

INTERIM PROGRAMMATIC ADAPTATIONS FOR WASTING PROGRAMMING IN RESOURCE-CONSTRAINED SETTINGS¹

This interim guidance (version as of May 2025) was commissioned by the Global Nutrition Cluster (GNC), and its development was led by Action Against Hunger, Save the Children, and Concern Worldwide, with contributions and technical review from the Wasting Thematic Working Group (GTWG). Regional offices were also consulted during its development to ensure contextual relevance and operational feasibility.

The guidance may be updated as new evidence emerges, operational lessons are learned, or programmatic contexts evolve. It is intended to support short-term decision-making in resource-constrained settings. While it does not replace national protocols for the treatment and prevention of wasting, it aims to complement and inform country-led processes by offering practical options to address pressing challenges.

Background and purpose of the document

This guidance was developed in response to the significant funding cuts currently affecting nutrition programmes globally. Across many countries, partners are navigating a complex situation in which critical, lifesaving services must be sustained, reorganized, or transferred to ministries of health (MoH) or local and national actors, often without sufficient time or resources for adequate preparation.

Its primary purpose is to support country-level decision-makers and implementers in identifying ethical, context-

appropriate, and operationally feasible adaptations when facing service disruptions or stockouts of essential nutrition commodities. In doing so, it provides not only a set of practical options but also a structured process to guide prioritization, coordination and temporary adjustments, while upholding humanitarian principles.

The recommendations are scenario-based, grounded in field realities, and were developed collectively by the **Wasting Global Technical Working Group (GTWG)** under the **Global Nutrition Cluster (GNC)**. They are intended to serve as temporary² and exceptional measures. This guidance does not replace national protocols but rather supports actors in constrained settings³ by offering an

¹ The terms 'wasting' and 'acute malnutrition' are used largely interchangeably in this document for simplicity while recognizing that acute malnutrition includes both wasting and nutritional oedema.

² We recommend that adaptations are 'temporary,' but the timeline can vary by context/scenario.

³ For the purposes of this guidance, a constrained context refers to a setting where acute limitations in financial, human, or material resources resulting from abrupt and significant funding cuts – undermine the capacity to deliver essential nutrition services at the required scale, quality, or frequency. Programmatic adaptations in these settings are considered **temporary and exceptional measures**.

interim, principled framework to mitigate risk, preserve quality and maintain continuity of care.

Scope and intended use

This document is intended for humanitarian implementers, technical advisors, and programme managers operating in resource-constrained settings. It provides a flexible, modular structure to support decision-making and facilitate dialogue within coordination platforms, government authorities and implementing agencies. While it targets immediate, field-level needs, it also supports medium-term planning by embedding principles that strengthen accountability, equity and systems alignment.

How to use this guidance

The document is structured as a modular tool, focusing on two major operational scenarios:

- **Module 1:** Managing services for wasting in children and undernourishment in pregnant and breastfeeding women and girls during sudden shortages of therapeutic and supplementary nutrition supplies.
- **Module 2:** Managing service delivery and human resource constraints to maintain the continuity of essential nutrition services.

Each module outlines:

- A stepwise approach to analysing the situation
- Prioritization frameworks for targeting services and populations
- Adaptation options that balance programme feasibility, ethics and health impact

Guiding principles

Adaptations proposed in this guidance are grounded in key humanitarian principles, continuity of care, equity, quality, transparency and accountability. These principles align with standards developed by the Global Nutrition Cluster (GTWG^{4,5}) and the Global Health Cluster for ethical decision-making in emergencies. Any adaptation should:

- Be temporary, justified and context-specific,
- Be agreed upon via coordination mechanisms and inclusive dialogue with national authorities at all levels, and
- Include a clear exit strategy and criteria for returning to standard care.

These principles aim to ensure that any programmatic adjustment respects national leadership, reinforces local systems, and safeguards the rights and health of affected populations, even in constrained settings.

Module 1: Managing services for wasting in children and undernourishment in pregnant and breastfeeding women and girls during sudden nutrition supply shortages.

1. CURRENT OPERATIONAL SITUATION

In the current crisis context, nutrition supply chains face critical disruptions due to widespread funding reductions. Shortages of essential therapeutic and supplementary nutrition products - including ready-to-use therapeutic foods (RUTF), ready-to-use supplementary foods (RUSF), F-75/F-100 therapeutic milks, and fortified blended foods (FBFs) – can severely impact services for children with acute malnutrition and undernourished pregnant and breastfeeding women and girls.

Key operational challenges include:

1. Denial or interruption of life-saving nutrition support for children and pregnant and breastfeeding women and girls in need due to product shortages or stockouts.
2. Confusion and inefficiencies in protocol implementation due to unpredictable supply flows.
3. Loss of community trust and reduced care-seeking when services become unreliable.
4. Inability to preposition stocks in hard-to-reach or seasonally-affected areas.

2. PURPOSE OF THE MODULE

Module 1 aims to provide practical options to reduce the risk of nutrition-related morbidity and mortality and suboptimal recovery among undernourished children and women being denied essential nutrition supplements during exceptional circumstances/periods of short supply. The module:

1. Recommends actions to improve logistics practices to reduce pipeline breaks.
2. Outlines prioritization criteria for distributing available supplies to areas or individuals.
3. Identifies feasible product substitutions in exceptional circumstances.
4. Highlights risks, preconditions and operational considerations for adapting standard protocols safely.

Plan beyond the short term: While many of the measures in this module are designed for acute disruptions, the underlying principles - prioritization, coordination and transparency - also apply to medium- and longer-term planning. Close coordination across ministries of health (MoH), United Nations agencies, clusters, non-governmental organizations and donors is critical to ensure a coherent response.

4 Global Nutrition Cluster, 'Global Nutrition Cluster: Working Groups', GNC,

5 Global Nutrition Cluster, 'The Wasting Global Thematic Working Group', GNC, <https://www.nutritioncluster.net/thematic-areas/management-wasting> <https://www.nutrition-cluster.net/thematic-areas>

3. STEPS TO ADAPT WASTING MANAGEMENT DURING NUTRITION SUPPLY GAPS

This guidance proposes a four-step process to address acute malnutrition product shortages in a principled and structured manner.

 3.1: STEP ONE	 3.1: STEP TWO	 3.1: STEP THREE	 3.1: STEP FOUR
Optimize management of supplies already in the pipeline a. Map and centralize nutrition stocks b. Setup/strengthen real-time stock monitoring system c. Deploy streamlined tools in priority areas d. Coordinate closely with donors and suppliers. e. Do not accept unsolicited BMS donations and ensure any BMS supplies are managed in line with the OG-IFE	Agree on which areas and individuals should be prioritized a. Geographic prioritization b. Prioritizing population groups c. Communicate and coordinate prioritization decisions	Identify protocol adaptations that are appropriate and feasible A. Consider critical points before initiating adaptation: ▪ Address pipeline issues in parallel ▪ Confirm the availability of substitute products before making changes ▪ Set a minimum timeframe for adaptations and define clear criteria for reverting to standard protocols B. Consider critical points DURING the implementation of adaptations: ▪ Ensure continuity of care -even in the absence of specialized nutrition products ▪ Document all adaptations, feedback, and outcomes	Consider product substitutions over the short term Substitutions must: ▪ Prioritize products that are nutritionally and programmatically the closest to the original product ▪ Prioritize SAM treatment over MAM support when RUTF stocks are critically low ▪ Be applied only under exceptional circumstances. Revert to standard products as soon as possible.

FIGURE 1. Steps for managing nutrition programmes during supply chain disruptions

3.1: STEP ONE

Optimize management of supplies already in the pipeline

The current crisis has worsened existing gaps in supply management, including fragmented stock tracking, weak coordination and limited visibility, especially for critical products like therapeutic milks. In many countries, incomplete and poorly integrated data make it difficult to plan timely allocations and mobilize emergency support.

Key actions to improve pipeline and last-mile management:

- **Map and centralize stock data:** Identify where nutrition products (RUTF, RUSF, F-75/F-100) are currently held across the ministry of health and partner networks, down to facility level where possible. The Nutrition Cluster, with the ministry of health, UNICEF, the World Food Programme (WFP) and logistics actors, should consolidate this information across systems to improve transparency and speed.
- **Establish real-time stock monitoring:** Strengthen or expand digital tracking tools at district and facility levels. Assess existing systems (e.g., Saga Stock, PIMS, LMSM) for scalability and compatibility. Avoid launching complex new tools unless justified by need and capacity.

Track intended versus actual use by partners and regularly check against admission numbers.

- **Deploy streamlined tools in priority areas:** Focus efforts on the most affected zones (as identified in Step 2). Create or adapt simple standard operating procedures (SOPs) for buffer stock management, joint warehousing, inter-partner borrowing and forecasting. Build on existing ministry of health or United Nations logistics protocols rather than starting from scratch.
- **Coordinate with donors and suppliers:** Engage early and transparently with donors to mobilize short-term bridge funding and avoid parallel systems. Speak directly with suppliers to clarify production timelines and centralize/coordinate procurement to reduce delays and costs.
- **Do not accept unsolicited breastmilk substitute (BMS) donations** and ensure any BMS supplies are managed in line with the [Operational Guidance on Infant and Young Child Feeding in Emergencies \(OG-IFE\)](#) to ensure breastfeeding is protected and promoted to save infant lives. See this useful infographic on [Preventing and managing inappropriate donations of breastmilk substitutes and other prohibited products](#).

3.2. STEP TWO

Agree on which areas and individuals should be prioritized

In the context of widespread supply constraints, a clear and evidence-informed prioritization process is critical to ensure continuity of care and maximize impact. Prioritization decisions must be coordinated across stakeholders, transparent and grounded in the assessment of vulnerability and needs.

A. Prioritizing geographic areas

Supplies should be directed to areas most at risk, based on the following criteria (adapted from the 2023 WHO Guidelines on the Prevention and Management of Wasting):

TABLE 1. Criteria for geographic prioritization

Priority criteria for geographic allocation include • Areas classified as 'IPC acute malnutrition' OR 'food insecurity Phase 4 or 5'. • Areas with the highest burden of acute malnutrition (if not already captured by IPC) – considering both prevalence (or proxy prevalence)⁶ and actual number of children with SAM/MAM. • Areas with the highest number of children with SAM/MAM, either currently or over the past one to two years (if not already captured by IPC). • Imminent stockout of SAM/MAM commodities.
Additional considerations: • For programmes for pregnant and breastfeeding women and girls: consider areas with a high proportion of pregnant and breastfeeding women and girls with low MUAC (from survey or screening data) or a high number of infants under 6 months at risk of poor growth and development. • Seasonal vulnerability: consider the timing and severity of the lean season, drought or flood impacts on livestock and crops, and anticipated access barriers (e.g., flooded roads) that may disrupt the delivery of supplies/services. • Areas with no data should not be automatically de-prioritized – use programmatic data and/or informed judgment when access and data are limited – these areas may be the most in need. • Transportation feasibility, cost-efficiency and product shelf life: consider the trade-offs before reallocating supplies between areas, including transport costs, time needed for delivery, and the remaining shelf life of products.

B. Prioritizing population groups

When supplies are insufficient to cover all needs, prioritization among population groups becomes necessary, based on vulnerability and risk of mortality.

TABLE 2. Criteria for prioritizing children and pregnant and breastfeeding women and girls for existing nutrition supplies

Principles for prioritization for children	Principles for prioritization for pregnant and breastfeeding women and girls
First priority: children under five years of age with SAM with or without complications (<i>we do not suggest prioritizing supplies for inpatients over outpatients considering the important public health impact of both</i>). Second priority: children 6-59 months with MAM with individual risk factors (agreed upon for the context) – see the 2023 WHO Guidelines on the Prevention and Management of Wasting, recommendation B13. Third priority: Other children 6-59 months with MAM.	First priority • Pregnant and breastfeeding women and girls with MUAC <210 mm • Third trimester pregnancy * 1st or 2nd trimester with other risk factors (e.g., medical complications/ comorbidities, adolescence, another infant <12 months). * Breastfeeding women with an infant under 6 months (prioritized above a child 6-23 months). Second priority: pregnant and breastfeeding women and girls with MUAC ≥210 and <230 mm

Prioritizing among children with MAM using individual risk factors. The 2023 WHO Guidelines on the Prevention and Management of Wasting outline the individual risk factors to consider if the prioritization of specially formulated foods (SFFs) for children who meet MAM criteria is needed in exceptional circumstances, e.g., when supplementary food stocks are insufficient for the all the children affected with MAM (see second priority above). When agreeing on risk factors for MAM prioritization, select a feasible, contextually-adapted set of risk criteria to apply systematically at the district level. Avoid long, complex lists that would be unrealistic to measure and risk inconsistent application. Where feasible, consider factors beyond MUAC alone, but consider the time required to assess and validate any additional criteria.

3.3. STEP THREE

Identify protocol adaptations that are appropriate and feasible

Adaptations must be carefully planned, implemented, and monitored to ensure they do not compromise safety or equity. Adaptations may involve:

- Adjusting admission criteria to prioritize children at the highest risk of death,
- Adapting the quantity of product given to each child or specific target groups, and
- Modifying discharge criteria from therapeutic or supplementary feeding services.

6 Proxy prevalence of global acute malnutrition (or SAM/MAM) uses methods other than SMART surveys or other statistically representative sampling approaches. This proxy prevalence is often derived from structured screening campaigns and is less representative of areas beyond the direct population measured.

A. Critical points before initiating adaptation

Before initiating any adaptation, it is essential to:

- Address pipeline issues in parallel (see Step 1).
- Ensure clear and official communication on the adaptation to health districts and facilities.
- Ensure front-line staff are trained and supported to apply the new protocols correctly.
- Implement adaptations at the district level, not individual facilities, to ensure consistency and monitoring.
- Set a minimum timeframe for adaptations and define clear criteria for reverting to standard protocols (e.g., stable stock for 3 months).
- Confirm the availability of substitute products before making changes.

B. Critical points DURING the implementation of adaptations:

While implementing adaptations, it is essential to:

- **Continue prevention actions⁷** and link with water, sanitation and hygiene (WASH), health, food security and social protection.
- **Ensure continuity of care - even in the absence of specialized nutrition products.** Continue providing medical assessment and treatment, counselling on infant and young child feeding (IYCF) and home-based follow-up. Refer to complementary services wherever possible (food security, etc.).

- **Promote consumption of nutritionally-adequate local family foods** post-recovery for children with SAM and to complement supplementary feeding for children with MAM.
- **Engage and inform communities** about changes; coordinate closely with local stakeholders.
- **Strengthen monitoring and follow-up**, especially for deteriorating cases.
- **Document all adaptations, feedback, and outcomes to inform future decisions and advocacy.**

****Always continue the fullest non-food package of support – even when no food supplement is available.****

The full non-food package for children with SAM & MAM and undernourished pregnant and breastfeeding women and girls should include at a minimum:

- Medical assessment, treatment and preventive health services, including vaccination.
- Messaging/counselling on infant and young child feeding and health/hygiene practices.
- Referral to other health and social protection services, emergency cash and vouchers, WASH or other interventions.
- Home-based follow-up for screening, referral and nutrition/health promotion.

Some caregivers/women may not want to return to the health facility/distribution point if no food is provided, but the services and support should still be made available and users informed.



⁷ Link to prevention guidance

C. Overview of adaptations

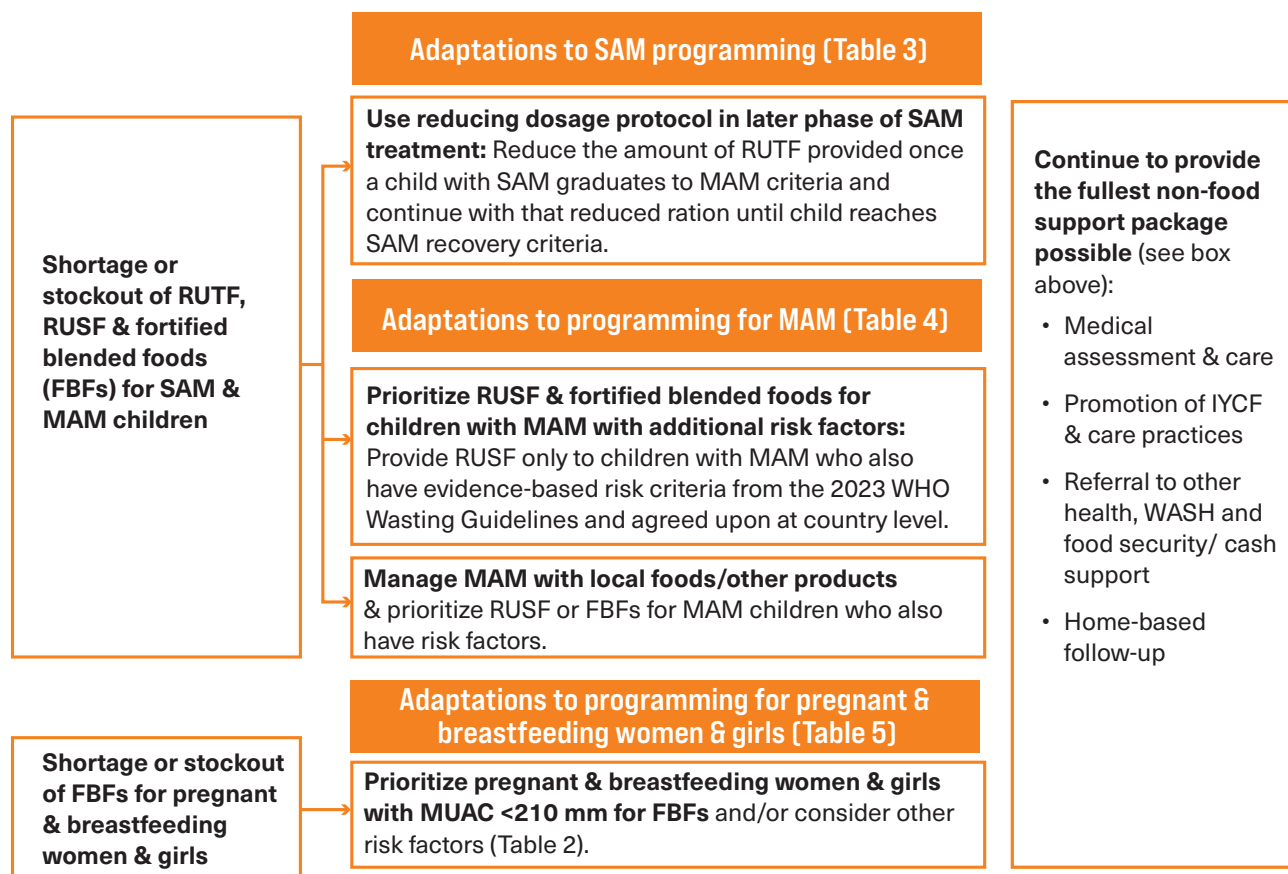
When RUTF and RUSF stocks are limited or unavailable, several adaptations can be considered to ensure continued care for children and pregnant and breastfeeding women. The aim is to prioritize those at the highest risk while making the most efficient use of available resources.

This visual map (see Figure 2) summarizes the key adaptation strategies, followed by **Table 1**, which presents

concrete options for reducing overall product use and targeting those most in need. A decision tree is also provided in **Annex 1** to help guide operational decisions in contexts of severe product shortages.

These adaptations are intended to be exceptional and temporary. Their implementation should be carefully monitored and coordinated, with clear criteria for returning to standard protocols as soon as the situation allows.

FIGURE 2. Adaptations for managing shortages or stockouts of RUTF, RUSF or FBFs



See also temporary Product Substitutions in Step 4 (and Annex 2)

TABLE 3. Adaptations for managing SAM during RUTF stockouts or shortages

Approach	What it is	Pre-conditions/ preparations	Risks and actions to address them
Reducing dosage of RUTF in later phase of SAM treatment	Reduce RUTF dosage for children 6–59 months with SAM enrolled in outpatient therapeutic services when they reach MAM criteria. Option 1. Weight-based reducing dosage protocol: • While the child meets SAM criteria:⁸ give 150–185 kcal/kg/day (standard RUTF ration). Continue until the child no longer has SAM. • Once the child graduates to MAM criteria:⁹ Reduce quantity to provide 100–130 kcal/kg/day until anthropometric recovery.¹⁰ * Note, the kcal/ kg/ day are based on the WHO Wasting Guidelines (recommendation B10) but assumes households are food secure, which may not be the case in these exceptional circumstances. See the simple table for reducing RUTF dosage by weight category (simplified based on the above kcal/kg/day) in Annex 4. Option 2. Reducing dosage protocol when ‘fixed dosage’ is already in place: If the ‘fixed RUTF dosage’ protocol is already being used in country, which means SAM cases get 2 sachets RUTF/day and MAM cases get 1 sachet RUTF/day, then the reducing dosage protocol will be: • While the child meets SAM criteria: 2 sachets RUTF • Once the child graduates to MAM criteria: 1 sachet RUTF* See the simple table for reducing RUTF dosage when fixed dosage is in place (Annex 5). *In both Option 1 and 2, RUTF could be replaced with RUSF once the child graduates to MAM criteria in order to prioritize RUTF for the early stages of SAM. Caution: documented evidence for any reduced dosage protocol beyond that outlined in the WHO Guidelines is very limited and should be used only in extreme RUTF shortages.	Train health care workers on reduced dosage protocols. Ensure guidelines/tables for reduced dosage are available. Provide clear guidance for transitioning children to family foods once children reach the MAM stage.	Potential relapse to severe wasting/oedema. Decreased weight gain velocity and increased length of stay. This may increase the amount of product needed, but it may be acceptable if it allows time for new supplies to arrive. Actions: - Monitor children closely and revert to the standard ration dosage if they are not recovering well, i.e., no weight gain for two consecutive weeks; weight and or MUAC loss, or other deterioration of nutritional status. - Ensure all other services/referrals are carried out, including regular medical follow-up (e.g., treatment and immunization), IYCF counselling and home visits.
See also Product substitutions (Step 4) and Decision tree on limited or no RUTF	Identify and use alternative nutritional products to temporarily: • Replace RUTF with RUSF, FBFs (or alternative foods in extreme circumstances). • Replace F-75/F-100 therapeutic milk made with locally available milk.		

8 SAM: MUAC <115 mm and/or WHZ < -3 and/or oedema.

9 MAM: MUAC ≥115 mm and WHZ ≥-3 and no oedema.

10 Anthropometric recovery: MUAC ≥125 mm and WHZ ≥-2 Z-score and no oedema.

TABLE 4. Adaptations for managing MAM during stockouts or shortages of RUSF or fortified blended food

Approach	What it is	Pre-conditions/ preparations	Risks and actions to address them
Prioritize RUSF or fortified blended foods (FBFs)/ improved FBFs for children with MAM with additional individual or social risk factors	Provide RUSF only to children with MAM who also have one or more of the following risk factors. Individual child risk factors: - Mid-upper arm circumference (MUAC) 115–119 mm - Weight-for-age z-score (WAZ) < -3 SD - Age 6 – < 24 months - Failing to recover from moderate wasting after receiving other interventions (for example, counselling alone) - Having relapsed to moderate wasting - History of severe wasting - Co-morbidity (medical problems needing mid- or long-term follow-up care with a significant association with nutrition status, e.g., HIV, tuberculosis or a physical or mental disability) Social risk factors: severe personal circumstances, such as mother died or poor maternal health and well-being.	Agree on the set of risk factors to use and apply on a district-by-district basis (not individual children or health facilities). Train all relevant staff and volunteers on new admission criteria for MAM. Ensure changes are communicated to community leaders/ carers.	- Confusion over protocol, or lack of transparency about its application, if not formalized and applied to a whole district (e.g., picking and choosing criteria for individual children). - Fewer children will be supported. Actions: ➔ Continuous training and supervision of admission. ➔ Ensure active screening to identify children as soon as they fall into MAM with higher risk criteria.
Manage MAM with local foods (and other non-product support)	Try to reserve RUSF or other SNF/SFF for children with MAM who have additional risk criteria. Managing MAM in children at higher risk with local foods should only be a last resort. All children with MAM – whether they receive SNF or not – should be supported to access a nutrient-dense diet. Also see 'Product substitutions' (Step 4). • Admit children as MAM and provide the full package of complementary services (medical assessment and treatment, counselling on infant and young child feeding, referral to other services and home-based follow-up). • In place of SNF/SFF, promote locally available, nutrient-dense foods in simple recipes to manage MAM in the absence of specialized nutritious foods. • Develop local recipes and train/support carers via cooking demonstrations and messaging/images. Recommended recipes should be analysed using a dietary software such as Nut Val (free to download). • Consider distributing cash or vouchers (or in-kind distribution of local foods) or referring to social protection services to support purchase of quality local foods for these children, in addition to household food assistance (dependent on the assessment of market functionality and availability of nutrient-dense foods and consumer preferences).	Identify suitable local foods and local recipes that meet nutritional requirements. Train health care workers and caregivers on preparing and using local foods. Ensure market is functional and nutrient-dense foods are available and affordable for purchase for the upcoming period (consider seasonality) – seek support from cash and voucher programs and social protection experts.	- Poor recovery if accessible local foods do not meet minimum nutrition requirements. - Potential food safety issues if foods not properly prepared. Actions ➔ Optimise nutritional adequacy of local foods promoted by analysing recipe options in Nut Val and promoting those that meet the most nutrient requirements while still being feasible for families to prepare from foods they can access. include hygiene promotion and cooking demonstrations where possible. If access to cooking materials or fuel is a serious constraint, consider providing them.

Approach	What it is	Pre-conditions/ preparations	Risks and actions to address them
See also 'Product substitution' (Step 4)	Identify and use alternative nutritional products to temporarily replace RUSF or FBFs normally given to children with MAM.	Be sure all products are available. Get approval from the relevant health authorities for the use of substitutes. Train staff on amounts to distribute. Ensure recipients have equipment/ capacity to cook foods that are not 'ready to use'.	As above for reduced dosage, as, usually, the substituted product is inferior to original product.

TABLE 5. Adaptations for managing targeted supplementary feeding for pregnant and breastfeeding women and girls during shortages or stockouts of FBFs

Approach	What it is	Preconditions and preparations	Risks and actions to address them
Use MUAC admission cut-off of 210 mm for pregnant and breastfeeding women and girls (see 'Principles of prioritization' above for other possibilities)	Some programmes may be using 230 mm as the MUAC admission criteria for women. Reducing the criteria to 210 mm will focus on women who are more at risk and reduce both the number of affected women and the nutrition commodities required for treatment.	- Consensus with the ministry of health and nutrition cluster partners. - Clearly communicate adaptation to programme participants, the wider community and health staff. - Frontline staff trained and equipped to implement new criteria. - Infants of breastfeeding women should be linked to IYCF counselling/support services. - Ensure referral pathways to other support services: cash & vouchers, general food assistance, ante/postnatal care & psychosocial support.	- Fewer women at risk receive supplementary feeding support. Action: ➔ Return to the original criteria as soon as possible, while providing the fullest package of ante and post-natal support possible throughout.
See also Product substitution (Step 4 and Annex 2)	Identify and use alternative nutritional products to temporarily replace the FBFs or RUTF normally given to pregnant and breastfeeding women and girls.	As above.	- Risk of deterioration of nutritional status for the mother and her infant or child in utero. Actions: ➔ Monitor MUAC closely and regularly; refer to health and other services.

3.4. STEP FOUR

Consider product substitutions over the short term

In case of prolonged shortages of specially formulated foods SFF/SNF,¹¹ alternative products may be temporarily used to ensure continuity of care. This guidance updates and harmonizes previous Global Nutrition Cluster documents – including the Management of wasting during a shortage or absence of specialised nutritious food products – in light of the 2023 WHO Guidelines on the Prevention and Management of Wasting and recent operational experiences.

Before using any substitute, confirm that no equivalent RUTF or RUSF product – in paste or biscuit form that meets Codex Alimentarius standards – is available.

Substitutions must:

- Prioritize products that are nutritionally and programmatically the closest to the original product.
- Prioritize SAM treatment over MAM support when RUTF stocks are critically low.
- Be applied only under exceptional circumstances. Revert to standard products as soon as possible.

Detailed substitution options for RUTF RUSF, and fortified blended foods, including available lipid-based nutrient supplements (LNS), are provided in **Annex 2: Product substitution table**.

Alternative recipes for F-75 and F-100 using locally available ingredients and a specialized Complex of Minerals and Vitamins Mix (CMV) are provided in **Annex 3**, for settings where therapeutic milks are unavailable. These adapted recipes align with Codex standards when prepared as specified.

4. PREPAREDNESS PLANNING TO PREVENT FUTURE STOCKOUTS

To reduce the impact of future pipeline disruptions, countries facing recurrent stockouts or managing large numbers of wasted children or undernourished pregnant or breastfeeding women and girls should invest in preparedness and anticipatory measures. One key strategy is the establishment of revolving emergency stocks of RUTF and other essential therapeutic or supplementary nutrition products. These stocks should be pre-positioned as close as possible to affected populations and regularly monitored to ensure freshness and readiness for rapid deployment.

Such contingency stocks can help buffer delays in procurement and delivery. They should be governed by clear release protocols and indicators agreed upon with key stakeholders, including ministries of health, UNICEF, the World Food Programme, donors and implementing partners.

Preparedness plans should also include:

- **Defined mechanisms for stock sharing across partners** in response to localized gaps.
- **Emergency transport solutions** from pre-positioned warehouses.
- **Integrated coordination systems** to trigger responses quickly and transparently.
- **Capacity-building for ministries of health** to progressively manage these contingency mechanisms directly.

Embedding these interim solutions into national preparedness frameworks can significantly reduce service disruptions and ensure the continuity of treatment at full dosage during future crises.

11 Specially formulated foods (SFFs) are foods specifically designed, manufactured, and used for special medical or dietary purposes, as defined by Codex Alimentarius (2023 WHO Guidelines on the Prevention and Management of Wasting). Specialized nutrition foods (SNFs) is the term used by the World Food Programme and is equivalent to SFFs. See more at: <https://www.wfp.org/specialized-nutritious-food>.

Module Two: managing service delivery and human resource constraints to maintain the continuity of essential nutrition services

1. CURRENT OPERATIONAL SITUATION

This scenario addresses the growing constraints on service delivery and human resources resulting from abrupt and widespread funding reductions since January 2025. Across multiple countries, nutrition partners are entering a complex situation phase in which services must continue, or adapt, despite significantly reduced staffing, shrinking geographic coverage and mounting operational barriers.

The following challenges are increasingly reported across contexts:

- Reduced capacity for routine and outreach services due to loss of staff, supplies, or logistical support;
- Disruptions in supervision, quality assurance, and training due to staff shortages and withdrawal of implementing partners;
- Pressure to scale back services or concentrate them in fewer locations;
- Limited capacity to engage communities or communicate service changes in a timely and transparent way; and
- Tension between maintaining coverage, service quality, and continuity of care under increasingly constrained resources.

This module provides practical and adaptable options to sustain essential nutrition services in settings where workforce and access limitations severely impact programme delivery.

2. PURPOSE OF THIS MODULE

This section outlines practical, context-driven adaptations to sustain essential nutrition and health services in settings where service delivery is severely constrained due to abrupt funding cuts. These constraints may include the sudden loss of personnel, reduced partner presence, breakdowns in supply chains, or limited access to facilities due to insecurity or remoteness.

3. KEY CONSIDERATIONS FOR ADAPTATION DECISIONS

This module applies core ethical and operational principles to contexts of service delivery and workforce constraints. In line with Global Health Cluster guidance, decisions should be made transparently, coordinated through national mechanisms and led by national authorities.

Adaptations should aim to strengthen national systems, ensure safe and equitable service delivery – especially for the most vulnerable – and maintain community trust through clear communication. All decisions must balance feasibility, quality and fairness, and be clearly documented.

4. PROCESS FOR DECISION-MAKING REGARDING ADAPTATION OPTIONS

This section presents a step-by-step framework of adaptable strategies to guide programming decisions in contexts with access and workforce constraints.



STEP 1 – Mapping constraints and current coverage

Key question: What is our current capacity, and what specific constraints require adaptation of our service delivery model?

A. Nature and extent of constraints

- *What is the magnitude of the funding reduction (percentage or absolute amount)? Which programme components are most affected (e.g., human resources, nutrition and medical supplies, supervision, outreach)?*
- What internal reorganization is feasible to reduce costs without reducing coverage?
- What is the timeline for scale-down (e.g., end of month, fiscal deadline)?

B. Current programme scope and health system capacity

- What is the current geographic and service coverage? What types of services are currently delivered (e.g., SAM/MAM treatment, IYCF, MAMI, community screening), and with what level of investment per site or per activity?
- What is the current number of affected population and performance level (e.g., cure rate, default rate)?
- What is the current capacity of the ministry of health in each area (e.g., staffing, supervision, supply chain)? Could some services be partially or fully transitioned to the ministry of health or local actors?
- Are there existing community structures (e.g., community health workers (CHWs), women's groups) that can help maintain outreach, prevention and follow-up for uncomplicated cases??

C. Vulnerability, equity and stakeholder landscape

- Which areas or groups would be most affected by reduced support?
- Are there high-vulnerability zones (e.g., IPC Phase 4 and 5, conflict-affected, epidemics)?
- What other partners or donors are operating in these areas?



Step 2 – Prioritization of activities, populations and areas

Key question: given our constraints, what are the most critical services, populations and areas to preserve? This step is about defining priorities when full coverage/range of services is no longer possible. The goal is to maximize impact and fairness under constraints, through a transparent, criteria-based process.

Is it feasible to maintain support to all currently covered sites? If not, which areas or facilities should be prioritized for continued support? Which activities or components are essential to maintain everywhere, and which could be reduced or suspended? What are the ethical red lines or minimum service standards to preserve in any case?

A. Geographic prioritization:

Geographic prioritization is used to determine where to concentrate support when full geographic coverage is no longer feasible. Use prioritization criteria outlined in [Module 1 \(Step 2\)](#) as the primary reference for geographic targeting. The following additional considerations may

complement those core criteria in contexts of constrained access or limited partner presence:

- Access by population: conflict-affected areas, zones with recurrent displacement, or regions not under government control; seasonal access barriers (e.g., flooding).
- Ministry of health capacity: light support or withdrawal may be considered if national systems are strong.
- Implementing partner landscape: prioritize areas with no active partners or where referral networks are fragile. Coverage surveys (e.g., SLEAC/SQUEAC) may guide decisions.

B. Target population prioritization:

This aims to guide which groups should be prioritized when full coverage is no longer possible. Core principles for prioritizing children with acute malnutrition as well as undernourished pregnant and breastfeeding women and girls are outlined in [Module 1 \(Step 2\)](#). The following additional considerations may support country-level decision-making:

TABLE 6. Prioritizing population groups for service support: criteria and considerations

Criteria	Considerations
Clinical and anthropometric vulnerability	First priority: prioritize children with SAM with and without medical complications. These children are at the highest risk of mortality if untreated. Prioritization should also apply to pregnant and breastfeeding women with low MUAC or other vulnerability markers. Second priority: children 6-59 months with MAM with individual risk factors*.
Age group	The relevance of age varies depending on the nutritional status of the child: • For children with wasting (SAM/MAM): age alone should not be used as a standalone criterion for prioritization, as it is not a strong predictor of mortality in this group. It should be combined with anthropometric and clinical indicators to determine risk. - Infants under 6 months should be considered a high-priority group due to their nutritional and clinical vulnerability, especially those with growth faltering or feeding difficulties. Ensure continuity of care through integrated maternal-infant approaches (e.g., MAMI). More broadly, for all children: those aged 6–24 months should be considered a particularly vulnerable group due to increased nutritional needs and challenges in complementary feeding. This age group should therefore be prioritized in preventive nutrition actions. See related guidance on programmatic adaptations for prevention developed by the GNC¹². - Pregnant and breastfeeding women should be prioritized where feasible, especially in high-risk contexts, based on nutritional risk or limited access to maternal health services.
Social vulnerability	Marginalized or underserved populations (e.g., remote rural, ethnic minorities).

*Note: In contexts where treatment of severe wasting (SAM) is prioritized over moderate wasting (MAM), it is essential to ensure the continuity of care for children with MAM. This includes systematic access to medical consultations, integration into routine health services, and active referral to preventive programmes (e.g. supplementary feeding or community-based nutrition interventions). Particular attention should be paid to children with MAM who are not from food-insecure households, to avoid gaps in support. Strengthening referral mechanisms across sectors is critical to maintain a continuum of care.

12 When available link Link to prevention guidance

C. Type of Activity: used to determine which interventions can be maintained, streamlined, or deprioritized.

TABLE 7. Prioritizing activities: criteria and considerations

Criteria	Considerations
Life-saving nature	Prioritize SAM treatment (in and outpatient) and referral care, MAM with higher risk of mortality, screening, IYCF promotion (see IFE guidance)
Feasibility of delegation	MUAC screening and stable case follow-up can be shifted to CHWs. If pre-existing trained CHWs (ex ICCM+ network), and capacity to support supplies and supervision for CHWs, then community-led treatment for uncomplicated SAM is possible.
Integration potential	Activities that can be absorbed into primary health care services: SAM treatment as part of the routine primary health package (no specific days and specific human resources) and others preventive services (IYCF, growth monitoring). Integration of pregnant and breastfeeding women and girls and MAM support (screening, medical follow-up, nutrition counselling) within routine maternal and child health services.
Adaptability of the activity	Where necessary, implement adaptations foreseen in national protocols for exceptional circumstances. These may include, for example, reduced follow-up frequency for stable SAM cases (e.g., bi-weekly visits) or temporary use of MUAC-only admission criteria in settings where WHZ measurement is not feasible due to severe constraints. ¹³

Step 3 – Adaptation planning based on prioritization outcomes

Once constraints have been mapped (Step 1) and strategic priorities clarified (Step 2), coordination bodies must plan specific adaptations. This step provides guidance on how

to reorganize, reduce, or transition services, depending on operational capacity and ethical considerations. The objective is to maintain service continuity wherever possible, without compromising quality, and with a clear focus on equity, alignment with national systems and sustainability.

TABLE 8. Planning adaptations: key questions and considerations for possible adaptations

Decision area	Guiding questions	Possible adaptations	Key considerations
A. Geographic coverage	Can full coverage be maintained? If not, which areas/facilities should be prioritized?	Concentrate support in priority areas based on context-specific criteria (e.g., food and nutrition insecurity, access, vulnerability, MoH capacity), as defined in Step 2. ✎ Maintain at least one referral-capable site per district wherever possible. ✎ In deprioritized areas: → Provide intermittent outreach. → Strengthen community-based referral mechanisms. → Explore task-shifting of uncomplicated SAM treatment to trained CHWs, where feasible and aligned with WHO guidance.	✎ Prioritization should be based on criteria agreed upon at national/cluster level (e.g., IPC phase, access barriers, displacement, existing services). ✎ Maintain clear documentation of selected areas and rationale. ✎ Task-shifting must be supported by adequate CHW training, tools and supervisory linkages. ✎ Ensure community-level communication to avoid misinformation or disengagement.
B. Target population	Can we continue serving all age and risk groups? If not, which groups should be prioritized?	✎ Prioritize high-risk groups: SAM cases with or without complications. ✎ -Maintain the integration of pregnant and breastfeeding women and girls and MAM support (screening, medical follow-up, nutrition counselling) within routine maternal and child health services. ✎ Adjust visit frequency for stable SAM cases (e.g., bi-weekly instead of weekly, MAM cases (from weekly to bi-weekly or even monthly). ✎ Reinforce prevention for infants <6 months and children 6–24 months by strengthening breastfeeding and complementary feeding support, including IYCF counselling and maternal nutrition.	✎ Integration of maternal nutrition and health services should be aligned with MoH protocols. ✎ Ensure continuity of care and minimum contact for pregnant and lactating women ✎ Adaptation should avoid excluding lower-risk groups without offering referral options or alternative support mechanisms.

¹³ This adaptation may be applied temporarily, under strict conditions and with close monitoring. It may exclude children who meet SAM criteria based on WHZ only

Decision area	Guiding questions	Possible adaptations	Key considerations
C. Type of services	Which activities are essential to maintain? Which can be simplified, delegated, or integrated?	☞ Maintain life-saving services as a priority (e.g., SAM treatment, inpatient care, infant and young child feeding in emergencies (IYCF-E), emergency referrals), in alignment with prioritization decisions made collectively. ☞ Maintain active community-based screening and referral. ☞ Integrate nutrition services such as (IYCF-E, SAM and MAM treatment) within broader primary health care delivery. ☞ Delegate specific tasks such as treatment of uncomplicated SAM to CHWs, where protocols allow. ☞ Use alternative approaches as defined in national protocols under exceptional circumstances (e.g., dosage reduction, family MUAC, MUAC-only approach, reduced follow-up schedules).	☞ -Ensure all adaptations are coordinated with the national MoH and the Health Cluster to maintain coherence with the broader health service package. ☞ -Task delegation must follow national guidelines and include CHW training and supervision. ☞ Integration should be prioritized in areas where primary health care platforms are functional and coordinated with the MoH. ☞ Avoid parallel structures that bypass national systems. ☞ Training materials, job aids, and supervision tools must be adapted and available. ☞ Maintain referral and counter-referral mechanisms. -Document and communicate decisions and justifications clearly.
D. Transition to MoH or other actors	Can some activities or sites be progressively transitioned to national actors? Is the MoH or another actor prepared to absorb these responsibilities?	☞ -Assess MoH/Local and National Actors readiness and capacity to implement wasting programmes (assessment should include technical capacity, supply chain, HR, infrastructure and financial sustainability). ☞ Identify services or activities that can be progressively handed over to MoH/LNA. ☞ Provide targeted capacity-building support (e.g., on-the-job coaching, simplified SOPs, supervision tools).	☞ Reference and align with the dedicated module on the transition to MoH. ☞ Conduct rapid capacity and risk assessment jointly with the MoH to identify what can be absorbed without jeopardizing service continuity or quality. ☞ Ensure that transitions include a minimum package of quality standards, a sustainability plan, and continued monitoring. ☞ Community communication and expectations management are essential during transition.

Minimum standards and escalation protocol

In all contexts, adaptations should never cross the following minimum standards:

- No suspension of treatment without alternatives or referral to relevant services.
- No delegation to untrained or unsupervised personnel.
- No withdrawal from ministry of health services without handover or coordination.
- No change in services without informing communities.

When these principles are at risk of being violated, partners should document and escalate through the relevant cluster or coordination mechanisms to trigger support and ensure accountability.

DOCUMENTING ADAPTATION AND RESOURCES

Documenting adaptations and learning

Tracking and learning from programmatic adaptations is essential to improve practices, support accountability, and reduce the risk of harm. Table 9 outlines key actions for documenting adaptations implemented under exceptional circumstances:

TABLE 9. Actions for documenting and learning

Key Action	Description
A. Describe the implemented approach	Clearly document the programmatic adaptation and how it diverges from the national or standard protocol. This should include admission criteria, dosage, delivery modality, or service structure.
B. Monitor patient-level effects	Use standard M&E processes to assess how adaptations affect individual outcomes (e.g., recovery, default, mortality). Compare with baseline data where available.
C. Monitor population-level effects	Track broader changes in nutritional status and mortality using surveillance data and context analysis. Identify external factors influencing trends beyond programme adaptations.
D. Integrate reflection into adaptive learning	Allocate space for joint analysis and reflection (e.g., pause-and-reflect sessions) to assess the relevance, safety and effectiveness of adaptations, and adjust where needed.
E. Invest in operational research where feasible	When possible, conduct observational studies or cohort tracking to generate stronger evidence. Ensure ethical safeguards including informed consent and institutional approval.

A collective effort in documenting and analysing adaptations will not only inform national decision-making but also contribute to global learning on programmatic flexibility and resilience in crisis settings.

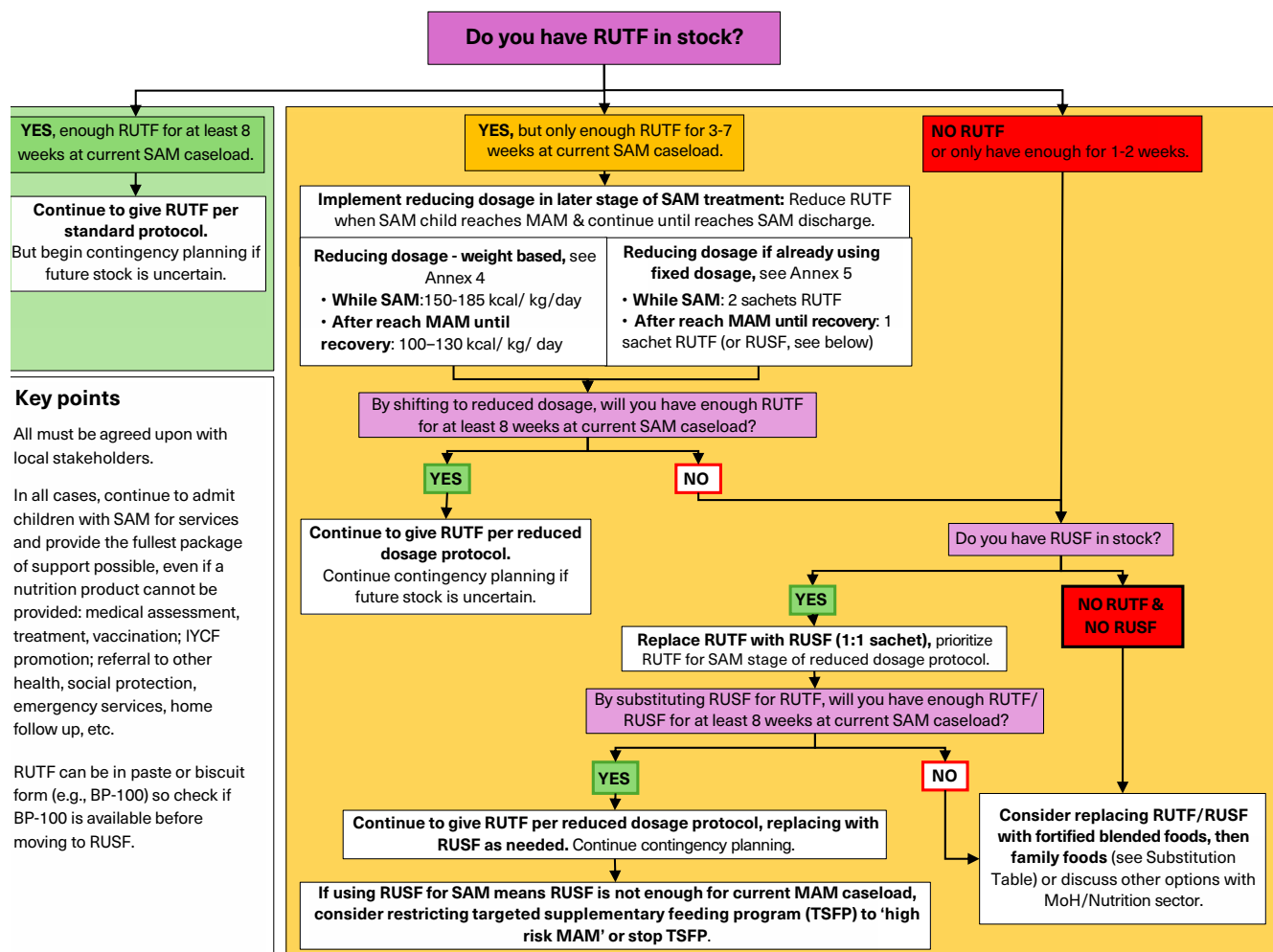
Links to existing tools & resources

All country teams are encouraged to align adaptation decisions with national protocols and coordination mechanisms, while documenting any divergence from existing standards. The following resources may support strategic reflection and implementation:

- [Global Health Cluster Guidance on service prioritization and ethical dilemmas in constrained settings](#) : [GHC guidance note: Prioritizing Essential Health Services](#) and [ethics key questions](#)
- [IYCF-E Support – Lifesaving Interventions](#)
- [GNC Operational Guidance on implementing simplified approaches and managing wasting in emergencies](#)
- [2023 WHO Guidelines on the Prevention and Management of Wasting](#)– for recommended practices and context-specific flexibility
- [Child wasting resource library](#)

These tools complement this guidance by offering scenario-specific protocols, ethical frameworks, and programmatic benchmarks that support principled decision-making under constraints.

ANNEX 1: RUTF STOCKOUT - DECISION TREE FOR ADAPTATIONS



ANNEX 2: PRODUCT SUBSTITUTION TABLES

This annex provides substitution options for ready-to-use therapeutic food (RUTF), ready-to-use supplementary food (RUSF) and fortified blended foods (FBFs) during stockouts, building on updates from the 2023 WHO Guidelines on the Prevention and Management of Wasting and field experiences. All substitutions must be temporary, context-specific and used only in exceptional circumstances.

Key terms

- Lipid-based nutrition supplements (LNS) are fortified food products, usually in a paste form, which provide energy, essential fatty acids and micronutrients. They include RUTF and RUSF and are often categorized by their intended daily dose:
 - * **Large-Quantity LNS** (LNS-LQ e.g., RUTF, RUSF): 150–180 kcal/kg/day (one to five 92/100 g sachets/day)
 - * **Medium-Quantity LNS** (LNS-MQ): ~250 kcal/day (one 50g sachet/day)
 - * **Small-Quantity LNS** (LNS-SQ): ~20g/day (one 20 g sachet/day)
- RUTF can come in the form of an LNS paste (e.g., 'Plumpynut') or biscuit (e.g., BP-100s). See the [RUTF CODEX Alimentarius specification](#) for details. Dosage for paste versus biscuit differs.

- RUSF is an LNS and usually comes in paste form. No CODEX exists but see the [UNICEF product specification sheet](#) for details.
- Fortified blended foods (FBFs) are blends of pre-cooked and milled cereals, soya, beans or pulses that are fortified with micronutrients. Improved FBFs contain sugar, oil and milk such as Super Cereal Plus. Otherwise, they are considered standard FBFs (such as Super Cereal or Corn Soya Blend CSB). FBFs may be distributed alongside a ration of oil or sugar if they do not contain any. They require cooking equipment and fuel to prepare. Note that Super Cereal is technically meant for children older than 3 years of age due to food safety issues (see Note below).
- BP-5 biscuits are compressed bars containing wheat, hydrogenated soybean oil, sugar, soy protein concentrate, amino acids and micronutrients. Water is often needed to mix into a porridge or when eating the biscuit, which is rather dry.

RUTF substitutions

Before moving to the first or second line of substitution, consider if RUTF supplies exist in LNS paste or biscuit form. However, there is no easy direct equivalent to substitute an RUTF biscuit (300 kcal/57g bar) for RUTF paste (500 kcal/92-gram sachet). For RUTF biscuit dosage tables, please contact the Global Nutrition Cluster Help Desk.

TABLE 10. Product substitutions for RUTF

	1st preference for substitution	2nd preference for substitution	3rd preference for substitution	4th preference for substitution
Product	RUSF (100 g per sachet)	ONLY IN EXTREME CIRCUMSTANCES: Improved FBFs <i>or</i> LNS-MQ	ONLY IN EXTREME CIRCUMSTANCES: BP-5 biscuits <i>or</i> standard FBFs (for children >36 months – see Note)	ONLY IN EXTREME CIRCUMSTANCES: General ration per Sphere standards <i>and/or</i> Promotion of local food recipes based on analysis (e.g., Nut Val) to optimize nutritional profile <i>and</i> Added supplements to meet micronutrient needs (see Figure 3 below)
Example	Plumpy'Sup™	Super Cereal Plus Plumpy'doz™	BP-5 biscuits	-
Units to best match kcal in 1 RUTF sachet	1:1 sachet	1:100g improved FBF14 1:max of 2 sachets of LNS-MQ (50 g each)	1:2 bars 1:100g Standard FBF15	-

14 100 g has been rounded down from 122g to fit a standard ration size. If resources allow, the Super Cereal Plus amount could be increased to 150 or 200g to allow for sharing in the household.

15 100 g has been rounded down from 122g to fit a standard ration size. If resources allow, the Super Cereal Plus amount could be increased to 150 or 200g to allow for sharing in the household.

RUSF substitutions

RUSF is considered superior to FBFs for the management of MAM according to the WHO guidelines on wasting (recommendation B15). RUTF is suggested below as a first preference to RUSF, but **ONLY** if the supply for RUTF is enough to cover the number of children with SAM for a sufficient period. This is to respect the principle of prioritizing children with SAM above those with MAM.

TABLE 11. Product substitutions for RUSF

	1st preference	2nd preference	3rd preference	4th preference
Product	RUTF (92 g sachet) **BUT ONLY IF RUTF SUPPLIES ARE SUFFICIENT TO COVER SAM CASES FOR AT LEAST 4 MONTHS** Always prioritize SAM over MAM	Improved FBFs <i>or</i> LNS-MQ (same as above for RUTF)	BP-5 biscuits <i>or</i> standard FBFs (for children >36 months – see Note) (same as above for RUTF)	ONLY IN EXTREME CIRCUMSTANCES: General ration per Sphere standards <i>and/or</i> Promotion of local food recipes based on analysis (e.g., Nut Val) to optimize nutritional profile <i>and</i> Added supplements to meet micronutrient needs (see Figure 3 below)
Examples	Plumpy'Nut®	Super Cereal Plus Plumpy'doz™	BP-5 biscuits Super-cereal	-
Units to best match kcal in 1 RUTF sachet	1:1	1:100g Super Cereal Plus ¹⁶ 1: max of 2 sachets of LNS-MQ (50 g each)	1:2 bars 1:100g standard FBF	-

A note on risk of standard FBFs for children under 36 months: Among the FBFs, only Super Cereal is recommended for children under 36 months. Standard (not improved) FBFs such as Super Cereal or CSB should only be used for children aged 36 months or older. This is because standard FBFs have been formulated and produced for the general population and specifications allow for a slightly higher level of acceptable mycotoxins not suitable for children under 36 months.

Fortified blended food substitutions

As outlined above, improved fortified blended foods (e.g., Super Cereal Plus) are preferred to standard FBFs, especially for children less than 36 months of age. Thus, implementers should opt for RUSF as a higher quality substitute for FBFs or BP-5s, especially for children under 36 months with MAM, if it is in sufficient quantity (Table 12). Otherwise, replace (RUSF, BP-5s or LNS-MQ) with standard FBFs for pregnant and breastfeeding women and girls (Table 13). For children under 36 months with MAM, try to provide BP-5s (if RUSF is not possible) before moving on to standard FBFs or general ration/local food substitute.

TABLE 12. Product substitutions for improved FBFs for children with MAM

	1st preference	2nd preference	3rd preference	4th preference
Product	RUSF (but prioritize RUSFs for children <36 months)	BP-5s <i>or</i> LNS-MQ	Standard FBFs for children >36 months (Prioritize RUSF, BP-5s or LNS-MQ for children <36 months)	ONLY IN EXTREME CIRCUMSTANCES: General ration per Sphere standards <i>and/or</i> Promotion of local food recipes based on analysis (e.g., Nut Val) to optimize nutritional profile <i>and</i> Added supplements to meet micronutrient needs (see Figure 3 below)
Examples	Plumpy'Sup™	BP-5 Plumpy'Doz™	Super Cereal/CSB	N/A
Units to best match 100 g of improved FBF	1 sachet	1:2 bars 1: max of 2 sachets of LNS-MQ (50 g each)	1: 100 g	N/A

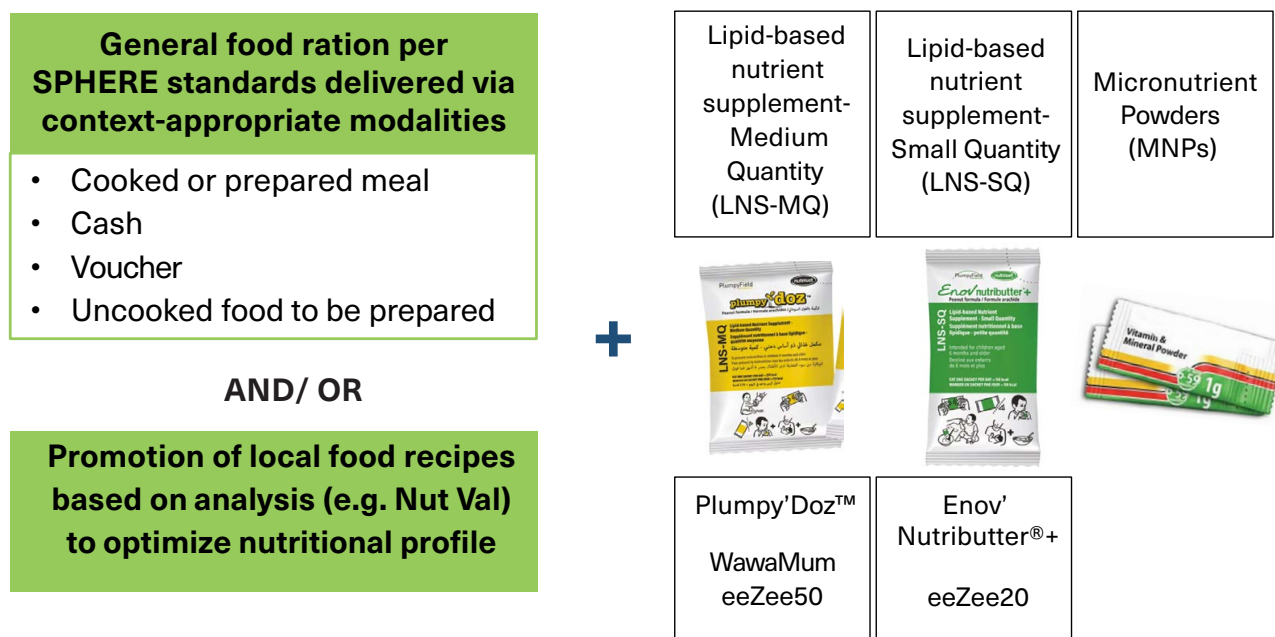
¹⁶ 100 g has been rounded down from 122g to fit a standard ration size. If resources allow, the Super Cereal Plus amount could be increased to 150 or 200g to allow for sharing in the household.

TABLE 13. Product substitutions for improved FBFs for undernourished pregnant and breastfeeding women and girls

	1st preference	2nd preference	3rd preference	4th preference
Product	RUSF (but prioritize RUSFs for children)	BP-5s <i>or</i> LNS-MQ (but prioritize for children <36 months)	Standard FBFs	ONLY IN EXTREME CIRCUMSTANCES: General ration per Sphere standards <i>and/or</i> Promotion of local food recipes based on analysis (e.g., Nut Val) to optimize nutritional profile <i>and</i> Added supplements to meet micronutrient needs (see Figure 3 below)
Examples	Plumpy'Sup™	BP-5 Plumpy'Doz™	Super Cereal/CSB	N/A
Units to best match 100 g of improved FBF	1 sachet	1:2 bars 1: max of 2 sachets of LNS-MQ (50 g each)	1:200 g	N/A

FIGURE 3. Suggested food substitution package when there is no RUTF or RUSF or FBFs

Possibly with added supplements to meet micronutrient needs:



A note on small and medium quantity LNS: LNS-small quantity (e.g., Enov'Nutributter™) and LNS-medium quantity (e.g., Plumpy'Doz™) should NOT be used as a substitute to provide a gram for gram or kcal for kcal replacement of an RUSF or RUTF sachet because they have different formulations and the micronutrient concentrations will exceed the recommended upper limits for several minerals and vitamins. However, they may be substituted in their recommended daily dose (per the tables above) and, ideally, to improve the nutrition profile (of PBWGs and children) of the fourth substitution preference in the tables above if there are no alternatives.

ANNEX 3. ALTERNATIVE RECIPES FOR THERAPEUTIC MILKS FROM LOCAL INGREDIENTS

When F-75 or F-100 is not available, the following recipes can be used in extreme circumstances.

TABLE 14. Recipes for F-75 therapeutic milks preparation from local ingredients and Complex of Minerals Vitamins Mix¹⁷

Type of milk	Milk (g)	Sugar (g)	Oil (g)	Cereal flour* (g)	CMV** red scoop = 6.35g	Water (ml)
Dry Skim Milk	50	140	54	70	1	Up to 2000
Dry Whole Milk	70	140	40	70	1	Up to 2000
Fresh cow milk	560	130	40	70	1	Up to 2000
Fresh goat milk	560	130	40	80	1	Up to 2000

* Cereal flour is cooked for about 10 minutes and then the other ingredients added.

** CMV = Special Mineral and Vitamin mix adapted to severe acute malnutrition treatment (®Nutraset)

To prepare the F75 diet, add the dried skim milk, sugar, cereal flour, and oil to some water and mix. Boil for 5 to 7 minutes. Allow to cool, then add the mineral mix and vitamin mix and mix again. Make up the volume to 2000 ml with water.

TABLE 15. Recipes for F-100 therapeutic milk preparation from local ingredients and Complex of Mineral Vitamin Mix

Type of milk	Milk (g)	Sugar (g)	Oil (g)	CMV** red scoop = 6.35g	Water (ml)
Dry Skim Milk	160	100	120	1	Up to 2000
Dry Whole Milk	220	100	60	1	Up to 2000
Fresh cow milk	1800	100	50	1	Up to 2000
Fresh goat milk	1800	100	60	1	Up to 2000

¹⁷ F-75 and F100 recipes are reproduced from the Global Nutrition Cluster, [Management of wasting during a shortage or absence of specialized nutritious food products](#) and adapted from the Kenya Integrated Management of Acute Malnutrition national guidelines.

ANNEX 4. REDUCING DOSAGE DURING SAM TREATMENT: SIMPLE DOSAGE TABLES

TABLE 16. Reference table for RUTF paste: Reducing dosage during SAM treatment based on a child's weight using simplified weight categories

WEIGHT RANGE (kg)	MUAC < 115 mm and/or WHZ < -3 and/or oedema		MUAC > 115 and < 125 mm and WHZ ≥ -3 and < -2 and NO oedema	
	150 kcal/child's weight/day		100 kcal/child's weight/day	
	RUTF sachets per DAY	RUTF sachets per WEEK	RUTF sachets per DAY*	RUTF sachets per WEEK*
3.0-4.9	1	7	1	7
5-7.9	2	14		
8.0-11.9	3	21	2	14
12.0 & above	4	28	3	21

*This could be replaced with RUSF if RUTF stocks are limited per product substitution options in Step 4.

ANNEX 5. REFERENCE TABLE FOR RUTF PASTE: REDUCING DOSAGE DURING SAM TREATMENT WITH 'FIXED DOSAGE'

Category of acute malnutrition	MUAC < 115 mm and/or WHZ < -3 and/or oedema		MUAC > 115 and < 125 mm and WHZ ≥ -3 and < -2 and NO oedema	
	150 kcal/child's weight/day		100 kcal/child's weight/day	
	RUTF sachets per DAY	RUTF sachets per WEEK	RUTF sachets per DAY	RUTF sachets per WEEK
SAM	2	14	N/A	N/A
MAM	1	7	1	7

ANNEX 6: GLOSSARY OF ACRONYMS

BMS	Breastmilk Substitute
BP-5	High-energy biscuit (compressed emergency food bar)
CHW	Community Health Worker
CMV	Complex of Minerals and Vitamins mix
CSB	Corn Soya Blend
FBF	Fortified Blended Food
GHC	Global Health Cluster
GNC	Global Nutrition Cluster
GTWGs	Global Thematic Working Groups
HR	Human Resources
ICCM+	Integrated Community Case Management (plus)
IPC	Integrated Food Security Phase Classification
IYCF	Infant and Young Child Feeding
IYCF-E	Infant and Young Child Feeding in Emergencies
LNA	Local and National Actor
LNS	Lipid-based Nutrient Supplement
LNS-LQ	Large-Quantity Lipid-based Nutrient Supplement
LNS-MQ	Medium-Quantity Lipid-based Nutrient Supplement
LNS-SQ	Small-Quantity Lipid-based Nutrient Supplement
LNSM	Last Mile Stock Management
MAM	Moderate Acute Malnutrition
MAMI	Management of small and nutritionally at-risk infants under 6-months and their mothers
MoH	Ministry of Health
MUAC	Mid-Upper Arm Circumference
OG-IFE	Operational Guidance on Infant and Young Child Feeding in Emergencies
PBWG	Pregnant and Breastfeeding Women and Girls
PIMS	Pipeline Inventory Management System
RUSF	Ready-to-Use Supplementary Food
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SFF	Specially Formulated Food
SLEAC	Simplified Lot Quality Assurance Sampling Evaluation of Access and Coverage
SOP	Standard Operating Procedure
SQUEAC	Semi-Quantitative Evaluation of Access and Coverage
WAZ	Weight-for-Age Z-score
WFP	World Food Programme
WHZ	Weight-for-Height Z-score

