**1. ASSESS**

**Measure and record:**
- weight and height
- If pregnant or postpartum woman use MUAC
- If child use length board and baby weighing scale

**Review:**
- Client records
- Medical history
- Lab test results

**Check for bilateral pitting edema**

**Ask about:**
- Food and drink consumed in last 24-hours
- Food allergies
- HIV status

**Do appetite test, if SAM**

**Record information**

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**2. CLASSIFY & INFORM**

**Classify nutritional status** by using the BMI wheel or chart, or MUAC for pregnant and postpartum women

**Inform** the client of his/her nutrition status

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**3. COUNSEL & EDUCATE**

**In an area as private as possible,** explain nutritional status

**Based on information collected from clients,** provide specific recommendations and discuss how the client can make changes

**Use printed materials to engage clients and clarify key messages**

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**Severe acute malnutrition (SAM)/severely underweight**
- BMI <16.0
- Or: bilateral pitting edema
- Or: MUAC < 18.5 cm
- If pregnant/postpartum: MUAC <21.0 cm
- If age 6-59 months, WHZ < -3 or MUAC < 11.5 cm

**Moderate-mild acute malnutrition (MAM)/moderately underweight**
- BMI 16.00 – 18.4
- Or: MUAC 18.5 – 20.9 cm
- If pregnant/postpartum: MUAC 21-23.0 cm
- If age 6-59 months, WHZ ≥ -3 to < -2 or MUAC ≥ 11.5 cm to < 12.5 cm

**Normal**
- BMI 18.5 - 24.9
- Or: MUAC ≥ 21.0 cm
- If pregnant/postpartum: MUAC ≥ 23.0 cm
- If age 6-59 months, WHZ ≥ -2 to < +2 or MUAC > 18.5 cm

**Overweight**
- BMI 25.0 – 29.9

**Obesity**
- BMI > 30

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**4. COMPLETE RECORDS**

- **Record** all information in the individual client card
- **Document** the next appointment and referrals
- **Put** the client card in folder
- **Complete** the Daily Register
- **Complete** Daily Activity tally card sheet
- **Submit** NACS monthly report

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**5. PLAN NEXT STEPS**

- If the client's HIV status is unknown, **refer** for provider-initiated testing and counselling (PITC)
- **If outpatient SAM or MAM schedule** follow up appointment in 1 or 2 weeks.
- **Arrange** for community worker to make home visit
- **Refer** to community-based food security programs
- **Schedule** follow up appointment in 2 months.
- **Refer** to community support activities.
- **Arrange** for community worker to make home visit

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**FOR ALL CLIENTS:**

**Provide** health and nutrition education in the triage/waiting area.

**Advise to:**
- Avoid smoking and drinking alcohol.
- Follow optimal food and water safety, hygiene and sanitation practices.
- Agree on a small, doable action step to improve nutrition.

**EXIT**

- **ASK:** Do you have any questions? What are you going to do after today, to improve your nutrition?
- **File** records