs of health workers by the IRC agents. This mentoring will be on a sliding scale throughout the project and will be linked to the empowerment of the health agents in the management of medical complications.
- Provision of materials, equipment, medicines, therapeutic milk, additional human resources, referral system and rehabilitation in the 3 SC (located in the HZ hospitals).

#### 2. At the health center level (OTP):

- Training of at least 2 health workers per health center by MoH and IRC agents.
- Continuous mentoring adapted to the specific needs of health workers by the IRC agents. This mentoring will be on a sliding scale throughout the project and will be linked to the empowerment of the health agents for CMAM.
- Provision of materials, equipment, and medicines for the management of malnutrition according to the needs of each health facility.
- Purchase of all RUTF needs to treat SAM cases.

#### 3. At the post health level (OTP)

- Training of at least 1 health worker per health post by MoH and IRC agents.
- Continuous mentoring adapted to the specific needs of health workers by the IRC agents. This mentoring will be on a sliding scale throughout the project and will be linked to the empowerment of the health agents for CMAM.
- Provision of materials, equipment, and medicines for the management of malnutrition according to the needs of each health facility.

#### 4. At village level – in hard-to-reach area through advanced vaccination strategy

- Provision of materials, medicines and transportation means to integrate SAM treatment within the treatment the advanced vaccination strategy.
- Continuous mentoring adapted to the specific needs of health workers responsible of the advanced vaccination strategy, by the IRC agents. This mentoring will be on a sliding scale throughout the project and will be linked to the empowerment of the health agents for CMAM.

#### 5. At village level – in hard-to-reach area through CHWs (iCCM+ nutrition)

- Training of community health worker working already on iCCM on treatment of SAM case at community level by MoH and IRC.
- Provision of materials, medicines and transportation means to integrate SAM treatment within iCCM package.



- Continuous mentoring adapted to the specific needs of community health workers by the IRC agents. This mentoring will be on a sliding scale throughout the project and will be linked to the empowerment of the health agents for CMAM.

### **Caregivers of children seek prompt treatment and adopt household practices for the appropriate management of acute malnutrition**

- Regular and continuous malnutrition screening through Family MUAC approach, which aims to train and equip each household on malnutrition screening. For that, community health volunteers (CHVs) from each village will be trained on Family MUAC by IRC and then will replicate the training at household level.
- Mass screening by CHWs in areas with low SAM admission rate by CHWs already trained.

### **Services are effectively planned, managed, and delivered in partnership with MoH and national actors including determining increased support during peak surges.**

- Quarterly joint supervision with MoH and IRC to evaluate the quality and coverage of nutrition treatment services at health facility and community level with priority given to facilities with low performance indicators.

### **Learning questions**

- Coverage survey planned each year in each HZ by IRC agents with the support of external consultant for the qualitative part.
- Routine data collected and analyzed through Commcare by the IRC agents.

## **6.4 NIGER**

### **Children under 5 have access to good quality treatment services including in hard-to-reach area**

#### 1. At the hospital level (SC):

- Training of at least 4 health workers per SC by MoH (national level) and IRC agents.
- Continuous mentoring adapted to the specific needs of health workers by the IRC agents. This mentoring will be on a sliding scale throughout the project and will be linked to the empowerment of the health agents in the management of medical complications.
- Provision of materials, equipment, medicines, additional human resources, referral system and rehabilitation in the 3 SC (located in the HD hospitals).

#### 2. At the health center level (OTP):

- Training of at least 2 health workers per health center by MoH and IRC agents.
- Continuous mentoring adapted to the specific needs of health workers by the IRC agents. This mentoring will be on a sliding scale throughout the project and will be linked to the empowerment of the health agents for CMAM.
- Provision of materials, equipment, and medicines for the management of malnutrition according to the needs of each health facility.
- Establishment of a RUTF buffer stock to respond to any possible stock out.

#### 3. At the post health level (OTP) with qualified health workers

- Training of at least 1 health worker per health post by MoH and IRC agents.

- Continuous mentoring adapted to the specific needs of health workers by the IRC agents. This mentoring will be on a sliding scale throughout the project and will be linked to the empowerment of the health agents for CMAM.
- Provision of materials, equipment, and medicines for the management of malnutrition according to the needs of each health facility.

### 3. At the post health level (OTP) WITHOUT qualified health workers – in hard-to-reach area through advanced vaccination strategy

- Provision of materials, medicines and transportation means to integrate SAM treatment within the treatment the advanced vaccination strategy
- Continuous mentoring adapted to the specific needs of health workers responsible of the advanced vaccination strategy, by the IRC agents. This mentoring will be on a sliding scale throughout the project and will be linked to the empowerment of the health agents for CMAM.

### **Caregivers of children seek prompt treatment and adopt household practices for the appropriate management of acute malnutrition**

- Regular and continuous malnutrition screening through Family MUAC approach, which aims to train and equip each household on malnutrition screening. For that, community health volunteers (CHVs) from each village will be trained on Family MUAC by IRC and then will replicate the training at household level.
- Mass screening by CHVs in areas with low SAM admission rate by CHVs already trained.

### **Services are effectively planned, managed, and delivered in partnership with MoH and national actors including determining increased support during peak surges.**

- CMAM Surge implementation to enables IRC and MoH to plan for and predict changes in malnutrition caseloads and access the capacity to manage these surges. For that, at least 2 health workers per health center workers will be trained and monitored by IRC on CMAM Surge approach.
- Quarterly joint supervision with MoH and IRC to evaluation the quality and coverage of nutrition treatment services at health facility and community level with priority given to facilities with low performance indicators.
- Support health district teams additional human resources (2 per Health District) and transport means to ensure regular supervision (weekly basis) of all nutrition treatment sites (approach assistant point focal)
- Support to the HD referral system (such as through the creation of additional savings mechanisms to cover medical evacuation) for SAM children with medical complication (from OTP to SC).

### **Learning questions**

- Coverage survey planned each year. One survey will be conducted in Balleyara HD and another one for Fillingue and Ouallam by IRC agents with the support of external consultant for the qualitative part.
- Routine data collected and analyzed through Commcare by the IRC agents

## **6.5 SOMALIA**

- At community level, community mobilization and sensitization will be a major component for creating awareness to mothers and caregivers to demand for nutrition services and thus increase

their uptake leading to improved coverage and nutrition and health status. Community mobilizers in collaboration with local leaders and authorities will be sensitized to conduct community mobilization. CHWs will be trained on Mother Led /Family MUAC for early detection and treatment and they will be expected to cascade this training to caregivers and other community members.

- Identification, referral and treatment of children suffering from severe acute malnutrition will be done through community, health facility through outpatient therapeutic program (OTP), supplementary feeding program (SFP) and Complicated cases of severe acute malnutrition (SAM) will be treated in stabilization centres (SC) managed by IRC and other partners.
- Prevention services will include deworming for children 12-59 months and pregnant women in the 2nd and 3rd trimester, counselling and promotion on infant and young child feeding. Community mobilization and screening as well as micronutrient supplementation for PLW (multiple micronutrients and Iron folate) and children 6-59 months with Vitamin A supplements. The program will promote home-based fortification to enrich the diets of young children 6 - 23 months through the distribution of micronutrient powder.
- Provision of routine immunization services to children and pregnant women in these project sites. Systematic defaulter tracing and follow up of absentees will be conducted at community level by community health workers.
- Building the capacity of health workers and CHWs on IMAM with emphasis on Severe Acute Malnutrition (SAM) to include screening, identification and treatment. They will also be trained on reporting including supplies for evidence-based programming. Infant and Young Child Feeding (IYCF) training will be done to enhance skills towards improvement of IYCF care practices.
- Annual coverage surveys and adaptations to improve coverage.
- Advocacy for simplified approaches for remote communities served through mobile outreaches.

## **7. Narrative of what you expect would happen in targeted areas in 2021 without GiveWell.**

### **7.1 BURKINA FASO**

In the absence of funding from GiveWell in the 3 HDs, the nutrition treatment services access would remain the same as today with very low admissions and coverage and absence of SC services as no other partner supports the region for nutrition. In the absence of GiveWell funding, we estimate the targeted area not treating more than 5,000 children per year.

### **7.2 CHAD**

In the absence of funding from GiveWell and in the absence of support from other donor and actors, the MoH will continue to run nutrition services. We would observe a decrease in access to and quality of nutrition treatment. With the withdrawal of IRC at the end of December 2018 in Mongo and Baro health district, there was a significant reduction of admissions and low access when support stopped to MoH (which is the current state of Baro HD since 2018). This is due to few investments in the SC care, closure of services, shortages in drugs and nutritional products and lack of supervision to detect and course correct quality issues. In Mongo HD, the number of new SAM admissions (OTPs) decreased by 30% during the first 6 months when IRC lost funding and withdrew (from January to Jun 2019). It is likely that over time this would get worse with more closures and stock-outs. We'd expect by the end of Y1 at least a 40% reduction in admissions leading to an estimated 6,072 children treated. In Y2, we'd expect at least a 50% reduction leading to 5,056 children treated and by Y3, we'd expect at least a 60% reduction leading to 4,045 children treated if not a complete disruption in treatment.

### **7.3 DRC**

In the absence of funding from GiveWell in the 3 HZs, the nutrition treatment services access will remain the same as today, with no services.

### **7.4 NIGER**

In the absence of funding from GiveWell in Fillingue and Ouallam HD, the MoH will continue to run nutrition services but a decrease in access to and quality of nutrition treatment is expected. There would be no services in Balleyara HD. With the withdrawal of IRC at the end of May 2021, no more actors supported MoH and the IRC already observed a reduction of nutrition treatment admissions and low access reported when stopping supporting MoH (example of Balleyara HD since 2020) with few investments in SC care, closure of services, shortages in drugs and nutritional products and lack of supervision to detect and course correct quality issues. It is likely that over time this would get worse with more closures and stock-outs. We'd expect by the end of Y1 in Fillingue and Ouallam (best case) that there would be a likely 40% reduction in admissions leading to 3254 children treated. In Y2, we'd expect at least a 50% reduction leading to 4,364 children treated and by Y3, we'd expect at least a 60% reduction leading to 3596 children treated if not a complete disruption of services. Services would be completely disrupted in Balleyara HD.

### **7.5 SOMALIA**

In Somalia, IRC has been implementing health and nutrition program since 2013 in Banadir region, with support from UNICEF in outpatient therapeutic program (OTP). From 2016 IRC received funding from SV, ECHO and BHA and implemented nutrition programs targeting under five children with uncomplicated severe acute malnutrition integrated with Infant and Young Child Feeding (IYCF) practices. In 2017, there was a severe drought across Somalia which exacerbated the rates of acute

malnutrition in the country and in response to this, the IRC expanded its nutrition intervention into Galgadud, Mudug and Nugal regions with support from DFID through the Building Resilient Communities in Somalia (BRICS) consortium. With this support, IRC has been implementing a multi-year integrated package of nutrition interventions targeting children with both severe acute malnutrition (SAM) and moderate acute malnutrition (MAM) through 4 mobile teams reaching 27 outreach sites to increase the access and coverage of nutrition services. IRC also set up one health facility with Stabilization Care (SC) services for treating SAM cases with complications. In addition, with support from ECHO, the IRC is conducting an operational study using the ComPAS protocol at the Karaan clinic and at KM8 clinic within the IDP settlement in Deynille district in Banadir region. In 2020, IRC reached 5,660 under five children through the ComPAS simplified protocol for treating MAM and SAM cases using reduced dosages of RUTF. For the last two years, the funding for malnutrition treatment and prevention has been unstable with some donors already withdrawing their support for the nutrition program such as BHA, SV and UNICEF which were coming to an end in June, 2021.

In the absence of GiveWell funding, it's expected that the prevalence of malnutrition would increase in these locations and no other partners nor the government would be able to cover the expected gaps in nutrition services, leading services to close down.

**8. Attach any malnutrition-related surveys that you are aware of in or near the areas proposed within the past 5 years.**

### **8.1 BURKINA FASO**

[SMART survey 2020](#)

[SMART survey 2020 visual maps](#)

[Burkina Faso Humanitarian bulletin, March 2021](#)

### **8.2 CHAD**

[SMART survey 2020](#)

[Chad Humanitarian overview April 2021](#)

[Chad Funding outlook May 2021](#)

[Twin peaks: the Seasonality of Acute Malnutrition, Conflict and Environmental Factors \(in Chad, Sudan and South Sudan\). Tufts September 2019](#)

### **8.3 DRC**

### **8.4 NIGER**

[Nutrition Causal Analysis in Niger \(FEWSNET, March 2017\)](#)

### **8.5 SOMALIA**

[Final SMART Survey Report for Abudwaq and Adado Districts, Galgaduud Region](#)

[Somalia 2020 Post-Gu Seasonal Food Security & Nutrition Assessment](#)

[Somalia 2020 Post-Deyr Seasonal Food Security & Nutrition Assessment](#)

[Somalia Humanitarian Dashboard April 2021](#)

[Somalia Humanitarian Needs Overview 2021](#)

[Global Nutrition Cluster – snapshot of current services provided in nutrition \(Jan-May 2021\)](#)

[SQUEAC Coverage Assessments of Dhusamareeb District, Galgaduud Region, Somalia 2017](#)

[Global Nutrition Report 2020 - Somalia](#)

## 9. Describe the data collection activities. Specifically, what data will be collected and when.

### 9.1 BURKINA FASO

**Coverage Data:** Data on treatment coverage will be collected annually through quantitative and qualitative coverage surveys. Given the homogeneity of the targeted area, one survey *covering all three Health Districts* will be conducted every year between August and September. For qualitative surveys, the methodology will be adapted based on the quantitative assessments results and will not be systematically repeated during the annual coverage surveys if the barriers remain the same.

**Programmatic Data.** IRC will develop an individual database using the CommCare software that will make it possible to record admission criteria (P/T, MUAC, oedema), types of admission (new case, relapse, readmission), referral method (spontaneous, PB Family, CHVs, other), discharge criteria (cured, death, defaulter, non-responder, medical transfer), and internal transfers between OTP/SC. The individual data will be collected through tablets by the IRC nutrition agents during their supervision visits (weekly or bi-weekly) and then verified and analyzed by the Manager M&E in charge of compiling and generating the monthly reports.

### 9.2 CHAD

**Coverage Data:** Data on treatment coverage will be collected annually through quantitative and qualitative coverage surveys. Given the disparity of the different areas targeted with Chad (specifically, the Melfi HD has more access challenges) and the absence IRC nutrition programming in Baro HD for the past two years, one quantitative survey will be conducted each year between July and August in *each of the three targeted HDs*. For qualitative surveys, the methodology will be adapted based on the quantitative assessments results and will not be systematically repeated during the annual coverage surveys if the barriers remain the same.

**Programmatic Data:** IRC will develop an individual database using the CommCare software that will make it possible to record admission criteria (P/T, MUAC, oedema), types of admission (new case, relapse, readmission), referral method (spontaneous, PB Family, CHVs, other), discharge criteria (cured, death, defaulter, non-responder, medical transfer), and internal transfers between OTP/SC. IRC Chad has several important experiences in collecting CommCare data, particularly for beneficiary surveys and program information at IDP sites. The individual data will be collected through tablets by the IRC nutrition agents during their supervision visits (weekly or bi-weekly) and then verified and analyzed by the Senior M&E Health Manager in charge of compiling and generating the monthly reports.

### 9.3 DRC

**Coverage Data:** Data on treatment coverage will be collected annually through quantitative and qualitative coverage surveys. Given the different scaling up and extension coverage throughout the project in the different HZ, one quantitative survey will be conducted each year *in each HZ* between September to October. For qualitative surveys, the methodology will be adapted based on the quantitative assessments results and will not be systematically repeated during the annual coverage surveys if the barriers remain the same.

**Programmatic Data.** IRC will develop an individual database using the Commcare software that will make it possible to record admission criteria (P/T, MUAC, oedema), types of admission (new case, relapse, readmission), referral system (spontaneous, PB Family, CHVs, other), discharge criteria (cured, death, defaulter, non-responder, medical transfer), and internal transfers between OTP/SC. The individual data will be collected through tablets by the IRC nutrition agents during their supervision visits (weekly

or bi-weekly) and then verified and analyzed by the Senior Manager M&E in charge of compiling and generating the monthly reports.

#### 9.4 NIGER

**Coverage data:** Data on treatment program coverage will be collected annually through quantitative and qualitative coverage surveys. Given the absence of recent programming by IRC in Balleyara HD for 1 year, compared to Fillingue and Ouallam, *one quantitative survey will be conducted in Balleyara and a separate survey will be conducted for the 2 other HDs together.* Surveys will be conducted each year between July and August. For qualitative survey, the methodology will be adapted based on the quantitative assessments results and will not be systematically repeated during the annual coverage surveys if the barriers remain the same.

**Individual data for each child admitted to the treatment program.** IRC will develop an individual database using the Commcare software that will make it possible to record admission criteria (P/T, MUAC, oedema), types of admission (new case, relapse, readmission), referral system (spontaneous, PB Family, CHVs, other), discharge criteria (cured, death, defaulter, non-responder, medical transfer), and internal transfers between OTP/SC. The individual data will be collected through tablets by the IRC nutrition agents during their supervision visits (weekly or bi-weekly) and then verified and analyzed by the Senior Manager M&E in charge of compiling and generating the monthly reports.

#### 9.5 SOMALIA

**Coverage data:** The data collection activities will include conducting an adapted Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) Survey at the start of the project (i.e. July-August) to determine the coverage, barriers, and access to nutrition services at the targeted areas. The 4 districts neighbor each other but have different livelihood zones. Wadajir is an urban district and IRC works within the displaced urban communities. Sampling will be done in each of the districts to establish baseline information on barriers to access. After the projects starts, the SQUEAC survey will be carried out at the end of every project year to measure on whether the provision of nutrition services through Give Well has improved the coverage and access.

**Individual data for each child admitted to the treatment program.** IRC will develop an individual database using the Commcare software to collect information at admission. Individual data level will be collected at the admission until the exit of the program. This will be included but not limited to: MUAC measurement, age, weight, name, number of RUFT child receives. There will be also accumulated data collection that captures the performance indicators of the program that encompasses total cases admitted, cured, defaulted, death, non-response and transferred disaggregated by age, gender and location. The average length of stay (LOS) will be calculated for all cases admitted and recovered successful in the course of the program. All these information will be in the registers, Commcare, COMET and ONA platform for easy analysis, decision making and future use for programming.