Manual for Country-Level Nutrition Advocacy Using PROFILES and Nutrition Costing

TEMPLATES

# Templates

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# Template: Agenda for Core Working Group Meeting

**Agenda for Core Working Group Meeting**

1. **Nutrition Advocacy Planning Process Using PROFILES [and Nutrition Costing]**

* Overview of Nutrition Advocacy Planning Process Presentation
* Handout on Advocacy to Reduce Malnutrition
* Review Concept Note for Nutrition Advocacy Using PROFILES [and Nutrition Costing]

1. **One-Day Stakeholder Meeting**

* Proposed Dates
* Proposed Agenda and Speakers
* Participant List and Invitation

1. **Next Steps**

# Template: Sample Concept Note

Concept Note on Nutrition Advocacy Using PROFILES *[and Nutrition Costing]* in [Insert Country]

OVERVIEW

[Insert country specific background such as: In 2017, the Ministry of Health in [insert country], in collaboration with several key stakeholders, began the process of revising the National Nutrition Plan. Conducting an updated PROFILES in tandem with the finalization and implementation of the National Nutrition Plan has the potential to greatly enhance stakeholder ownership by prioritizing key advocacy messages and harmonizing advocacy activities to address the Plan’s priorities.]

## PROFILES is a spreadsheet-based nutrition advocacy tool used to calculate consequences if malnutrition does not improve or change over a defined time period and the benefits of improved nutrition over the same time period, including lives saved, disabilities averted, human capital gains, and economic productivity gains (or, put another way, economic productivity losses averted). PROFILES estimates are based on reduction in the prevalence of several nutrition problems, such as iron deficiency anemia; low birth weight; vitamin A deficiency; iodine deficiency; suboptimal breastfeeding practices; and childhood stunting, underweight, and wasting. To calculate estimates, PROFILES requires current country-specific information (e.g., nutrition, demographic, and employment data) that are identified and agreed upon in collaboration with stakeholders in country. PROFILES results can be used to engage government and other high-level stakeholders in a collaborative process to identify, prioritize, and advocate for evidence-based actions to reduce malnutrition. Such actions may include developing or refining policies, implementing existing policies, identifying priority geographic areas in which selected interventions should be focused, scaling up current interventions, and introducing new nutrition interventions, among others.

[If applicable] PROFILES was last completed in [insert country] in [insert year]. This provided valuable information on the economic and health impact of nutrition issues as well as the consequences of inaction. Since then, new data is available through the nationally representative [insert country] Demographic and Health Survey implemented in [insert year]. In addition, the tools and outputs of the PROFILES process have been strengthened to provide more robust information to support the costing and advocacy of nutrition interventions.

A unified and harmonized approach to nutrition advocacy in [insert country] would maximize the effectiveness of the efforts of the Government of [insert country] and partners. Key steps in this process are forming a core working group that oversees the process and bringing together key stakeholders from multiple sectors, donors, and implementing agencies to agree on a national and subnational approach to nutrition advocacy, including implementation plans and timelines. Consultative workshops and meetings between the core working group and other stakeholders will provide a forum to develop estimates from PROFILES related to undernutrition (stunting, wasting, and underweight), low birth weight, micronutrient deficiencies (vitamin A deficiency, iron deficiency anemia, and iodine deficiency), and breastfeeding practices, *[as well as nutrition costing estimates]* and a roadmap for nutrition advocacy that aligns with the priorities and outcomes outlined in [insert relevant national documents]. The outcome of the series of workshops and meetings is a national nutrition advocacy plan and corresponding nutrition advocacy materials. Additional outcomes include preliminary PROFILES *[and nutrition costing]* results, which would be reviewed during a meeting by multisectoral stakeholders from government, donors, United Nations agencies, and other stakeholders.

EXPECTED DELIVERABLES

1. Estimates from PROFILES, which calculate consequences if malnutrition does not improve over a defined time period and the benefits of improved nutrition over the same time period, including lives saved, disabilities averted, human capital gains, and economic productivity gains (or, put another way, economic productivity losses averted).
2. Cost estimates in local currency and U.S. dollars of implementing a comprehensive set of nutrition programs in a country over a specific time period.
3. A harmonized, multisectoral, national nutrition advocacy plan.
4. Nutrition advocacy materials based on the national nutrition advocacy plan.
5. A PROFILES report *[and costing final report],* and an accompanying summary of the report.

ACTIVITIES

Months 1–2: Constitute a multi-stakeholder core working group

Working with the [insert host country government agency] and various stakeholders, a small, multisectoral core working group will be formed. This working group will be central to the development of preliminary PROFILES *[and Nutrition Costing]* estimates and nutrition advocacy plan development. The core working group will contribute to the planning and implementation of workshops and meetings to develop and refine PROFILES *[and Nutrition Costing*] estimates, as well as develop a nutrition advocacy plan and review materials. Core working group members could include representatives from government; USAID; development partners such as REACH, UNICEF, WHO, WFP, and FAO; civil society; and USAID-funded implementing partners, to name a few.

Months 1–2: Nutrition advocacy stakeholder meeting

This one-day stakeholder meeting will bring together experts working in the fields of nutrition, health, agriculture, education, finance, and other relevant fields to begin the nutrition advocacy planning process using PROFILES. During the meeting, participants will discuss a time period for the estimates created in PROFILES, identify data sources for indicators used in the PROFILES spreadsheet to create the estimates, discuss possible targets for the indicators, *[and have initial discussions on nutrition costing].* Participants will also discuss and identify nutrition advocacy needs at the national level.

The stakeholder meeting objectives include discussion of:

* The current nutrition situation in [insert country] and government priorities
* Time period for PROFILES
* Data sources for information and targets to be used as input for PROFILES
* Nutrition advocacy needs in [insert country]
* *[Possible nutrition interventions to be costed]*

Months 3–6: PROFILES workshop

A 2.5-day consultative workshop is the next step in developing PROFILES estimates. The core working group will actively contribute, ensuring broad ownership and involvement, increasing the likelihood of a unified and harmonized approach to nutrition advocacy across the country. Workshop participants will build on the work done during the stakeholder meeting on sources of information, time period, and targets for PROFILES. Participants will work with PROFILES spreadsheet models to produce preliminary estimates of the negative consequences if there is no improvement in malnutrition in the country (expressed as number of deaths, permanent disabilities, human capital losses, and economic productivity losses), and of benefits from improved nutrition (expressed as lives saved, disabilities averted, human capital gains, and economic productivity gains).

The workshop objectives are to complete the PROFILES spreadsheets and generate preliminary results. The next step is to finalize a PROFILES Final Report along with a summary version.

[If applicable] Months 3–15: Nutrition Costing consultations and present preliminary results

To begin developing Nutrition Costing estimates, individual and/or group consultations will be held with key multisectoral stakeholders and health economists. During the consultations, stakeholders will engage collaboratively in defining the assumptions upon which the costing estimates will be based—for instance, selecting necessary interventions and activities, and defining a management structure for service provision—which helps to identify the required inputs for each activity, and to estimate the program cost for a specified time period.

Consultation objectives include:

* To determine nutrition interventions for costing and identify required inputs for each activity
* To develop initial cost estimates for a national nutrition program

A consultative meeting will be held to present the preliminary results of Nutrition Costing for input and feedback from stakeholders. The next step is to finalize a Nutrition Costing Final Report along with a summary version. This can be combined with the PROFILES Final Report.

Months 3–12: Nutrition advocacy plan and material workshop

Building on current advocacy efforts to create an enabling environment for nutrition programs, a 4-day workshop at the national level will identify nutrition problems, prioritize interventions to improve nutrition, establish advocacy objectives, and identify the steps needed to achieve those objectives. The process will include segmenting target audiences (e.g., media, policymakers, politicians, civil society, etc.) and determining materials and activities for each audience based on desired changes and perceived barriers and benefits among each audience. In addition, the national nutrition advocacy plan would include an implementation plan with a timeline and monitoring and evaluation indicators to help track progress. During the workshop, participants would also develop creative briefs to guide the development of advocacy materials for each target audience. See Annex A for an illustrative example of a national nutrition advocacy plan.

The workshop objectives include:

* To develop an initial harmonized multisectoral strategic nutrition advocacy plan, which includes a timeline for advocacy activities and development/dissemination of materials
* To draft creative briefs to guide the development of advocacy materials for each target audience

As a next step, nutrition advocacy materials that correspond with the nutrition advocacy plans should be developed and finalized with input from core working group members.

Ongoing: Support Implementation of the Nutrition Advocacy Plans using PROFILES [and national and/or subnational Nutrition Costing] Estimates

Implementation of the nutrition advocacy plans includes conducting advocacy outreach with target audiences at national and subnational levels to disseminate PROFILES *[and Nutrition Costing]* results using the nutrition advocacy materials.

[If needed] Annex A. Sample Nutrition Advocacy Plan

*[Please note: this strategy is illustrative to provide an example of how the plan would be organized and seek suggestions for improving it. The information in the table is not intended to be the plan for [insert country]—it will be country/context specific.]*

Country X has used the PROFILES tool to estimate the consequences of undernutrition and micronutrient deficiencies in the country and conducted various mapping and situational analyses to understand the profile of nutrition in the country. A task team composed of the Ministry of Health, Ministry of Agriculture, Ministry of Finance, Ministry of Education, United Nations agencies, USAID, academia, and implementing partners has developed a plan of follow-up advocacy activities. The first activity was to determine a strategic advocacy approach to achieve increased funding and support for nutrition activities, and develop/adapt and disseminate advocacy materials.

The team participated in a consultative workshop to develop the following advocacy plan and to develop draft nutrition advocacy materials. This process included determining key audiences and tailoring planned activities and materials to each audience based on desired changes and perceived barriers and benefits among each audience. The activities outlined in the following advocacy plan are expected to contribute to increased visibility and resources for nutrition in the health, agricultural, education, and gender sectors.

This plan focuses on advocacy as the first phase of the communication approach to build support for an enabling environment for nutrition targeting media, politicians, policymakers, and civil society. The second phase will build on advocacy while also focusing on behavior change communication and social mobilization to ignite change. This phase will build on existing interventions that target those most affected by the problem (e.g., pregnant and lactating women, children under 5, and adolescents) as well as those who directly influence them (e.g., caregivers of children under 5, husbands/partners, relatives, neighbors and peers, community media, teachers, health workers/extension workers, traditional healers, community and religious leaders, etc.).

Sample Nutrition Advocacy Plan

|  |  |
| --- | --- |
| **Problem** | Undernutrition remains a widespread problem that has not improved much in recent years. While nutrition plays a crucial role in health, education, and economic productivity, opinion leaders and decision makers do not recognize nutrition as a key issue and there is little intersectoral collaboration. There is little understanding of the effects of undernutrition on society and no real pressure from the public to hold the government accountable for combating malnutrition. In fact, there is a perception that nutrition is an individual problem, has not been a priority at the government level, and therefore funding for nutrition is low and there are few nutrition champions at any level. |
| **Changes the Problem Calls For** | Advocacy should support the following changes:   1. Increased funding 2. A wide social movement to rally support for nutrition services 3. Nutrition champions who vocalize nutrition issues at all levels—national, regional, and local 4. Skilled staff to undertake action planning for nutrition at the district and community levels |
| **Final Audience Segmentation** | **Those Most Affected by the Problem:**   * Pregnant and lactating women * Children under 5 years of age * Adolescents * People with infectious diseases, such as HIV and tuberculosis   **Those Directly Influencing the Most Affected:**   * Caregivers of children under 5 (including mothers and fathers) * Husbands/partners of pregnant and lactating women * Relatives of pregnant and lactating women and caregivers of children under 5, including siblings, in-laws, and extended family * Neighbors and peers of caregivers and mothers of children under 5 * Community media * Health workers/extension workers * Traditional healers * Teachers * Community leaders including Chiefs and Queen Mothers * Religious leaders   **Those Indirectly Influencing the Most Affected:**   * Media practitioners including journalists and gatekeepers (i.e., editors and producers in television, radio, print, and online) * Policymakers * Politicians * Civil society * Officials at district and regional levels * Food value chain operators including farmers, food processors, distributors, and sellers * Development partners and large nongovernmental organizations |
| **Strategic Approach/ Framing** | In order to create an enabling environment, an advocacy approach is needed. The first phase will target media, politicians, policymakers, and civil society. A mutually reinforcing mix of activities that include events, workshops and trainings, print materials, and one-on-one meetings with selected influential individuals will build a critical mass of nutrition advocates and promote a national coordinated effort on nutrition. The second phase will target those most affected by the problem (e.g., pregnant and lactating women, children under 5, adolescents, and those with infectious diseases) as well as those who directly influence them (e.g., caregivers of children under 5, husbands/partners, relatives, neighbors and peers, community media, teachers, health workers/extension workers, traditional healers, community and religious leaders, etc.). This will entail expanding the scope of the campaign to include behavior change communication and social mobilization. |
| **Advocacy Activities and Materials** | A combination of:   * Information sheets and other print materials * Presentations/guides * Workshops, seminars, and trainings with commitment to action * One-on-one meetings * Video documentary * Media outreach and press briefings (with TV, radio, and print coverage as an outcome) |
| **Desired Changes, Barriers, Advocacy Intents, and Advocacy Activities and Materials** | **AUDIENCES INDIRECTLY INFLUENCING THOSE MOST AFFECTED (Advocacy Audiences):**  **Media**  *Desired Changes:* Increased number of accurate reports on nutrition issues in television, radio, print, and online media that increases awareness among the public about the importance of nutrition.*Key Barriers*:   * Inaccurate information on nutrition and its impact on health, education, and development * Low priority of nutrition issues with the media * Lack of skills of media to conduct investigative journalism and link nutrition to development * Lack of motivation and incentives to report on nutrition   *Advocacy Intent:* By the end of 2015, there will be an increase in the number of media houses and media practitioners with adequate skills, information, and understanding of the benefits of reporting on nutrition issues.  *Advocacy Activities and Materials*   * Roundtable discussions/workshops * Press briefing * Seminars * Five-day targeted workshop for promising “nutrition champions” * Media monitoring to determine how nutrition and health issues are reported in the media   **Policymakers (specific agencies listed)**  *Desired Changes:* High prioritization of nutrition across government sectors reflected in increased collaboration among sectors and more resources allocated for the implementation of nutrition interventions.  *Barriers:*   * Competing programs at the national level * Lack of appreciation for the benefits of nutrition * Insufficient information on investment needed for nutrition   *Advocacy Objective*: By the end of 2015, there will be an increase in the number of policymakers who understand the significance of nutrition issues on health, education, and development and the need for a coordinated national response to undernutrition.  *Advocacy Activities and Materials*   * Advocacy seminar * One-on-one meetings with select policymakers * Press conference   **Politicians at all levels**  *Desired Changes*: Nutrition champions at every level to position nutrition as a development strategy and increase investment for nutrition.  *Barriers*:   * Low awareness of nutrition and its impact on health, education, and development * Low priority of nutrition * Competing demand for resources   *Advocacy Intent*: By the end of 2015, there will be an increase in key legislation to support nutrition.  *Advocacy Activities and Materials*   * Half-day retreat * Briefing packet * Stakeholder meeting   **Civil Society Organizations (CSOs)**  *Desired Changes:* Increased involvement of CSOs as champions for nutrition and increased influence in their communities.  *Barriers:*   * Low awareness of nutrition and its impact on health, education, and development in their communities * Limited skills and resources to be nutrition advocates/champions   *Advocacy Intent*: By the end of 2015, there will be an increased number of CSO staff who act as advocates/champions for nutrition.  *Advocacy Activities and Materials*   * Seminars/stakeholder meetings with CSOs at the national level * Professional and other association meetings (e.g., Farmers and Fishermen, Nutrition and Dietetic Association, women’s groups) * Seminars/stakeholder meetings with CSOs at the regional level * One-on-one meetings with targeted leaders and identified advocates within CSOs at the national, regional, and district levels * Training of advocates |

Sample Implementation Plan Matrix

*[This section will outline activities for specific target groups and identify necessary inputs, timeline, who is responsible, and how this work will be tracked.]*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Target Group: *[separate sections for media, policymakers, politicians, CSOs, and different behavior change communication audiences]*** | | | | | | |
| **Activity** | **Materials** | **Timeline** | **Proposed Responsible Organizations** | **Possible Supporting Organizations** | **Indicators** | **Means of Verification** |
|  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- |
| **Target Group: *[separate sections for media, policymakers, politicians, CSOs, and different behavior change communication audiences]*** | | | | | | |
| **Activity** | **Materials** | **Timeline** | **Proposed Responsible Organizations** | **Possible Supporting Organizations** | **Indicators** | **Means of Verification** |
|  |  |  |  |  |  |  |

# Template: Agenda for Stakeholder Meeting

**Agenda for Stakeholder Meeting on Nutrition Advocacy using PROFILES**

***[and Nutrition Costing]***

|  |  |  |
| --- | --- | --- |
| **Time** | **Session** | **Speaker/ Facilitator** |
| 8:30–9:00 a.m. | Registration |  |
| 9:00–10:00 a.m. | Welcoming Remarks from the Government of [insert country] and donor [insert country]  Purpose of Meeting | [insert speakers] |
| 10:00–10:30 a.m. | Overview of the Nutrition Situation in [insert country] | [insert speakers] |
| 10:30–10:45 a.m. | Break | |
| 10:45–11:05 a.m. | Global Progress on Nutrition | [insert speakers] |
| 11:05–11:25 a.m. | Overview of Nutrition Advocacy Process using PROFILES *[and Nutrition Costing]* | [insert speakers] |
| 11:25–11:45 a.m. | Approach Used in PROFILES | [insert facilitators] |
| 11:45 a.m.–12:20 p.m. | Discussion of Time Period for Estimates | [insert facilitators] |
| 12:20–12:30 p.m. | Introduction to Group Work | [insert facilitators] |
| 12:30–1:30 p.m. | Lunch | |
| 1:30–3:00 p.m. | Discussion in Groups:   1. Data Sources and Targets for Estimates  * Anthropometry and Low Birth Weight * Micronutrients * Breastfeeding * Employment and Education * Risk Factors of Stunting  1. Advocacy Needs 2. [Nutrition Costing] | [insert facilitators] |
| 3:00–4:40 p.m. | Plenary Discussion from Groups: Data Sources and Targets for Estimates | [insert facilitators] |
| 4:40–5:20 p.m. | Plenary Discussion from Groups: Advocacy Needs *[and Nutrition Costing]* | [insert facilitators] |
| 5:20–5:30 p.m. | Wrap-up and Way Forward (followed by tea/coffee) | [insert facilitators] |

# Template: Agenda for PROFILES Workshop

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| **DAY ONE** | |
| **Time** | **Session** |
| 8:30–10:00 am | Session 1: Welcome and Introduction to the PROFILES Workshop |
| 10:00–10:45 am | Session 2: Review of the Nutrition Advocacy Approach andOverview of Stakeholder Meeting (revise if stakeholder meeting was not held) |
| 10:45–11:00 am | Break |
| 11:00 am–12:00 pm | Session 3: Scientific Basis for PROFILES |
| 12:00–12:30 pm | Session 4: Approach and Assumptions Used in PROFILES Spreadsheet Models |
| 12:30–1:30 pm | Lunch |
| 1:30–2:15 pm | Session 5[[1]](#footnote-2): Considerations for Setting the Time Period for PROFILES Estimates |
| 2:15–3:30 pm | Session 6: Time Period, Available Information Sources, and Targets |
| 3:30–3:45 pm | Tea Break |
| 3:45–5:15 pm | Session 6 (continued): Discussion of Time Period, Available Information Sources, and Targets |
| 5:15–5:30 pm | Wrap-Up |

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| **DAY TWO** | |
| **Time** | **Session** |
| 8:30–9:00 am | Session 7: Recap of Day One and Scoreboard Updates |
| 9:00–10:00 am | Session 8: Demography and Other Indicators Needed for PROFILES |
| 10:00–10:30 am | Session 9: Introduction to *PROFILES Spreadsheet Workbook* |
| 10:30–10:45 am | Tea Break |
| 10:45 am–12:30 pm | Session 10: Introduction to Nutrition and Health in PROFILES–Concurrent Sessions:   1. Anthropometry 2. Micronutrients 3. Low birth weight/breastfeeding |
| 12:30–1:30 pm | Lunch |
| 1:30–2:00 pm | Plenary Report-Out |
| 2:00–2:45 pm | Session 11: Introduction to Nutrition’s Impact on Human Capital (Learning) and Economic Productivity Outcomes—Concurrent Sessions:   1. Stunting and low birth weight (if applicable) 2. Anemia and iodine deficiency |
| 2:45–3:15 pm | Plenary Report-Out |
| 3:15–3:30 pm | Tea Break |
| 3:30–4:30 pm | Session 12: Introduction to Addressing Risk Factors to Reduce Stunting—Concurrent Sessions:   1. Inadequate dietary diversity and stunting 2. Teenage pregnancy and stunting |
| 4:30–5:15 pm | Plenary Report-Out |
| 5:15–5:30 pm | Wrap-Up |

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| **DAY THREE** | |
| **Time** | **Session** |
| 8:30–9:00 am | Session 13: Recap of Day Two |
| 9:00–10:30 am | Session 14: Gallery Walk: Review of Preliminary Estimates from PROFILES |
| 10:30–10:45 am | Tea Break |
| 10:45 am–12:15 pm | Session 15: Discussion of Advocacy Needs |
| 12:15–1:00 pm | Session 16: Next Steps/Wrap-Up |
| 1:00–2:00 pm | Lunch |

# Template: Information Needed Worksheets

## Worksheet: Information Needed—Anthropometry (used in sessions 6, 10, 11, and 12)

As a group, fill in the following information that is needed to calculate the PROFILES estimates.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Indicator** | **Age (mos.)** | **Starting prevalence (%)** | | | **Mean height/age z-score at 0-59 months\*** | **Data source** | **Table #/page in source** | **Targeted reduction in prevalence (%)** | **Target prevalence (%)** |
| **Severe** | **Moderate** | **Severe + moderate** |
| Stunting | 0–59 | \_\_\_\_% | \_\_\_\_\_\_% | \_\_\_\_\_\_ % | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_% |
| Provide information on why the source was selected: | | | | | | | | | |
| Provide information on how and why the target was selected: | | | | | | | | | |
| Additional notes: | | | | | | | | | |

\*Information is typically found in the Demographic and Health Survey in the same table as the prevalence information for stunting, wasting and underweight.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Indicator** | **Age (mos.)** | **Starting prevalence (%)** | | | **Mean height/age z-score at 24-35 months\*** | **Data source** | **Table #/ page in source** | **Targeted reduction in prevalence (%)** | **Target prevalence (%)** |
| **Severe** | **Moderate** | **Severe + moderate** |
| Stunting | 24–35 | \_\_\_\_% | \_\_\_\_\_\_% | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_% |
| Provide information on why the source was selected: | | | | | | | | | |
| Provide information on how and why the target was selected: | | | | | | | | | |
| Additional notes: | | | | | | | | | |

\*Information is typically found in the Demographic and Health Survey in the same table as the prevalence information for stunting, wasting and underweight.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Indicator** | **Age (mos.)** | **Starting prevalence (%)** | | | **Mean weight/age z-score at 0-59 months\*** | **Data source** | **Table #/page in source** | **Targeted reduction in prevalence (%)** | **Target prevalence (%)** |
| **Severe** | **Moderate** | **Severe + moderate** |
| Underweight | 0–59 | \_\_\_\_\_% | \_\_\_\_\_\_% | \_\_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_% | \_\_\_\_\_\_% |
| Provide information on why the source was selected: | | | | | | | | | |
| Provide information on how and why the target was selected: | | | | | | | | | |
| Additional notes: | | | | | | | | | |

\*Information is typically found in the Demographic and Health Survey in the same table as the prevalence information for stunting, wasting and underweight.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Indicator** | **Age**  **(mos.)** | **Starting prevalence (%)** | | | **Mean weight/ height z-score at 0-59 months\*** | **Data source** | **Table #/ page in source** | **Targeted reduction in prevalence (%)** | **Target prevalence (%)** |
| **Severe** | **Moderate** | **Severe + moderate** |
| Wasting | 0–59 | \_\_\_\_% | \_\_\_\_\_\_% | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_% |
| Provide information on why the source was selected: | | | | | | | | | |
| Provide information on how and why the target was selected: | | | | | | | | | |
| Additional notes: | | | | | | | | | |

\*Information is typically found in the Demographic and Health Survey in the same table as the prevalence information for stunting, wasting and underweight.

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| --- | --- | --- | --- | --- |
| **Indicator** | **Age (months)** | **Prevalence of weight-for-height above +2 SD** | **Data source** | **Table number/ page in source** |
| Overweight/ obesity | 48–59 | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Provide information on why the source was selected: | | | | |
|  | | | | |
| Additional notes: | | | | |

## Worksheet: Information Needed—Low Birth Weight and Breastfeeding (used in sessions 6, 10, and 11)

As a group, fill in the following information that is needed to calculate the PROFILES estimates.

**Low birth weight (LBW) among newborn infants with a known birth weight**

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| --- | --- | --- | --- | --- | --- |
| **Indicator** | **Starting prevalence (%)** | **Data source** | **Table #/ page in source** | **Targeted reduction in prevalence (%)** | **Target prevalence (%)** |
| LBW (birth weight below 2,500 g) | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_% |
| Provide information on why the source was selected: | | | | | |
| Provide information on how and why the target was selected: | | | | | |
| Additional notes: | | | | | |

**Breastfeeding practices (during the 24 hours before the interview) among children 0–5 months of age**

Exclusive, predominant, partial, and no breastfeeding for infants 0–5 months are defined as follows.

* Exclusive breastfeeding refers to those who received only breast milk from his or her mother or a wet nurse, or expressed breast milk, and no other liquids or solids except vitamins, mineral supplements, or medicines in drop or syrup form.
* Predominant breastfeeding refers to those who received breast milk as the predominant source of nourishment during the previous day. Predominant breastfeeding allows oral rehydration salts, vitamin and/or mineral supplements, ritual fluids, water and water-based drinks, and fruit juice. Other liquids, including non-human milk and food-based fluids, are not allowed, and no semi-solid or solid foods are allowed.
* Partial breastfeeding refers to those who received breast milk as well as non-human milk, food-based fluids, and semi-solid and/or solid foods.
* No breastfeeding refers to those who did not receive any breast milk.

Indicators needed to calculate the suboptimal breastfeeding and mortality model for children 0-5 months of age are:

* Exclusive breastfeeding (0–5 months of age), %
* Predominant breastfeeding (0–5 months of age), %
* Partial breastfeeding (0–5 months of age), %
* No breastfeeding (0–5 months of age), %

An example of how to find the indicators necessary to generate PROFILES estimates is demonstrated through the use of the Tanzania 2010 Demographic and Health Survey (DHS). The Tanzania 2010 DHS divides breastfeeding status into the following categories:

* Exclusively breastfed
* Plain water only
* Non-milk liquids/juice
* Other milk
* Complementary foods

These groups are hierarchical and mutually exclusive, and their percentages add to 100%. Therefore, to obtain the percentage for “predominant breastfeeding,” within each age group in the report table, you would add the percentages for “plain water only” and “non-milk liquids/juice.” To obtain the percentage for “partial breastfeeding,” you would add the percentages for “other milk” and “complementary foods.”

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Indicator** | **Starting prevalence (%)** | **Data source** | **Table #/page in source** | **Targeted reduction in prevalence (%)** | | **Target prevalence (%)** |
| Early initiation of breastfeeding (within 1 hour of birth) | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | | \_\_\_\_\_\_% |
| Ever breastfed | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | | \_\_\_\_\_\_% |
| Never breastfed\* | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | | \_\_\_\_\_\_% |
|  | | | | | | |
| Exclusive breastfeeding  (0–5 months of age) | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | | \_\_\_\_\_\_% |
| Predominant breastfeeding  (0–5 months of age) | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | | \_\_\_\_\_\_% |
| Partial breastfeeding (0–5 months of age) | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | | \_\_\_\_\_\_% |
| No breastfeeding\* (0–5 months of age) | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | | \_\_\_\_\_\_% |
|  | | | | | | |
| Exclusive breastfeeding  (4–5 months of age) | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_% | |
| Provide information on why the source was selected: | | | | | | |
| Provide information on how and why the target was selected: | | | | | | |
| Additional notes: | | | | | | |

\*These indicators are calculated automatically by the PROFILES spreadsheet.

**Breastfeeding practices (during the 24 hours before the interview) among children 6–23 months of age**

Any breastfeeding and no breastfeeding for **children 6–23 months** are defined as follows:

* **No breastfeeding** refers to those who were not breastfed at the time of the survey (this comprises children who were no longer breastfed and those who were never breastfed).
* **Any breastfeeding** refers to all other children who were still breastfeed

Indicators needed to calculate the suboptimal breastfeeding and mortality model for children 6–23 months of age are:

* Any breastfeeding (6–23 months), %
* No breastfeeding (6–23 months), %

To calculate the percentage of children 6–23 months who were not breastfed or who were in the category “any breastfeeding”, you may need to do a weighted average if, for example, you are using a DHS as the source of information. For example, a table in the Zimbabwe 2010-2011 DHS (Table 11.3) report shows breastfeeding practices according to the following age groups: 6–8, 9–11, 12–17, and 18–23 months. To get the “no breastfeeding” prevalence among children 6–23 months, a weighted average must be calculated[[2]](#footnote-3). To do a weighted average, take the percentage for each age group and multiple it by the denominator (N) (total number of children) for that age group to obtain the numerator for the age group (age group % x N). Then add up the values (numerators) for the four age groups and then divide that number by the total N for the four age groups combined.

Using the information in the table below, the equation would be as follows: (326 x 0.035) + (321 x 0.065) + (586 x 0.174) + (377 x 0.703) = 399.

Then, this sum is divided by the total number of children 6–23 months to give you the weighted average and the percentage of children in this age group who are not breastfed: 399/1,610 = 0.248 or 24.8%.

To then determine the percentage of children 6–23 months with “any breastfeeding,” subtract the percentage of “no breastfeeding” infants from 100%, i.e., if 24.8% of infants are not breastfed, then “any breastfeeding” is 75.2%.

**Table Example Information for Calculating Weighted Average for Indicators on No/Any Breastfeeding at 6–23 Months**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **From a table in the source** | | | **Calculated** | | |
| **Age group**  **(months)**  **(a)** | **% not**  **breastfed**  **(b)** | **Number of children in the age group**  **(c)** | **Numerator (d)**  **d=c\*b** | **% not breastfed**  **6–23 months (e)**  **e=d\*100/c** | **% any breastfed**  **6–23 months (f)**  **f=100%-e** |
| 6–8 | 3.5% | 326 | =326\*3.5%=11 |  |  |
| 9–11 | 6.5% | 321 | =321\*6.5%=21 |  |  |
| 12–17 | 17.4% | 586 | =586\*17.4%=102 |  |  |
| 18–23 | 70.3% | 377 | =377\*70.3%=265 |  |  |
|  |  | ↓ sum of rows above (from source or calculated) | ↓ sum of rows above (calculated) |  |  |
| 6–23 |  | 1,610 | 399 | 399/1,610  =24.8% | 100%-24.8% =75.2% |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Indicator** | **Starting prevalence (%)** | **Data source** | **Table # page in source** | **Targeted reduction in prevalence (%)** | **Target prevalence (%)** |
| Any breastfeeding (6–23 months) | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_% |
| No breastfeeding (6–23 months)\* | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_% |
| Provide information on why the source was selected: | | | | | |
| Provide information on how and why the target was selected: | | | | | |
| Additional notes: | | | | | |

\*This indicator is calculated automatically by the PROFILES spreadsheet.

## Worksheet: Information Needed—Micronutrients (used in sessions 6, 10, and 11)

As a group, fill in the following information that is needed to calculate the PROFILES estimates.

**Anemia**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Indicator** | **Starting prevalence (%)** | **Data source** | **Table # page in source** | **Targeted reduction in prevalence (%)** | **Target prevalence (%)** |
| Pregnant women (15–49 years) (hemoglobin < 11 g/dl) | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_% |
| Adult women (15–49 years) (hemoglobin < 12 g/dl) | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_% |
| Adult men (15–49 years)\* (hemoglobin < 13 g/dl) | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_% |
| Children (6–59 months) (hemoglobin < 11 g/dl) | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_% |
| Children (5–14 years)\*\*  (hemoglobin < 12 g/dl) | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_% |
| Provide information on why the source was selected: | | | | | |
| Provide information on how and why the target was selected: | | | | | |
| Additional notes: | | | | | |

\*This exact age group does not have to be available as some countries have different age groups for anemia among men. In addition, this information may not be available in every country. If that is the case, skip this indicator.

\*\* Note if a percentage is not available for the entire age group (5-14 years), then the user may need to compute a weighted average that combines the prevalence of anemia for two separate groups to find the weighted average percentage for the entire group. An example of how to do a weighted average can be found above in Table 1.

**Vitamin A Deficiency (including subclinical)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Indicator** | **Starting prevalence (%)** | **Data source** | **Table #/page in source** | **Targeted reduction in prevalence (%)** | **Target prevalence (%)** |
| Children 6–59 months with vitamin A deficiency | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_% |
| Provide information on why the source was selected: | | | | | |
| Provide information on how and why the target was selected: | | | | | |
| Additional notes: | | | | | |

**Iodine Deficiency**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Indicator** | **Starting prevalence (%)** | **Data source** | **Table #/page in source** | **Targeted reduction in prevalence (%)** | **Target prevalence (%)** |
| % with goiter | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_% |
| Other information on iodine deficiency (if needed): | | | | | |
| Provide information on why the source was selected: | | | | | |
| Provide information on how and why the target was selected: | | | | | |
| Additional notes: | | | | | |

## Worksheet: Risk Factors of Stunting (used in sessions 6 and 12)

As a group, fill in the following information that is needed to calculate the PROFILES estimates.

**Inadequate dietary diversity**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Indicator** | **Starting prevalence of risk factor (%)** | **Data source** | **Table #/ page in source** | **Targeted reduction in prevalence of risk factor (%)** | **Target prevalence of risk factor (%)** |
| Inadequate dietary diversity (fewer than four foods groups) among children 6–23 months | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_% |
| Provide information on why the source was selected: | | | | | |
| Provide information on how and why the target was selected: | | | | | |
| Additional notes: | | | | | |

**Stunting Risk Factor Estimates – Teenage Pregnancy**

**Children born to teenage mothers (The model on increased risk for stunting among children born to teenage mothers).**

One of the models on risk factors for stunting requires information on the proportion of children who are born to teenage mothers among all births born during a time period. Possible sources of this include DHS surveys and the UN WPP database.

If the report from a DHS survey is used as the source, this information can usually be derived from a table called “Assistance during delivery” (or something similar); that table shows information by various background characteristics, including “Mother’s age at birth” (the categories are generally: <20, 20–34, and 35–49 years). For example, in the report for the Zambia DHS 2013–2014, the table shows the “percent distribution of live births in the five years preceding the survey by person providing assistance during delivery, percentage of births assisted by a skilled provider, and percentage delivered by caesarean section, according to background characteristics.” In this survey, 2,480 children were born to mothers who were teenagers (<20 years); the table also shows that the total number of births was 13,383. Hence, among all the births, 18.5 percent (2,480/13,383) were born to teenage mothers.

If the information necessary to calculate the percentage of births born to teenage mothers is not available from a DHS survey, the UN WPP database can be used (<https://esa.un.org/unpd/wpp> – accessed March 12, 2018). The following description indicates how to use the UN WPP to access this information and reflects the structure and wording on the UN WPP website at present (March 2018):

1. Click on “Download Data Files.”
2. Then, under “Major topic/Special groupings,” click on “Fertility indicators.” Download the Excel file named “Births by Age of Mother.”
3. After opening the file, notice that the sheet named “Estimates” shows estimates for 5-year groupings from “1950–1955” through “2010–2015.” Future projections are shown in four separate sheets, each reflecting a different assumption regarding the fertility variant. Each of these sheets shows projections from “2015–2020” through “2095–2100.” The sheets in this file show estimates of the number of births by mother’s age in 5-year age groups, from “15–19” through “45–49.”
4. To obtain the percentage born to teenage mothers (this is labeled as 15–19 years in this data source), first find the country and identify the 5-year time period that encompasses the first year of the PROFILES time period.
5. Next, calculate the sum of births across all the age groups.
6. Then find the number of births to teenage mothers (15-19 years).
7. Finally, to find the percentage among all births that are born to teenage mothers, divide the number of births to teenage mothers by the sum of births across all the age groups.

**Teenage Pregnancy**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Indicator** | **Starting prevalence of risk factor (%)** | **Data source** | **Table #/page in source** | **Targeted reduction in prevalence of risk factor (%)** | **Target prevalence of risk factor (%)** |
| Proportion of children born to a mother less than 20 years of age (%) | \_\_\_\_\_\_% | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_% | \_\_\_\_\_\_% |
| Provide information on why the source was selected: | | | | | |
| Provide information on how and why the target was selected: | | | | | |
| Additional notes: | | | | | |

## Worksheet: Demographic and Other Information Needed (used in sessions 8, 10, and 11)

Fill in the following information that was assigned to your group.

|  |  |  |  |
| --- | --- | --- | --- |
| **Population Information** | | | |
| **Total population** (most recent official estimate/projection) | **Data source** | **Table number/page in source** |
| \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Rationale for choosing source of information: | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Mortality Information** | | | |
| **Indicator** | **Ratio/Rate** | **Data source** | **Table number/ page in source** |
| Maternal mortality ratio | \_\_\_\_\_\_ deaths/100,000 live births | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Perinatal mortality rate | \_\_\_\_\_\_ deaths/1,000 births | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Neonatal mortality rate | \_\_\_\_\_\_ deaths/1,000 births | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Infant mortality rate | \_\_\_\_\_\_ deaths/1,000 births | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Under-5 mortality rate | \_\_\_\_\_\_ deaths/1,000 births | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Rationale for choosing source(s) of information: | | | |

**Additional Information on How to Calculate Manual Labor**

PROFILES requires several indicators on manual labor to generate the economic productivity estimates. These indicators include:

* Number of males and females employed in manual labor X 100/number of males and females of working age, %
* Number of females employed in manual labor X 100/ number of females of working age, %
* Number of males employed in manual labor X 100/number of males of working age, %
* Proportion of manual labor that is “heavy” (approximately 10% is often used), %

In most countries, there is no singular manual labor indicator available and therefore it must be calculated using categories of employment. Typically, Labor Force Surveys (or other surveys containing employment information) contain tables with categories of multiple types of employment (e.g., agriculture, mining, domestic services). An example is shown in the table on the next page.

The table (showing employment by industry), from a 2006 Tanzania Labor Force Survey, is an example of the types of categories that have been used to calculate manual labor in previous PROFILES workshops. The table below shows the percent of males and females employed by industry category among persons who are working. During a PROFILES workshop in Tanzania, the group reviewed and discussed labor categories similar to those listed in the table; in the Tanzania workshop, special tabulations had been provided to workshop participants by the National Bureau of Statistics. The yellow highlighted employment categories in Table 2 were determined to be manual labor jobs. The group then added the percentage of each labor category (highlighted in yellow) for males and females to get the total percentage of manual labor by gender, and for both males and females combined. As shown in the red circles in the table, the totals were 77.2% for males, 86.3% for females, and 81.9% for both combined. Note, this is just an example as PROFILES workshop participants will need to discuss the available categories of employment in their country-specific employment information source and agree upon what should be counted as manual labor.

In order to arrive at the indicators required by the *PROFILES Spreadsheet Workbook*, the percentages for manual labor shown in the table below would need to be multiplied by the employment-to-population ratio[[3]](#footnote-4) (referred to as the “employment ratio” in the 2006 survey) for males (80.8%), females (77.6%), and both combined (79.2%). Hence among the working age population the percentage are:

* Males and females employed in manual labor: 64.9%
* Females employed in manual labor: 67.0%
* Males employed in manual labor: 62.4%

**Table Example Information from the 2006 Tanzania Labor Force Survey Used to Calculate Manual Labor**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Percentage among | | |  | Percentage among | | |
| Labor Force Survey 2006 | employed/working persons: | | | | employed/working persons: | | |
|  | Male | Female | Total |  | Male | Female | Total |
| Agriculture/ hunting/ forestry | 70.6 | 79.7 | 75.3 |  | 70.6 | 79.7 | 75.3 |
| Fishing | 2.1 | 0.3 | 1.2 |  | 2.1 | 0.3 | 1.2 |
| Mining & quarry | 0.9 | 0.1 | 0.5 |  | 0.9 | 0.1 | 0.5 |
| Manufacturing | 3.4 | 1.9 | 2.6 |  |  |  |  |
| Electricity, gas & water | 0.2 | 0 | 0.1 |  |  |  |  |
| Construction | 2.1 | 0.1 | 1.1 |  | 2.1 | 0.1 | 1.1 |
| Wholesale & retail trade | 9.3 | 6.1 | 7.6 |  |  |  |  |
| Hotels & restaurants | 1.1 | 2.8 | 2 |  |  |  |  |
| Transport/storage & communication | 2.9 | 0.2 | 1.5 |  |  |  |  |
| Financial intermediation | 0.1 | 0.1 | 0.1 |  |  |  |  |
| Real estate/renting & business activities | 0.8 | 0.1 | 0.5 |  |  |  |  |
| Public admin & defense | 1.9 | 0.3 | 1.1 |  |  |  |  |
| Education | 1.6 | 1.2 | 1.4 |  |  |  |  |
| Health & social service | 0.5 | 0.7 | 0.6 |  |  |  |  |
| Other community/social & personal service activities | 1 | 0.4 | 0.7 |  |  |  |  |
| Private households with employed persons | 1.5 | 6.1 | 3.8 | 1 | 1.5 | 6.1 | 3.8 |
| Total | 100 | 100 | 100 |  |  |  |  |
| Manual labor (sum yellow categories) among employed |  |  |  |  | 77.2 | 86.3 | 81.9 |

This example used information from a labor force survey; other potential sources of information include other types of national surveys (if they include labor statistics) or possibly some international sources such as international labour.org (ILO) or Food and Agriculture Organization of the United Nations (FAO) databases.

|  |  |  |  |
| --- | --- | --- | --- |
| **Employment Information** | | | |
| **Indicator** | **Percentage** | **Data source** | **Table number/ page in source** |
| ***Employment in all sectors*** | | | |
| Employed[[4]](#footnote-5)/population (referred to as economic activity rate or labor force participation rate) | \_\_\_\_\_\_ % | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| ***Employment in manual labor*\*** | | | |
| Number of males and females employed in manual labor X 100/number of males and females of working age, % | \_\_\_\_\_\_ % | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Number of females employed in manual labor X 100/ number of females of working age | \_\_\_\_\_\_ % | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Number of males employed in manual labor X 100/number of males of working age | \_\_\_\_\_\_ % | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Proportion of manual labor that is “heavy” (approximately 10% is often used) | \_\_\_\_\_\_ % | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Rationale for choosing source(s) of information: | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Economic Information** | | | |
| **Indicator** | **Data** | **Data source** | **Table number/ page in source** |
| ***Average annual wage (in national currency)*** | | | |
| Manual labor | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| All sectors | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| ***Exchange rate*** | | | |
| Exchange rate (per US$1) | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| ***Gross domestic product (GDP)*** | | | |
| GDP per capita | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Rationale for choosing source(s) of information: | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Education Information** | | | |
| **Indicator** | **Data** | **Data source** | **Table number/ page in source** |
| Primary school starting age (in years) | \_\_\_\_ years | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Number of years of school (duration of schooling according to education policy)\* | \_\_\_\_ years | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Rationale for choosing source(s) of information: | | | |

\* This could include secondary education if it is recommended in the country-specific education policy. If a country does not have a goal/expectation that all children complete primary school, or if there is no education policy available, use the recommended number of years of primary school based on universal recommendations by the Organization for Economic Cooperation and Development, the European Union, and UNESCO Institute for Statistics in the *International Standard Classification of Education (ISCED)* *2011*, which is 6 years of primary school.

# Template: Nutrition Advocacy Plan

|  |  |
| --- | --- |
| **Problem** |  |
| **Changes the Problem Calls for** |  |
| **Final Audience Segmentation** | People most affected by malnutrition: |
| People who directly influence those most affected by malnutrition: |
| People who indirectly influence people most affected by malnutrition: |
| **Strategic Approach/ Framing** |  |

**Advocacy Audiences**

**Note: The number of advocacy audiences below will depend on the country context and priorities set during the nutrition advocacy planning workshop.**

| **Audience #1:** | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Desired Changes** | |  | | | | | | |
| **Key Barriers** | |  | | | | | | |
| **Advocacy Intent** | |  | | | | | | |
| **Implementation Matrix** | | | | | | | |
| **Indicators** |  | | | |  | | |
| **Means of Verification** |  | | | |  | | |
| **ACTIVITY** | | | **MATERIALS TO SUPPORT ACTIVITIES** | **TIMELINE** | | **PROPOSED RESPONSIBLE ORGANIZATIONS** | **POSSIBLE SUPPORTING ORGANIZATIONS** |
|  | | |  |  | |  |  |
|  | | |  |  | |  |  |
|  | | |  |  | |  |  |

| **Audience #2:** | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Desired Changes** |  | | | | | | |
| **Key Barriers** |  | | | | | | |
| **Advocacy Intent** |  | | | | | | |
| **Implementation Matrix** | | | | | | |
| **Indicators:** |  | | |  | | |
| **Means of Verification** |  | | |  | | |
| **ACTIVITY** | | **MATERIALS TO SUPPORT ACTIVITIES** | **TIMELINE** | | **PROPOSED RESPONSIBLE ORGANIZATIONS** | **POSSIBLE SUPPORTING ORGANIZATIONS** |
|  | |  |  | |  |  |
|  | |  |  | |  |  |
|  | |  |  | |  |  |

| **Audience #3:** | |
| --- | --- |
| **Desired Changes** |  |
| **Key Barriers** |  |
| **Advocacy Intent** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Implementation Matrix** | | | | | |
| **Indicators:** |  | | |  | |
| **Means of Verification:** |  | | |  | |
| **ACTIVITY** | | **MATERIALS TO SUPPORT ACTIVITIES** | **TIMELINE** | **PROPOSED RESPONSIBLE ORGANIZATIONS** | **POSSIBLE SUPPORTING ORGANIZATIONS** |
|  | |  |  |  |  |
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| **Audience #4:** | | | | | | | |
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| **Desired Changes** |  | | | | | | |
| **Key Barriers** |  | | | | | | |
| **Advocacy Intent** |  | | | | | | |
| **Implementation Matrix** | | | | | | | |
| **Indicators** | |  | | |  | | |
| **Means of Verification** | |  | | |  | | |
| **ACTIVITY** | | | **MATERIALS TO SUPPORT ACTIVITIES** | **TIMELINE** | | **PROPOSED RESPONSIBLE ORGANIZATIONS** | **POSSIBLE SUPPORTING ORGANIZATIONS** |
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| **Audience #5:** | | | | | | | |
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| **Desired Changes** |  | | | | | | |
| **Key Barriers** |  | | | | | | |
| **Advocacy Intent** |  | | | | | | |
| **Implementation Matrix** | | | | | | | |
| **Indicators:** | |  | | |  | | |
| **Means of Verification** | |  | | |  | | |
| **ACTIVITY** | | | **MATERIALS TO SUPPORT ACTIVITIES** | **TIMELINE** | | **PROPOSED RESPONSIBLE ORGANIZATIONS** | **POSSIBLE SUPPORTING ORGANIZATIONS** |
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| **Audience #6:** | | | | | | | |
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| **Desired Changes** |  | | | | | | |
| **Key Barriers** |  | | | | | | |
| **Advocacy Intent** |  | | | | | | |
| **Implementation Matrix** | | | | | | | |
| **Indicators** | |  | | |  | | |
| **Means of Verification** | |  | | |  | | |
| **ACTIVITY** | | | **MATERIALS TO SUPPORT ACTIVITIES** | **TIMELINE** | | **PROPOSED RESPONSIBLE ORGANIZATIONS** | **POSSIBLE SUPPORTING ORGANIZATIONS** |
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| **Audience #7:** | | | | | | | | |
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| **Desired Changes** |  | | | | | | | |
| **Key Barriers** |  | | | | | | | |
| **Advocacy Intent** |  | | | | | | | |
| **Implementation Matrix** | | | | | | | |
| **Indicators** | |  | | |  | | |
| **Means of Verification** | |  | | |  | | |
| **ACTIVITY** | | | **MATERIALS TO SUPPORT ACTIVITIES** | **TIMELINE** | | **PROPOSED RESPONSIBLE ORGANIZATIONS** | **POSSIBLE SUPPORTING ORGANIZATIONS** |
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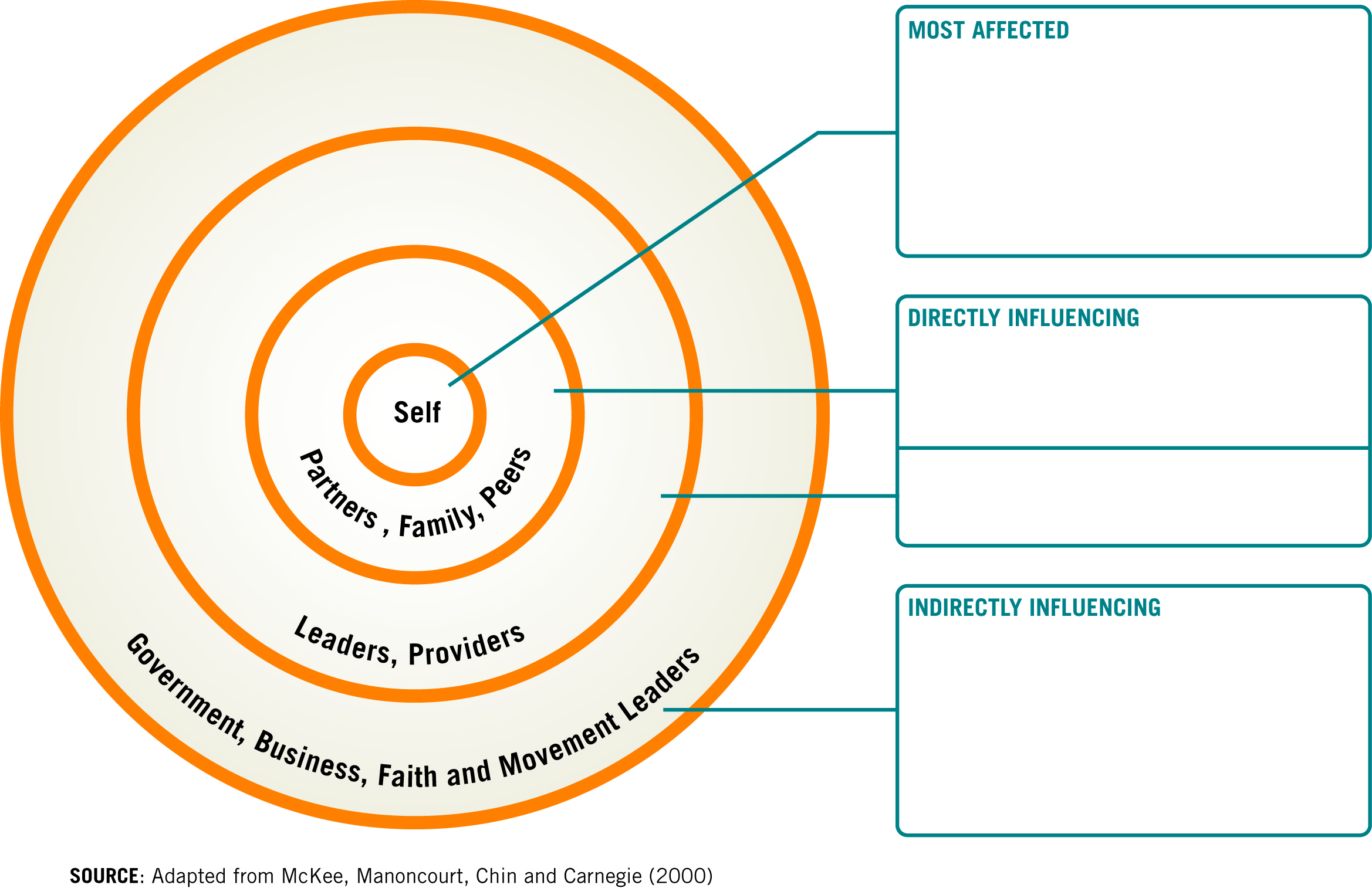
# Template: Agenda for the Nutrition Advocacy Planning Workshop

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| **DAY ONE** | | |
| **Time** | **Session** |
| 8:30–8:45 am | Welcoming Remarks |
| 8:45–9:30 am | Session 1: Purpose of the Workshop—Why Advocacy and Why Now?  Review of Agenda |
| 9:30–10:00 am | Session 2: The Nutrition Situation in [insert country] |
| 10:00–11:00 am | Session 3: Review of Existing Advocacy Activities and Materials |
| 11:00–11:15 am | Break |
| 11:15–11:45 am | Session 4: Components of a Nutrition Advocacy Plan  Review of the Problem and Possible Solutions |
| 11:45 am–12:30 pm | Session 5: Summary of PROFILES Estimates |
| 12:30–1:00 pm | Session 6: Audience Analysis and Segmentation Using the Socio-Ecological Model |
| 1:00–2:00 pm | Lunch |
| 2:00–3:00 pm | Session 6 Continues: Audience Analysis and Segmentation Using the Socio-Ecological Model |
| 3:00–3:30 pm | Session 7: Context Analysis |
| 3:30–3:45 pm | Break |
| 3:45–5:20 pm | Session 8: Desired Changes, Barriers, and Advocacy Intent for Each Audience |
| 5:20–5:30 pm | Wrap-Up and Closing |

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| **DAY TWO** | |
| **Time** | **Session** |
| 8:30–9:00 am | Recap of Day One |
| 9:00–10:00 am | Session 9: Discussion of Desired Changes, Barriers, and Advocacy Intent for Each Audience |
| 10:00–10:30 am | Session 10: Revision of Desired Changes, Barriers, and Advocacy Intent for Each Audience |
| 10:30–10:45 am | Break |
| 10:45–11:45 am | Session 11: Advocacy Activities and Materials for Each Audience |
| 11:45 am–1:00 pm | Session 12: Discussion of Advocacy Activities and Materials for Each Audience |
| 1:00– 2:00 pm | Lunch |
| 2:00–2:30 pm | Session 13: Revision of Advocacy Activities and Materials for Each Audience |
| 2:30–3:30 pm | Session 14: Indicators and Means of Verification for Each Audience |
| 3:30–3:45 pm | Break |
| 3:45–5:20 pm | Session 15: Discussion of Indicators and Means of Verification for Each Audience |
| 5:20–5:30 pm | Wrap-Up and Closing |

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| **DAY THREE** | | | |
| **Time** | **Session** |
| 8:30–9:00 am | Recap of Day Two |
| 9:00–9:30 am | Session 16: Revision of Indicators and Means of Verification for Each Audience |
| 9:30–10:30 am | Session 17: Timeline and Responsible/Supporting Organizations for Each Audience |
| 10:30–10:45 am | Break |
| 10:45 am–12:30 pm | Session 18: Discussion of Timeline and Responsible/Supporting Organizations for Each Audience |
| 12:30–1:00 pm | Session 19: Revision of Timeline and Responsible/Supporting Organizations for Each Audience |
| 1:00–2:00 pm | Lunch |
| 2:00–3:30 pm | Session 20: Introduction to Material Planning Tool and Review of Draft Material |
| 3:30–3:45 pm | Break |
| 3:45–5:20 pm | Session 21: Discussion and Revision of Draft Material |
| 5:20–5:30 pm | Wrap-Up and Closing |
| **DAY FOUR** | | |
| **Time** | **Session** |
| 8:30–10:30 am | Session 22: Review of the Completed Nutrition Advocacy Plan |
| 10:30–10:45 am | Break |
| 10:45 am–12:00 pm | Session 23: Material Planning Tool—Key Promise, Support Statement, and Call to Action |
| 12:00–1:00 pm | Session 24: Material Planning Tool—Discussion of Key Promise, Support Statement, and Call to Action |
| 1:00–2:00 pm | Lunch |
| 2:00–2:30 pm | Session 25: Material Planning Tool—Revision of Key Promise, Support Statement, and Call to Action |
| 2:30–3:30 pm | Session 26: Material Planning Tool—Key Content (Detailed Outline of Document) and How it Fits the Mix/Creative Considerations |
| 3:30–3:45 pm | Break |
| 3:45–4:45 pm | Session 27: Material Planning Tool—Discussion of Key Content (Detailed Outline of Document) and How it Fits the Mix/Creative Considerations |
| 4:45–5:15 pm | Session 28: Material Planning Tool—Revision of Key Content (Detailed Outline of Document) and How it Fits the Mix/Creative Considerations |
| 5:15–5:30 pm | Closing and the Way Forward |

# Template: Audience Analysis Worksheet



**Directions:**

* In the **center** are individuals (**self)**. Identify the members of this group by asking, “Who are the people most affected by the issue?”
* In the next ring are the **partners, family, and peers** of self. Identify the members of this ring by asking, “Who are the people who have contact with the individuals in the center ring and directly influence them?”
* In the next ring are the **leaders and providers,** Identify the members of this ring by asking: “Who in the community allows certain activities?” and “Who controls resources?” and “Who controls access to, the demand for, and the quality of health and nutrition services and products?”
* In the outermost “environmental”ring arethe **government, business, faith and movement leaders**. Identify the members of this ring by asking, “Who indirectly influences the individuals in the center?”

Template: Material Planning Tool

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|  | **Illustrative Examples** |
| 1. Audience |  |
| Who is the target of this material? | Policymakers and parliamentarians |
| 2. Desired Changes |  |
| What do you want the audience to change—perceptions, knowledge, feelings, topics of discussion, skills, or actions—after experiencing your communication? | * Draft and enact a policy on the fortification of micronutrients, including vitamin A, iron, and zinc * Enact a policy on code of marketing for breast milk substitutes * Draft and enact a policy on maternity protection, including the extension of maternity leave for 6 months and the provision of paternity leave * Increase resource allocation for nutrition programs |
| 3. Obstacles and Barriers |  |
| * Why are people not doing what they should be doing? (Would they change their behavior if they had more knowledge? Or is something else missing that prevents them from changing?) * Select one key barrier. | Inadequate awareness of the magnitude of the nutrition problem and the investment needed for nutrition |
| 4. Advocacy Intent |  |
| How will the advocacy communication address the key barrier? | By the end of 2016, policymakers and parliamentarians will have a greater understanding of the benefits of improving nutrition, which will result in a greater allocation of resources and increased commitment to policies that improve nutrition. |
| 5. Message Brief |  |
| Includes instructions for the design and development of the messages (by writers, designers, and producers) |  |
| **a.** The **key promise** is the most compelling benefit of taking the desired action. The key promise should:   * Represent a subjective experience in your audience’s mind * Promise a reward in the (near) future * Be truthful and relevant to your audience | Investment in nutrition and commitment to policies that improve nutrition will result in a healthier and better educated constituency, leading to economic productivity gains for the country. |
| **b.** The **support statement** convinces the audience they will actually experience the benefit. It should provide reasons why the key promise outweighs the key constraint (barriers). The support statement often becomes the message. | Commitment to policies that promote micronutrient food fortification, restrict marketing of breast milk substitutes, and provide an enabling environment for women to exclusively breastfeed will decrease chronic malnutrition in the country and save the lives of mothers and children. |
| **c.** A **call to action** should tell your audience what you want them to do or where to go to use the new product. | Invest in programs, enforce existing laws, and enact policies that improve nutrition. |
| 6. Key Content |  |
| Outline the material’s content and include sources of information for each section |  |
| Nutrition situation | * Prevalence of stunting, wasting, and micronutrient deficiencies [Source: Demographic and Health Survey (DHS)] * Malnutrition’s impact on health, education, and economic development [Source: PROFILES and Cost of Hunger in Africa (COHA)] |
| Policies to provide an enabling environment for nutrition | * Micronutrient food fortification policy and benefits * Code of marketing for breast milk substitutes policy and benefits * Maternity protection (maternity leave and paternity leave) policy and benefits |
| Proven solutions to improve nutrition [Source: Scaling Up Nutrition (SUN)] | * Interventions focused on prevention of malnutrition |
| Benefit to the country (Source: PROFILES and COHA) | * Improved health * Improved education * Economic productivity gains |
| Call to action | * Enact policies and enforce existing laws on food fortification, code of marketing for breast milk substitutes, and maternity protection * Invest more resources in the prevention of malnutrition |
| 7. How It Fits the Mix and Creative Considerations |  |
| * How does this material or activity relate to other materials or activities you are creating? * What else might be important to keep in mind when creating, producing, or distributing this communication product? * Will the material be presented in more than one language? What is the literacy level of your audience? Is there anything particular regarding style, layout, or visuals? What logos need to be used? How will the material be branded? | The fact sheet will be used in one-on-one meetings and during advocacy workshops with policymakers and parliamentarians. It will be used in conjunction with a multi-media presentation. The language for the fact sheet will be English and the literacy level is high for the target audience. The material will be branded with the government and partner logos. |

1. This session is optional if a stakeholder meeting is held, since the time period may have been discussed and decided upon during the stakeholder meeting. [↑](#footnote-ref-2)
2. The example uses the column showing the percentage “not breastfeeding” because this information is commonly available, although in the Zimbabwe DHS report there is also a column showing the percentage who are “currently breastfeeding.” [↑](#footnote-ref-3)
3. Although the employment-to-population ratio is not required in the spreadsheet, this indicator might be needed for some calculations to arrive at information required by the spreadsheet, as is the case in this example. [↑](#footnote-ref-4)
4. This rate includes people who are available for work as well as those who are actually working. [↑](#footnote-ref-5)