Indicator description	**Number of children under five, breastfeeding and pregnant women reached through DFID's nutrition-relevant programmes**
Indicator Type	Peak year (but can report cumulatively over time if double counting is avoided)
Methodological Summary	These refer to those programmes that have specific nutrition objectives, outputs or outcomes. For example, these can range from sector support programmes in health or agriculture, to specific micro-nutrient provision programmes. This indicator should include the results of: • Direct Interventions – based on the Lancet's proven interventions[1]: **Interventions with Sufficient Evidence to Implement in All Countries** **Maternal and Birth Outcomes** • Iron folate supplementation • Maternal supplements of multiple micronutrients • Maternal iodine through iodization of salt • Maternal calcium supplementation • Interventions to reduce tobacco consumption or indoor air pollution **Newborn Babies** • Promotion of breastfeeding (individual and group counselling) **Infants and Children** • Promotion of breastfeeding (individual and group counselling) • Behaviour change communication for improved complementary feeding • Zinc supplementation • Zinc in management of diarrhea • Vitamin A fortification or supplementation • Universal salt iodization • Handwashing or hygiene interventions • Treatment of SAM • Nutrition sensitive programmes – where the logical frameworks report against a nutrition outcome / objective for under-fives and/or pregnant or breastfeeding women[2]. This can include: health, sanitation, livelihoods, education, agriculture and women's empowerment programmes that explicitly aim to impact on nutrition (alongside other goals). The panel below provides a definition of nutrition-specific and nutrition-sensitive interventions and programmes.

[1] Bhutta, Z.A, et al, 2008, 'What works? Interventions for maternal and child undernutrition and survival' *The Lancet, Volume 371, Issue 9610, Pages 417-440.*

[2] For example, this may include wider programmes with outcome indicators related to stunting, weight, anaemia, dietary status, wasting, malnourishment, de-worming, breast fed children, vitamin A, diarrhoea etc and similar indicators related to pregnant mothers.

Panel 1: **Definition of nutrition-specific and nutrition-sensitive interventions and programmes**

Nutrition-specific interventions and programmes

- Interventions or programmes that address the immediate determinants of fetal and child nutrition and development—adequate food and nutrient intake, feeding, caregiving and parenting practices, and low burden of infectious diseases
- Examples: adolescent, preconception, and maternal health and nutrition; maternal dietary or micronutrient supplementation; promotion of optimum breastfeeding; complementary feeding and responsive feeding practices and stimulation; dietary supplementation; diversification and micronutrient supplementation or fortification for children; treatment of severe acute malnutrition; disease prevention and management; nutrition in emergencies

Nutrition-sensitive interventions and programmes

- Interventions or programmes that address the underlying determinants of fetal and child nutrition and development—food security; adequate caregiving resources at the maternal, household and community levels; and access to health services and a safe and hygienic environment—and incorporate specific nutrition goals and actions
- Nutrition-sensitive programmes can serve as delivery platforms for nutrition-specific interventions, potentially increasing their scale, coverage, and effectiveness
- Examples: agriculture and food security; social safety nets; early child development; maternal mental health; women's empowerment; child protection; schooling; water, sanitation, and hygiene; health and family planning services

Adapted from Scaling Up Nutrition[9] and Shekar and colleagues, 2013.[10]

The annual reach of these programmes should be measured as follows:

- Where the programme directly targets under 5s and/or pregnant/breastfeeding women and management information is available regarding reach, the numbers should be taken directly from programme information.
- Where the programme targets a wider age group, it is necessary to determine the size of the population to whom the programme is available and the size of the population actually accessing the programme (coverage). The number of under 5s reached can then be estimated using the percentage of under 5s in the wider age group from routine population statistics.
- The number of breastfeeding mothers and pregnant women should be counted if data are already available. Breastfeeding is a challenging indicator to measure and country offices/partners should NOT start new surveys in order to count breastfeeding mothers, so alternatives are:
    - Breastfeeding prevalence (from Demographic and Health Surveys or similar datasets) can be used to estimate the percentage of new mothers who are breastfeeding their children up to the age of 6 months.
    - If those data are not available, the number of mothers of children up to 6 months who are reached by nutrition services is a proxy measure. This will often only require that the pregnant

	women continue to be counted for 6 months minus the mortality numbers for babies aged less than 6 months. • If the programme was funded by multiple donors or was a form of sector / budget support, the total number of children should be calculated based on the proportion of DFID funding provided. The reach of these programmes refers to unique, individual children aged under 5 and breastfeeding/pregnant women. It is important to ensure that there is no double counting between nutrition sensitive and direct nutrition programmes. In this sense, we are counting the **number of people reached, not the number of interventions.** So, for example, even if someone receives 20 different interventions through a multitude of programmes – the reach is still 1 person. In particular: • Where there are non-continuous programmes, the peak number of unique children and/or pregnant/breastfeeding women receiving the programme over the year should be recorded. • Where there are continuous programmes, the number of unique children and breastfeeding/pregnant women in the latest period should be recorded. Where countries have multiple programmes, they should: • Return the total unique reach of the programmes if known. • Otherwise, they should return the sum of the reach of each programme along with an estimate of the percentage of the estimated overlap between programmes. It is also important to avoid double counting in persons reached over time. Where country offices can identify or undertake a reliable estimation for unique children and pregnant or breastfeeding women across years then, in year 1, country offices should identify unique pregnant or breastfeeding women and children reached and in year 2 they should aim to identify additional children and pregnant or breastfeeding women that were not supported in year 1 and add this to the total from year 1. This ensures we are only counting unique individuals reached over time. This approach should be repeated in all later years. Where country offices cannot reliably estimate unique children and pregnant/breastfeeding women across years then they should simply return annual figures of the number of unique children and pregnant or breastfeeding women reached in each year. These figures should not be added up across years due to the likelihood that programmes will reach some of the same children or women each year. Breastfeeding women and their children should only both be

	counted if both are direct recipients of an intervention. For example, if breastfeeding women are receiving nutritional support and their children are also receiving a specific intervention then both should be counted. However, if breastfeeding women are being targeted but the children are not receiving an intervention only the breastfeeding women should be counted. The children of these women will potentially be indirect beneficiaries of the programme but should not be included to avoid double counting. The methodology set out in this note is used to calculate results obtained through our bilateral programmes. Published results against this indicator also include results from our core contributions to relevant multilateral agencies, where the risk of double counting can reasonably be eliminated.
Rationale	Estimates the number of children and pregnant/breastfeeding women reached through DFID's nutrition-relevant programmes. This allows DFID to assess the reach of its investment in nutrition and related areas. An increase in the number of children or pregnant/breastfeeding women reached through its nutrition-relevant programmes should lead to a reduction in the number of children going hungry.
Country Office Role	DFID Country Offices select the most relevant data and calculations and submit these to the DFID HQ. The final numbers and calculations are then quality assured by DFID HQ. Where a Country Office is supporting a national-level food fortification programme, they are advised to contact the nutrition adviser in Human Development Department to discuss reach estimates before they are submitted to the centre. This is to ensure that an appropriate methodology is being applied.
Data Sources	<u>Bilateral</u> Programmes included are nutrition-specific interventions or those which are nutrition sensitive as defined in the methodological summary. Budget support would only be included if nutrition outcomes were specifically highlighted in the government's results framework. Humanitarian programmes providing nutrition-specific interventions are only included if the programme has an explicit objective to support system strengthening/resilience building for nutrition and is at least three years in duration. The methodology set out in this note is used to calculate results obtained through our bilateral programmes. Published results against this indicator also include results from our core contributions to relevant multilateral agencies, where the risk of double counting can reasonably be eliminated.
Reporting	DFID for bilateral programmes, and the World Food Programme

Organisation(s)	and UNICEF for multilateral programmes.
Worked Example	*Worked Example:* DFID is directly supporting vitamin A distribution at child health weeks. These are expected to reach the entire under 5 population of the country (around 1 million under 5s in any given year). DFID provides 10% of the funding for this programme and therefore can claim 100,000 under 5s reached with vitamin A supplements in year 1. In year 2, roughly 20% of the children under 5 in year 1 will have moved out of that age group, with the remaining 80% receiving the supplement again. This 80% should not be counted again in year 2. However, 200,000 new 0-1 year olds will have entered this population in year 2. Therefore in year 2, DFID will have reached an additional 20,000 unique children. Similarly in years 3 and 4. Therefore by the end of year 4, DFID will have reached 1.6m unique under 5s with vitamin A interventions.
Most Recent Baseline	By 2013-14, DFID had reached 19.3 million children under 5 and pregnant/breastfeeding women through DFID's nutrition-relevant programmes.
Good Performance	We expect to reach approximately 20 million children under five years of age and pregnant and breastfeeding women by the end of 2015.
Return format	Number of children under five and pregnant/breastfeeding women reached through DFID's nutrition-relevant programmes per year, disaggregated by sex wherever possible, along with a record of workings. Any deviations from the standard methodology described in this note should be clearly highlighted.
Data dis-aggregation	Mandatory: none. Additional: Data should be disaggregated by sex where possible. If possible it would be helpful to have data disaggregated by socio-economic quintile, although we recognise this is not likely to be available annually. It could possibly be built into baseline and endline surveys.
Data availability	Data is available annually.
Time Period/ Lag	The timeliness of the data varies across countries. Data from routine monitoring systems may be available on a regular basis in-year. Administrative or census data may have a time lag of several years. Evaluation data are likely to have a lag of at least one year. Partner Government reporting years may be different to the UK Government Financial Year, so countries should choose the partner Government Financial Year which is the closest to the UK Government Financial Year. International
Quality Assurance Measures	There are three layers of quality assurance (QA) in place, not including any processes put in place by partners or implementers. 1. Country Offices comment on the quality of the data (see annex A), and provide a link to the calculations spreadsheet,

	in their return. In addition, Country Offices also assess data quality used during Annual Reviews and Project Completion Reviews and some conduct field visits, evaluations or triangulate data with other sources. Some offices also use third party monitors to conduct verifications in areas which it is not safe for DFID to visit. 2. Policy divisions check the return, and the calculations, and record any issues in a QA log. 3. FCPD review the QA log to ensure resolution of issues.
Data Issues	There is potential for double counting of children reached across a number of years, given that many programmes provide support to children over a five year period. Given the methodology looks at peak year contributions and calculates annually, not cumulatively, it should be possible to avoid this. Coverage may be difficult to determine in nutrition education campaigns, e.g. through the radio or other media.
Additional Comments	None.
Country Office/Spending Department Variation	Some country offices (for example Bangladesh) report cumulative rather than peak year results, as they are able to identify unique beneficiaries (see methodology section above for more information).