Sweden
Sverige

ACTION AGAINST HUNGER

MANAGEMENT OF ACUTE MALNUTRITION AND ANTICIPATORY ACTIONS PROTOCOLS

AN INTEGRATED APPROACH

METHODOLOGICAL NOTE

ACRONYM TABLE

AA	Anticipatory Action
AAWG	Anticipatory Action Working Group
ACF	Action Against Hunger
CPSS	Community Prevention Support Structures
DRM	Disaster Risk Management
EWS	Early Warning System
FG	Focus Group
H&N	Health and Nutrition
LRDMC	Local Risk and Disaster Management Committee
MAM	Management of Acute Malnutrition
MEAL	Monitoring, Evaluation, Accountability, Learning
PCVA	Participatory Capacity and Vulnerability Survey
PBFW	Pregnant and/or breastfeeding women
SOP	Standard Operating Procedure
SIDA	Swedish International Development Agency
ToR	Terms of Reference
WHH	Welthungerhilfe

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EXECUTIVE SUMMARY

In 2025, Action contre la Faim (ACF) developed and tested a rapid methodology with the support of its partner 'Swedish International Development Agency' (SIDA) aimed at integrating the Management of Acute Malnutrition (MAM) into Anticipatory Action (AA) protocols in Mali and Madagascar. This approach addresses a problem that has been identified in many humanitarian contexts: national and sectoral AA frameworks, although increasingly widespread, remain insufficiently attuned to nutritional issues.

Natural disasters and man-made crises have an immediate impact on food security, health and access to health-care. In areas where acute malnutrition rates are already high, these disruptions lead to a rapid deterioration in nutritional status, exacerbated by breakdowns in MAM services. Integrating nutrition into AA helps to ensure continuity of care, bolster community capacity and prevent avoidable deteriorations before the onset of a shock.

This methodological note presents operational approach, based on field experience, for integrating MAM components into an AA protocol focused on an external hazard (flood, drought, cyclone, man-made shock). It proposes:

1/ **Criteria for identifying contexts that are conducive to this integration;**

2/ **Tools for collecting and analysing primary and secondary data;**

3/ **Frameworks for conducting participatory workshops and formulating recommendations;**

4/ **Guidelines for implementing and monitoring the actions identified.**

This document is particularly aimed at operational and technical managers, with DRM or health & nutrition profiles, from civil society or the authorities. It aims to support the revision and creation of AA protocols incorporating MAM components. It can be useful both for capital-based teams involved in national AA working groups and protocols, and for sub-regional teams responsible for implementation and data collection in the field.

This note does not replace sectoral or global AA manuals; **it is a specialised complement to them, designed to reinforce the nutritional sensitivity of AA protocols and improve the resilience of communities to shocks**. *The list below presents main resources about AA. It is not exhaustive; we invite you to consult the Anticipation Hub website for general and specific resources (risks, sector).*

TRAINING MODULE	Short AA awareness module – ACF Full AA training module from the Asia-Pacific working group ANTICIPATION HUB online training module Localised gender-sensitive Anticipatory Action - CARE
MANUALS	Prediction-based financing handbook - RC/RC Step-by-step guide to identifying and developing anticipatory action - WHH
PLATFORMS AND TOOLS	Anticipation Hub Anticipatory Action - OCHA Handbooks, guides and guidance notes - Start Fund Network

INTRODUCTION

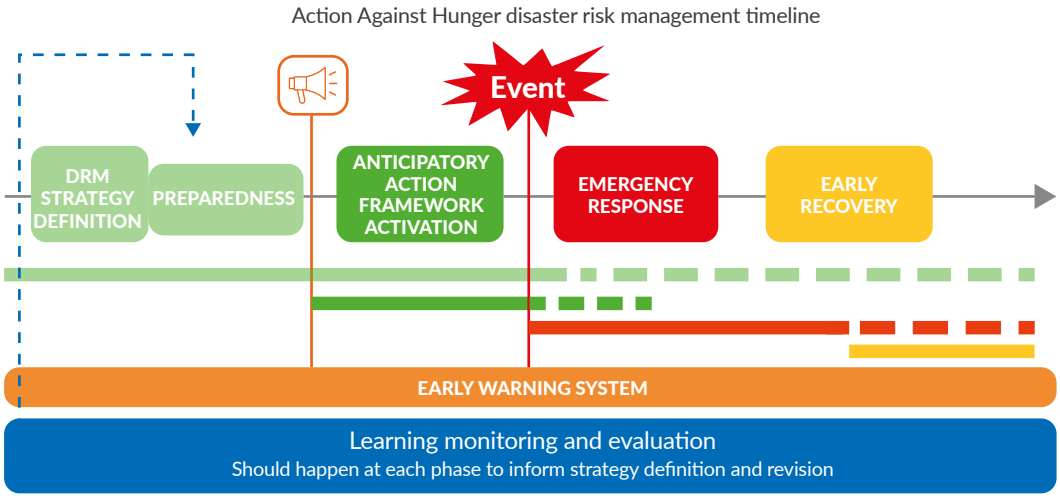
ANTICIPATORY ACTION (AA AND ITS GENERAL FRAMEWORK)

Disaster Risk Management (DRM) encompasses all strategies aimed at: preventing the occurrence of new shocks (Disaster Risk Reduction), reducing the impact of existing risks (Anticipatory Action and Preparedness), responding to the needs created by residual risks (Preparedness and Response) and strengthening the resilience of communities at risk[1].

In this context, anticipatory action (AA) is a proactive DRM approach designed to be implemented ahead of foreseen dangerous events in order to mitigate or limit their humanitarian impact. AA is characterised by the presence of three markers specific to its nature and implementation. Thus an AA mechanism systematically incorporates[1] :

- Predefined alerts and trigger thresholds;
- Predefined rapid actions to implement when the alert is activated;
- A predefined budget and pre-acquired sources of funding for implementation.

Figure 1. the diagram below describes how AA is integrated into ACF's DRM cycle[2]



1 REAP, P. CLARK, Glossary of Early Action Terms, 2022
2 Extract from the AA Position Paper - ACF France

AA is not a specific sector but a means of taking operational action. AA can be multi-sector (recommended) or sector-specific, depending on the mandate and expertise of the stakeholders when the plan is designed with communities to complement existing DRM mechanisms. Action Against Hunger has developed solid expertise in this field, and formalised a position paper that defines its anticipation intervention framework in 2024.

For further details on the distinctions between Disaster Risk Reduction, Preparedness and Anticipatory Action – distinctions based primarily on the timing of the measures in relation to a shock – additional resources are listed in the executive summary section of this note.

WHY INCLUDE MAM IN ANTICIPATORY ACTION?

Natural, climatic or man-made shocks (slow or quick)[3] have a rapid and profound impact on food security, livelihoods and access to essential services. In many already fragile contexts, these disruptions lead to an immediate increase in nutritional risks, particularly among children under five years old and pregnant and/or breastfeeding women.[4]

Three fundamental phenomena justify systematically integrating nutrition into AA protocols:

1/ Shocks rapidly increase nutritional vulnerability:
Disruption of food chains, reduced food diversity, rising prices, animal mortality, crop destruction: all of these factors lead to a sudden reduction in access to essential nutrients. In already vulnerable populations, the consequences can appear in a matter of days.

2/ The health and MAM systems suffer critical interruptions:
Shocks frequently lead to:
- La rupture des consultations et dépistage;
- Breaks in consultations and screening;
- Weakened healthcare structures;
- The interruption of essential treatments;
- Difficult access to service points.

These breakdowns contribute to a rapid deterioration in nutritional status and can compromise months of prevention and care efforts.

3/ Current AA frameworks are still insufficiently attuned to nutrition:
National and sector-specific AA protocols often focus on general risks (rainfall, agriculture, flooding, drought) and still rarely take the continuity of nutritional care or the specific needs of vulnerable populations into account.

3 A 'slow' shock is one whose impact is felt several months after it occurs (e.g. the real effects of a drought are not felt until several months after the harvest). A 'quick' shock, on the other hand, will have direct consequences on the population (e.g. a cyclone can cause communities to lose all their possessions within the space of an hour).

4 It is not currently possible to conduct AA on the risk of earthquakes due to a lack of predictive capabilities. For 'diffuse' conflict risks that are not linked to a specific timetable (e.g. elections), the approach has been tested with some success by stakeholders in Central Africa, but this requires a longer implementation period and more advanced expertise.

Systematically incorporating MAM into AA protocols makes it possible to:

- Anticipate nutritional needs before a shock;
- Maintain continuity of care;
- Strengthen protective community practices;
- Limit avoidable deterioration in nutritional status;
- Improve the resilience of communities in the face of repeated crisis impacts.

There are two integration options:

a) Integrate MAM into AA protocols focused on an external hazard (flood, cyclone, drought).
b) Treat malnutrition as a major hazard, with its own warning mechanisms and thresholds.

This methodological note deals exclusively with case a), i.e. integrating MAM into an existing AA protocol or one that is being designed for a natural or man-made hazard. It does not cover approaches that focus on malnutrition as the main risk b), which require specific warning systems.

PURPOSE, SCOPE AND COMPLEMENTARITY OF THIS METHODOLOGY NOTE

This note has been designed to complement the existing literature on Anticipatory Action, its framework and its implementation, while providing humanitarian stakeholders with a clear operational methodology for integrating the Management of Acute Malnutrition (MAM) into AA protocols (existing or in creation).

It is based on the approach developed and tested by ACF and its partners in 2025 in Mali and Madagascar and summarises the tools, stages and recommendations. It aims to guide:

- National and local government stakeholders;
- NGOs and civil society organisations;
- AA, DRM, and Health & Nutrition working groups;
- The ACF teams involved in designing or revising AA protocols.

The note describes the tools recommended by ACF for taking MAM and related healthcare into account in an AA protocol, either one that already exists or one that is in the process of being created, in anticipation of a natural or man-made risk. **The proposed elements and tools of this note include:**

- **Criteria for identifying a context that is conducive to integrating MAM**
- **The primary and secondary data collection tools and methods needed to integrate MAM into AA protocols**
- **Advice and reference frameworks for analysing and summarising results**
- **The organisation of feedback workshops and the formulation of recommendations, as well as presentation materials**
- **Recommendations for follow-up action and integration into existing AA frameworks**

Finally, this note proposes a specialised methodology for ensuring AA frameworks are more attuned to nutrition, while remaining compatible with global practices and standards.

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FEASIBILITY & DESCRIPTION OF THE APPROACH

OBJECTIVE AND GUIDING PRINCIPLES

The aim of this methodological approach is to provide a quick, operational and reproducible process for integrating MAM components into an Anticipatory Action (AA) protocol focused on an external hazard. Developed and tested in Mali and Madagascar in 2025, it can be implemented over a short period (two to six weeks) by a small team, in close coordination with the authorities and the AA and Health & Nutrition working groups.

This approach makes it possible to:

- Analyse the nutritional risks associated with an anticipated shock;
- Understand how this shock affects MAM and community access to care;
- Identify realistic, feasible and appropriate anticipated action;
- Integrate it effectively into existing or emerging AA protocols.

It is based on eight successive steps, from the identification of the targeted AA protocol to the dissemination of results and capacity building. Its effectiveness is down to the use of lightweight tools, mixed data collection (secondary + primary), multi-actor cross-referenced analysis and institutional validation, making it possible to obtain, within a few weeks, a consolidated view of nutritional risks and the capacity of the MAM system to absorb an anticipated shock.

This approach focuses on:

- The simplicity of the tools used;
- The active involvement of local stakeholders;
- Joint multi-sector analysis of Nutrition–DRM–Health;
- Systematic integration into existing national frameworks;
- The creation of operational recommendations that can be directly integrated into AA Standard Operating Procedures (SOPs).

PROFILES AND SKILLS REQUIRED FOR IMPLEMENTATION

Two technical profiles are recommended to steer the approach as a standard minimum:

- **A Health & Nutrition (H&N) specialist:** Knowledge of MAM, what determines malnutrition, the supply circuits of nutritional inputs and management systems (their operational capacities and constraints);
- **A Disaster Risk Management (DRM) specialist:** Expertise in national AA protocols, national warning systems, hazard modelling and multi-sector integration.

Additional skills required for the approach:

- Workshop facilitation skills;
- Qualitative and quantitative analysis
- Local knowledge (or local support)
- Corporate communication.

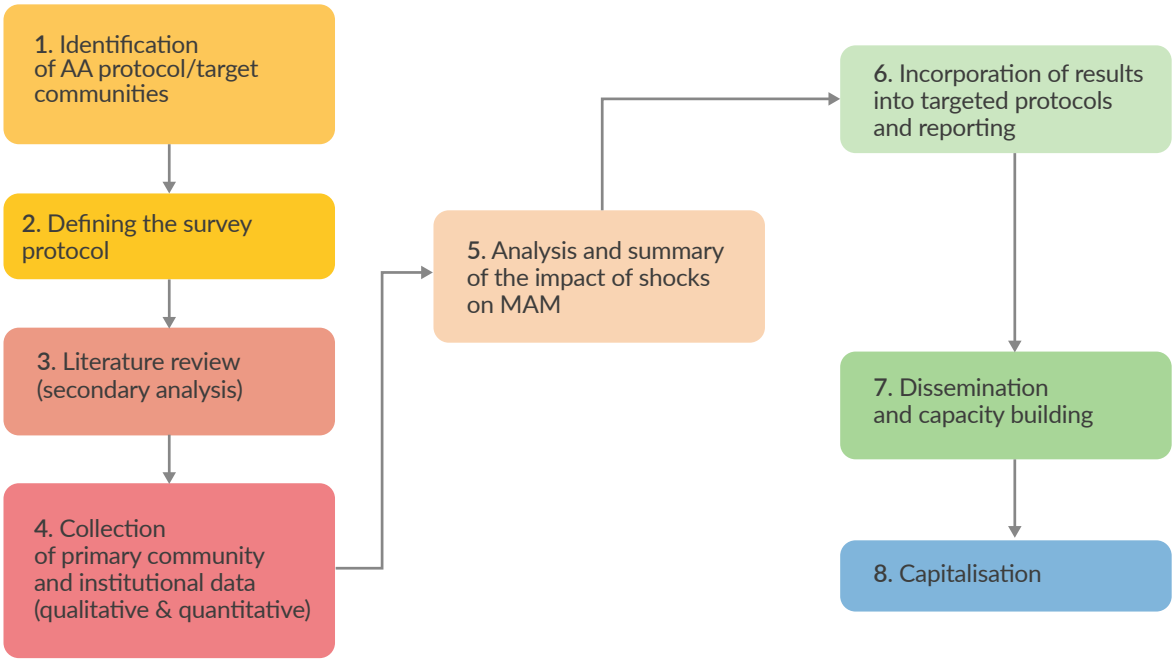
NB : The systematic participation of focal points (governmental/Health Ministry, working groups/AA structures, clusters/ health or nutrition coordination groups) is strongly recommended for institutional accountability, process legitimacy and final integration.

STEP-BY-STEP APPROACH

The approach is based on eight steps that correspond to the project's methodological framework (see chart below):

1. Identification of AA protocol/target communities
2. Definition and contextualisation of the survey protocol
3. Literature review and collection of secondary data
4. Collection and analysis of primary community and institutional data (qualitative and quantitative)
5. Analysis and summary of the impact of shocks on the MAM system
6. Incorporation of results into targeted protocols
7. Dissemination and capacity building
8. Capitalisation

Figure 2. Summary of the various steps in the approach:



STEP 1: IDENTIFICATION OF AA PROTOCOL/TARGET COMMUNITIES

Step 1 is the foundation of the process. It aims to identify, from the outset, an existing or emerging AA framework within which MAM can be integrated coherently. This methodology is not intended to create an AA protocol from scratch or to replace a non-existent national AA framework: it is intended to strengthen and enhance a system that is either already in place or being prepared.

At this stage, it is crucial to:

- Examine existing AA protocols, those under revision and those being created;
- Analyse the area's exposure to priority hazard(s) (flood, drought, cyclone, man-made shocks, etc.) in consultation with the authorities and other key stakeholders/partners;
- Perform a quick analysis of the available Early Warning System (EWS) and its data, trigger thresholds, return periods and seasonal models;
- Identify priority communities based on:
  - Pre-existing nutritional vulnerability
  - The operation and accessibility of MAM services
  - Community dynamics and socio-cultural constraints

Three essential prerequisites for implementing the approach:

PREEXISTING OR EMERGING AA PROTOCOLS	A FUNCTIONAL EARLY WARNING SYSTEM (EWS)	A STRONG INSTITUTIONAL COMMITMENT
Introducing this methodology is easier when local stakeholders are already familiar with AA concepts and have a minimum framework: coordination mechanisms, anticipation principles, thresholds or operational prerequisites. This makes it possible to: • Avoid lengthy preparatory stages (identification of institutional mandates, AA governance, etc.); • Provide Health and Nutrition stakeholders with a clear framework to guide their thinking; • Ensure that MAM recommendations are seamlessly integrated into existing SOPs. There are two possible configurations: • The AA protocols and framework already exist → the methodology can be implemented without any major adaptations; • The AA protocols do not exist but are currently being created → the diagnostic tools must be adjusted to incorporate MAM elements from the outset. This avoids duplicating diagnostics and ensures that nutritional risks are taken into account right from the design stage of the AA protocol.	An EWS is a set of mechanisms for anticipating a shock and alerting the communities and services affected in good time. In an AA approach, EWS must enable: • Monitoring of the context and critical indicators; • Dissemination of graduated alerts; • Triggering of early action sufficiently in advance; • Implementation of measures adapted to each activation threshold. The thresholds are always specific to the hazard covered (rainfall, water levels, cyclone forecast, etc.). A robust EWS or one requiring only minor reinforcements is strongly recommended, as AA projects generally have limited resources to create or restructure an entire alert system. *Important : This methodological note is not intended to define thresholds relating to malnutrition. MAM integration takes place within an AA protocol focused on an external hazard, without creating a separate nutritional EWS.*	The success of the approach depends on the active involvement of: • Local and traditional authorities; • Sector-specific government bodies (Health, Nutrition, DRM); • AA platforms; • Clusters or technical groups; • International and civil society organisations. Institutional adoption is essential for: • Accessing data; • Conducting interviews and collecting data at local level; • Guaranteeing participation in feedback workshops; • Ensuring recommendations are definitively integrated into national and sub-national AA protocols. Securing this involvement upstream is a key condition for avoiding blockages later on.

An AA & Nutrition diagnostic format is available in the toolbox of this note for formalising this step

STEP 2: DEFINING THE SURVEY PROTOCOL

Defining the Terms of Reference (ToR) is an essential step in determining the precise scope of the research assignment. The ToR clarify:

- Collection objectives;
- Methodologies used;
- Expected results;
- Responsibilities;
- The schedule and necessary resources (e.g. logistical and human resources required).

In this approach, the ToRs systematically incorporate a dual methodology:

- Collection of secondary data (literature review – see step 3 for more information);
- Primary data collection (interviews with experts, focus groups and households).

The survey protocol, drawn up jointly by MAM (nutrition) and DRM specialists, guarantees a shared understanding of the issues, harmonises methods, avoids duplication, ensures analytical consistency and facilitates institutional validation before deployment.

It must be consistent with:

- AA needs in relation to the context;
- Field constraints;
- The actual capacity of the healthcare system and MAM structures;
- The timeframes linked to the hazard in question.

A model ToR is available in the toolbox of this note.

STEP 3: LITERATURE REVIEW (SECONDARY ANALYSIS)

Collecting and analysing secondary data is a key stage in the methodological process. It helps build an initial understanding of the context, guides primary data collection, identifies gaps in documentation and avoids unnecessarily asking institutional stakeholders for information that already exists.

In particular, it aims to: identify existing institutional, legal and operational frameworks; identify AA SOPs, EWS indicators, contingency plans and response or anticipation protocols; document nutritional trends (prevalence, seasonality, aggravating factors).

Initial hypotheses are also formulated at this stage and will guide the qualitative interviews and community surveys: possible nutritional vulnerabilities, MAM constraints that have already been documented, seasonal dynamics, or the robustness of the EWS.

The primary data collection tools will then be adapted to elements that are either missing or poorly documented.

The dedicated tool (secondary data collection table in the toolbox) facilitates the identification, compilation and classification of relevant documents for DRM, AA, Health, Nutrition and MAM. It mainly mobilises national or regional focal points, such as:

- Ministries and technical departments (Nutrition, Health, DRM, EWS);
- Technical working groups (AA, DRM, Health/Nutrition);
- National risk management platforms;
- Sector-specific data systems (DHIS2, EWS, seasonal bulletins, clusters).

Best practices

- Carry out initial documentary research (Internet, sector-specific libraries, institutional portals).
- Contact go-to resources sufficiently early in the process (ministries, EWS, clusters, regional departments).
- Check for inconsistencies or missing data, which will guide the priorities for primary data collection.
- Systematically extract relevant information for MAM and DRM/AA, including:
  - Existing preparedness and response protocols;
  - EWS operation and limitations;
  - Contingency mechanisms in the healthcare system;
  - History and seasonality of shocks;
  - Nutritional situation in the area;
  - Capacities and constraints of MAM structures.

Once consolidated, the literature review provides a solid analytical framework, making it possible to contextualise field tools, orient the priority themes of the primary data collection and prepare the cross-referenced analysis that will be finalised in the following steps.

STEP 4: COLLECTION OF PRIMARY COMMUNITY AND INSTITUTIONAL DATA (QUALITATIVE & QUANTITATIVE)

Community data collection often constitutes the methodology's qualitative core. It enables us to understand not only nutritional vulnerabilities but also the social dynamics, behaviour, representations and impacts of shocks at play, and the mechanisms that limit or facilitate access to MAM services.

This step requires a high degree of adaptability, as access to communities, the availability of participants and geographical or climatic conditions can change rapidly. The interviewers must be able to adjust:

- The order of their visits;
- The composition of groups;
- The length of discussions;
- The priority themes according to local realities.

AN APPROACH FOCUSED ON LOCAL PERCEPTIONS AND PRACTICES:

Risk perception, eating habits, community solidarity mechanisms and knowledge of MAM services vary greatly according to:

- The season;
- Gender;
- Age;
- Social status;
- Level of education.

Documenting these variations makes it possible to identify particularly vulnerable groups that could be disproportionately affected by an anticipated shock.

UNDERSTANDING ACCESS BARRIERS TO MAM SERVICES:

The collection process and its tools must take the following factors into account:

- Travel distances and difficulties (e.g. unusable roads, flooding, seasonal isolation);
- Direct and indirect costs (e.g. transport, loss of income, household expenses);
- Beliefs and social norms;
- Effects of gender (limited mobility, burden of care on women);
- Trust in the authorities or the healthcare system.

These barriers influence MAM in periods of stability and become critical in the event of a shock.

PRIMARY DATA COLLECTION TOOLS

Unlike traditional nutritional assessments (SMART, prevalence surveys, etc.), primary data collection in this methodology:

- Does not attempt to measure the exact level of acute malnutrition;
- Does not focus on all of the household's nutritional practices;
- Rather, it aims to understand the effect of shocks on:
  - Healthcare practices,
  - Access to MAM,
  - Behaviour in the face of risk,
  - Seasonal constraints,
  - Community capacity to adapt,
  - The resilience of health services,
  - Critical gaps that must be filled by early action,
  - Consistency or inconsistency between community and institutional perceptions and quantitative data.

The tools have been specifically designed to highlight the link between shocks, MAM systems, DRM systems and community practices and to identify opportunities to introduce anticipatory action. The diversity of the tools (household, expert and FG surveys) enables robust triangulation of information through the adaptation, contextualisation and preparation of their deployment.

KEY ACTIONS TO BE TAKEN BEFORE IMPLEMENTING THE TOOLS PROVIDED:

ADAPTATION	CONTEXTUALISATION	PREPARATION
• To the type of hazard (flood, drought, cyclone, etc.); • To the local language; • To local terminology (Health/Nutrition and DRM); • To local governance (roles, responsibilities, organisation charts); • To community practices; • To socio-cultural constraints.	• Explicitly ask whether agents are familiar with national AA directives; • Check whether contingency plans are applied; • Document any breakdowns that have already occurred.	• Encode forms; • Train interviewers and supervisors; • Involve local authorities; • Identify and plan to meet key stakeholders; • Perform site and route planning.

Best practices for adapting and implementing data collection tools

Adapt methods to local conditions:

- Secure access;
- Socio-cultural constraints;
- Availability of target groups.

Identify households via:

- MAM consultations at health centres;
- Mobile clinics;
- Pre/postnatal consultations;
- Community screening (health workers, relays);
- Mother and child groups;
- Women's mutual aid groups;
- Nurseries and infant schools (for screening);
- Distribution sessions (hygiene kits, food supplements).

Train interviewers: the AA–Nutrition approach covers a combination of complex concepts:

- Anticipatory vs. Preparation;
- Acute malnutrition vs. Food insufficiency;
- Risk chains and systemic vulnerabilities.

The interviewers must:

- Master these concepts;
- Be able to explain AA/MAM concepts;
- Be trained in qualitative data collection (accurate recording of speech);
- Be continuously supervised.

TARGETS AND SAMPLING FOR PRIMARY DATA COLLECTION

/ ! \ SAMPLING: THE QUOTAS INDICATED ARE MINIMUM RECOMMENDATIONS AND THE EXACT FIGURES WILL HAVE TO BE REVISED UPWARDS IN THE EVENT OF A WIDER SCOPE			
PRIMARY DATA TOOLS		**TARGET/DATA SOURCE**	**TARGET (MINIMUM)**
HOUSEHOLD INTERVIEW GRID	QUANTITATIVE	• Households with pregnant and/or breastfeeding women • Households with children under 5 years old	150 people
FOCUS GROUP GRID	QUALITATIVE	• Local and community Health & Nutrition organisations, traditional practitioners within the community	1 group
	QUALITATIVE	• Men in the community	1 group
	QUALITATIVE	• Women in the community	1 group
	QUALITATIVE	• Local and community DRM organisations	1 group
KEY EXPERTS INTERVIEW GRID	Individual interviews with health workers, local managers, EWS representatives or leaders make it possible to: • Understand the institutional perception of risk, • Clarify the feasibility of anticipated action, • Check for consistency or inconsistency in the documentary data obtained in Step 3, • Identify levers for community involvement and support.		
	QUALITATIVE	• Health structure manager	1 x sub-zone (e.g. 1 per municipality)
	QUALITATIVE	• Head of DRM and/or EWS	1 x sub-zone and/or region
	QUALITATIVE	• Manager/Nutrition Focus Point	1 x sub-zone and/or region
	QUALITATIVE	• Regional Health Ministry representative	1 x sub-zone and/or region
DIRECT OBSERVATION	QUALITATIVE	Direct observation provides essential information for checking: • The quality and availability of care inputs and materials; • Staff capacity (numbers, skills, rotation); • Seasonal variations in the number of cases; • Infrastructure constraints (storage, ventilation, water, cold chain). This makes it possible to anticipate breakdown points that are likely to be made worse by a shock (e.g. already frequent stock shortages → critical risk during a flood).	For each structure visited

The qualitative and quantitative data collected at this stage:

- Provide the base of the AA actoin specific or sensitive to PECMA matrix (Step 5);
- Allow recommendations to be prioritised (Step 6);
- Provide a solid local foundation for the recommendations validated in the workshop (Step 7).

They ensure that early action is not theoretical or sector-specific, but realistic, appropriate and socially acceptable.

Case study: survey implementation in Mali (July 2025)

As part of the pilot for this initiative, the Ségou region was selected for implementing the survey and its tools. After a month-long phase of preparation, adaptation and contextualisation of the data collection tools and protocols, the survey was successfully carried out according to the following parameters:

- **Timing :** 2 weeks of data collection + 1 week of processing/setting up data analysis parameters
- **Team :** 9 interviewers + 2 ACF supervisors + 1 MEAL staff member
- **Total cost :** €9,500

This case study proves the feasibility of quick and robust data collection, and its analysis demonstrates the crucial added value of triangulating qualitative and quantitative data between households, communities and experts in the area in order to obtain a global, multi-level view of the situation.

The primary data collection tools (household questionnaire, expert questionnaire and FG questionnaire) are available in the toolbox..

STEP 5: ANALYSIS AND SUMMARY OF THE IMPACT OF SHOCKS ON MAM

The analysis of the impact of shocks is based on all the primary and secondary data collected in the previous steps. The aim of this analysis is not only to understand the vulnerabilities of the MAM system and communities, but also to highlight existing capacities and adaptation strategies and practices that could be strengthened in the context of AA.

This step transforms the wealth of data collected (qualitative, quantitative, institutional, community) into a consolidated diagnostic, then into suggested avenues for anticipatory action. It has three main components:

1. Processing and visualisation
2. Analysis and contextualisation
3. Production of a preliminary investigation report

1. DATA PROCESSING AND STRUCTURING:

Initial processing is carried out using visualisation software (e.g. Power BI), making it possible to:

- Separate results into zones (for multi-regional or multi-country deployment);
- Triangulate primary and secondary data (e.g. to check the implementation of policies and procedures in the field);
- Compare qualitative vs. quantitative outputs, specifically by illustrating quantitative results with quotes and accounts from experts and the community;
- Analyse variations according to:
  - Location of respondents
  - Gender
  - Status (household vs. institutional expert)
  - Households with or without malnourished children
  - Households with or without pregnant and/or breastfeeding women

This disaggregation is essential for identifying the most vulnerable groups, exclusion mechanisms and foreseeable breakdowns in the MAM system.

2. ANALYSIS AND CONTEXTUALISATION OF RESULTS: THE KEY ROLE OF THE DRM-MAM TWO-PERSON TEAM

The in-depth analysis is carried out jointly by the Nutrition/MAM and DRM/AA specialists.
This cross-referencing highlights

- The impact of the shock on communities and MAM systems: increased difficulties in accessing care; input shortages made worse by the hazard; overload or absence of staff; interruption of screening and referrals.
- Existing practices and capacities.

Certain positive practices must be: highlighted, documented, reinforced and/or replicated in other areas.

Practices that can deteriorate nutritional status, limit continuity of care and prevent the adoption of good anticipatory practices must be precisely identified in order to propose tangible corrective measures.

- The level of coordination: existing or inadequate DRM/Health/Nutrition coordination; lack of discussion between EWS, MAM structures and communities; incoherent multi-sector mechanisms.
- EWS operation and efficiency: real capacity to anticipate shocks; dissemination of warnings and community understanding; time between warning and impact; ability of MAM services to react upstream.
- Institutional gaps in AA or MAM frameworks: absence of MAM stakeholders in AA groups; communities not integrated into warning mechanisms; gaps in health/nutrition contingency plans. Identifying these 'gaps' is essential if structural recommendations are to be made.

3. PRODUCTION OF A PRELIMINARY INVESTIGATION REPORT

The main product of this step is a structured preliminary report, including:

- Key results;
- Analysis;
- Priorities;
- Initial avenues for anticipatory action and system reinforcement.

Bonnes pratiques pour la formulation des recommandations

Pre-screen actions before the workshop

The pre-identified recommendations must take into account: the prioritisation of communities; the feasibility of the measures; the urgency; the relevance for AA; the institutional mandate.
It is advisable to define the recommendations in advance, clearly specifying that they:

- Are open for discussion;
- Can be reformulated;
- Are adaptable;
- Or can be removed.

Sort respondent feedback

Some of the recommendations put forward by communities or institutions may not correspond to the AA framework (e.g. post-shock distribution).
They must be triaged and recorded because they can feed into:

- Contingency plans;
- Reactive response plans;
- Broader multi-sector strategies.

Systematically link recommendations to identified problems

Each formulation must be derived from:

- An observed problem;
- A cross-referenced analysis;
- A feasible forward-looking solution.

This report serves as a basis for discussion at the multi-sector workshop (Step 6). A report format is provided in the toolbox.

Examples of recommendations (depending on the problems identified)

Problem: The EWS does not anticipate the impact on MAM or communities

- Strengthen community relays (including women, traditional practitioners, health workers);
- Train these relays to issue alerts;
- Develop anticipatory messages incorporating nutritional advice and protective practices.

Problem: Discontinuity of screening and MAM before/during a shock

- Strengthen screening and community referral;
- Distribute rations or supplements (vitamin A, energy biscuits) in advance to households suffering from malnutrition;
- Provide pre-shock monetary assistance to vulnerable households;
- Train health workers to strengthen community-focused approaches before impact.

Problem: Lack of multi-sector coordination

- Organise cross-disciplinary DRM-Health/Nutrition training on shock/nutrition interactions;
- Set up or strengthen multi-sector AA working groups;
- Integrate MAM stakeholders into AA processes.

STEP 6: INCORPORATION OF RESULTS INTO TARGETED PROTOCOLS AND REPORTING

Once the analyses have been consolidated and the preliminary recommendations formulated (Step 5), it is essential to go back to all stakeholders to:

- Present the results,
- Verify and triangulate conclusions,
- Build and finalise anticipatory action,
- Collectively validate the measures to be included in AA protocols.

This step is essential in guaranteeing the technical quality of the recommendations, their institutional feasibility and, above all, their appropriation by the stakeholders responsible for implementing them.

ORGANISATION OF FEEDBACK WORKSHOPS

The workshops generally take place at two complementary levels:

- Sub-national (field/collection area);
- National (validation and strategic integration).

WORKSHOPS OBJECTIVE AND TARGETED PARTICIPATION

	OBJECTIVES	PARTICIPANTS
SUB-NATIONAL WORKSHOP (field level, AA protocol anchor zone)	• Present the results of the analysis; • Bolster the ability of local stakeholders to incorporate AA concepts; • Co-construct specific recommendations to be incorporated into targeted AA protocols.	• Key informants (health, nutrition, DRM, EWS); • Local stakeholders involved in AA; • AA working groups; • Nutrition or DRM cluster; • Local authorities.
NATIONAL WORKSHOP (central level/ institutional validation)	• Present the consolidated results; • Build AA capacity (as required); • Examine the recommendations provided at sub-national level; • Incorporate these recommendations into national AA frameworks and sectoral SOPs.	• Nutrition cluster; • Health, Nutrition, DRM and EWS representatives; • National AA working groups; • National authorities and relevant ministries. • Local AA representatives involved in the protocols.

*We recommend organising the workshop over two days (national and sub-regional) in order to ensure that the concepts are understood in the same way by all participants. **The following sequencing is recommended:***

WORKSHOP SEQUENCING	
DAY 1: AA CAPACITY BUILDING	**DAY 2: FEEDBACK AND CO-FORMULATION OF RECOMMENDATIONS**
• Early trigger; • EWS; • Action windows; • Anticipatory pre-positioning vs. post-shock reaction logic; • Role of MAM services in AA.	• Presentation of the survey results; • Discussion of key vulnerabilities; • Validation of proposed recommendations; • Action formulations: - Precise - Feasible - Aligned with AA Standard Operating Procedures (SoP), - Clearly assigned (who does what, when, how)

Facilitation tools (PowerPoints) are available in the Integration in AA protocols toolbox.

The validated recommendations are then incorporated into:

- Existing AA protocols;
- Sector-specific protocols;
- Multi-sector AA frameworks.

Each recommendation must be associated with:

- Clear responsibility;
- Logistical or institutional prerequisites;
- An activation window;
- A monitoring/trigger indicator.

This structure guarantees action feasibility and complete integration into the national AA system.

An Anticipatory Action Sheet template is provided in the toolbox of this note.

Case study – Madagascar (2024-2025)

The regional workshop brought together 47 participants (Ministry of Public Health, National Nutrition Office, local authorities, Health & Nutrition clusters, NGOs). Three MAM initiatives have been integrated into the AA drought protocol: a community mechanism for early referral, light pre-positioning of nutritional inputs, and increased community screening prior to a shock.

STEP 7: DISSEMINATION AND CAPACITY BUILDING

Once the feedback workshops have been held and the recommendations validated, the aim of this step is to anchor the progress made in the long term. The goal is to ensure that AA protocols enriched with MAM components do not remain isolated documents but become tools that are used, understood and acted upon by the relevant stakeholders.

Several complementary levers can be activated depending on the context: see next table.

DISSEMINATION AND INSTITUTIONAL OWNERSHIP	It is essential to widely disseminate: • The survey report; • The results summary; • The validated recommendations; • Updated versions of AA protocols. Priority recipients include: • Sub-regional and national working groups (AA, DRM, Nutrition); • Local and national authorities; • Sector-specific clusters; • EWS and warning mechanisms; • NGOs and coordination platforms. This dissemination must be accompanied by explanations and dialogue to ensure genuine ownership.
CAPACITY BUILDING (MULTI-LEVEL)	Integrating MAM into AA requires: • A technical understanding of how AA works; • Full working knowledge of EWS mechanisms; • Knowledge of best practices in nutrition and MAM; • Effective coordination between stakeholders. Training courses can target: • Local authorities; • Regional and sub-regional health teams; • Community health workers; • Community Prevention Support Structures (CPSS); • Community leaders; • Local NGOs; • Members of the AAWG. **The training materials from the capitalisation workshop (see toolbox) can be used.**
SUPPORT IN DRAFTING OR REVISING PROTOCOLS	Depending on the country, implementing the recommendations may require: • Revision of AA protocols (national or regional); • Integration of MAM initiatives into multi-sector SOPs; • Updating of contingency plans; • Clarification of institutional responsibilities; • Definition of activation or monitoring indicators. This technical drafting work is often decisive in transforming recommendations into institutionalised action.
ACTIVITIES TO STRENGTHEN COMMUNITIES	Some recommendations require direct support for communities: • Training community relays; • Upskilling DRM committees; • Awareness-raising campaigns on best anticipatory practices; • Improved alert reception at local level; • Reinforced community preparation for shocks. These activities consolidate local resilience and responsiveness to EWS alerts.
ACTIVITIES FOCUSED ON EWS	Integrating MAM into AA may require: • Improvements in alert distribution; • Clarification of activation indicators; • Training in understanding and using alerts; • Equipping relays or communities to receive information effectively (radios, solar devices, etc.).

These examples illustrate how step 7 has been implemented in different contexts:

Mali – 2025: MAM & AA post-workshop follow-up

- *Support for media coverage of the seminar to validate the national AA flood protocol;*
- *AA/DRM capacity building through local training for CPSS and community leaders.*

Madagascar – 2025: MAM & AA post-workshop follow-up

- *Provision of hand-crank radios to improve alert reception at community level;*
- *Revision of the AVOSTE project protocols to incorporate MAM;*
- *Revitalisation of DRM committees in four AVOTSE project towns, with a specific AA + Nutrition focus;*
- *Support for the LRDMC to conduct mass awareness-raising campaigns about AA;*
- *Support for the national AAWG in organising a workshop to revitalise the Grand Sud AAWG;*
- *Participation in the revision of national contingency plans (overall and sector-specific).*

STEP 8: CAPITALISATION

The aim of capitalising on the implementation of this initiative is to identify the lessons learned from the process in order to improve future iterations of the methodology and enhance its effectiveness, efficiency and ownership.

To ensure continuous learning, we recommend maintaining a logbook throughout the implementation period, with systematic documentation of:

- The technical and operational successes and difficulties encountered;
- The quality and availability of the data collected;
- The involvement and commitment of institutional and community stakeholders;
- Any methodological limitations observed;
- Data volumes (number of tools used, participants, localities covered);
- Questions, suggestions and recommendations from the workshops;
- The timescales for implementing each step.

These elements make it possible to:

- Provide input for future iterations in other regions or countries;
- Improve how the methodology is adapted to specific contexts;
- Refine data collection, analysis and reporting tools;
- Enhance the effectiveness of advocacy focused on integrating MAM into AA.

A structured capitalisation process is therefore a key element in guaranteeing continuous improvement and organisational learning around this approach.

CONCLUSION

This document aims to build the capacity of DRM, health and nutrition stakeholders to effectively integrate MAM into Anticipatory Action protocols. Based on a proven, quick and adaptable methodology, it provides an operational framework for anticipating the effects of shocks on nutrition and strengthening the resilience of the communities most at risk.

The approach presented is neither exhaustive nor set in stone. It must be adapted to local realities, enriched with feedback and fuelled by close collaboration between the authorities, civil society, community stakeholders and technical partners. It is this collective momentum that ensures the relevance and ownership of anticipated action.

Lastly, the sustainability of the approach depends on establishing regular mechanisms for capitalising on and documenting what has been learned and sharing best practices across sectors. These elements are essential for improving future initiatives, harmonising AA protocols and strengthening the integration of MAM into anticipation efforts in the long term.

Toolbox

The various templates and formats used in this approach are provided in the appendix to this note to help interested parties disseminate and adopt this methodology. If you experience access problems, please contact: **errurequest@actioncontrelafaim.org**

- AA and nutrition context diagnostic tool
- Sample Terms of Reference for the survey
- Secondary data collection grid
- Secondary data collection forms:
  - Household interview grid (1)
  - Key experts interview grid (4)
  - Community and focus group grids (4)
- Template for summarising recommendations for sensitive MAM-specific initiatives
- Template for report/summary of survey results and recommendations
- Facilitation tool for feedback workshops (PowerPoint format)

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