



WASH'Nutrition Strategy for South Sudan

FINAL

March 2018

This strategy has been developed based on a consultation process and participatory analysis with the WASH and Nutrition Clusters, particularly the Cluster Coordinators XXX and Isaack Manyama and the Strategic Advisory Groups (SAGs) of the WASH and Nutrition Clusters together with other key stakeholders in South Sudan.

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List of Acronyms

ACS – Accelerated Child Survival

AWD – Acute Watery Diarrhea

BCC – Behavior Change Communication

CHW – Community Health Worker

CLTS – Community Led Total Sanitation

EPRT – Emergency Preparedness and Response Team

HMIS – Health Management Information System

HSS – Health System Strengthening

IYCN – Infant and Young Child Nutrition

NMIS – Nutrition Management Information System

NFI – Non Food Items

OTP – Outpatient Therapeutic Programme

RRT – Rapid Response Team

SDG – Sustainable Development Goal

SC – Stabilization Centre

SDA – Small Doable Action

SFP – Supplementary Feeding Programme

SDA – Small Doable Action

1. Framework

WASH & Malnutrition in South Sudan

Following a relative period of stability following the 20 year conflict with Sudan, South Sudan returned to conflict and humanitarian crisis in 2013. As a result of the ongoing crisis the government and humanitarian actors are struggling to support the population who are facing chronic and acute food insecurity, poor basic services, instability and mass displacement. Throughout the history of humanitarian crisis in South Sudan there have been high levels of malnutrition and there is now a clear understanding that this cannot be reduced without tackling the underlying causes. In the past efforts to address food insecurity and malnutrition through improved food intake for IDP populations and other vulnerable households did not recognise the poor WASH conditions and high levels of diarrhea and pneumonia which were ultimately responsible for the majority of deaths in the 1998 famine (Biong, 1999).

Beyond what is known globally about the important linkages between WASH and Nutrition, there is also direct evidence of the links emerging from South Sudan.

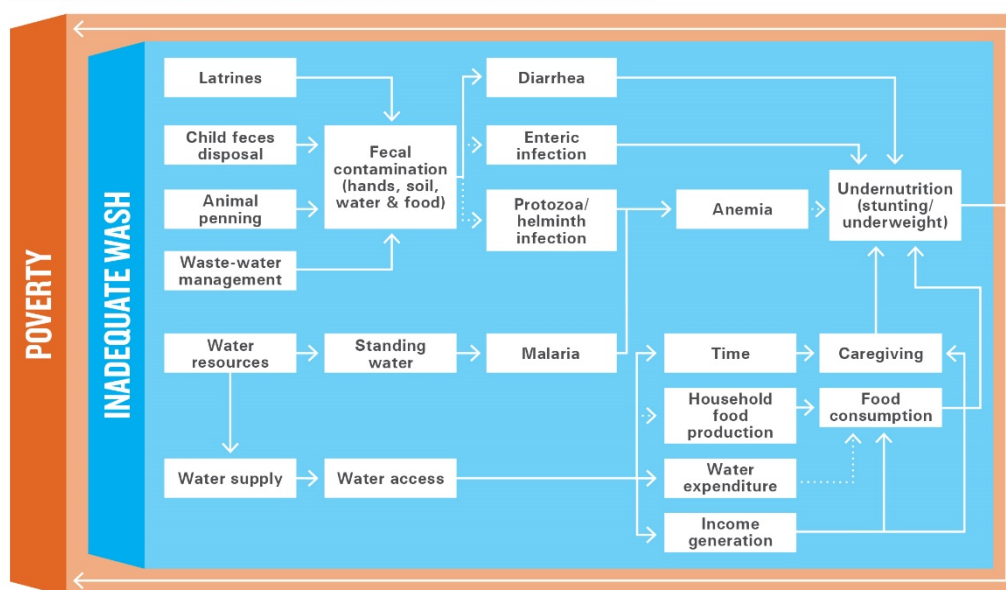
- An investigation into the determinants of nutrition status in South Sudan (A2Z, 2007) found that while Food insecurity is important, the causes of malnutrition are much broader and include a high burden of infectious diseases including malaria, diarrhea, and pneumonia, and that these infections worsen the severity of malnutrition that already and worsens them in a vicious downwards cycle.
- An Integrated Food and Nutrition Security Causal Analysis (IFANSCA, 2017) found that the population with highest GAM levels had the highest child morbidity. And that the most common morbidities amongst children were water and sanitation related – being malaria and diarrhea. In this analysis one of the three independent predictors of morbidity was whether the household owned a toilet.
- A study done by Mercy Corps in Northern Bahr el Ghazal (2017) indicated positive WASH behaviours are correlated with better nutritional outcomes (through the disease pathway) with the strongest connection being between drinking from unsafe water sources and prevalence of undernutrition.
- A nutrition causal analysis lead by Action Against Hunger, also in Northern Bahr el Ghazal (2011), found that household water treatment, hand washing behaviour, child illness especially diarrhea and malaria, and excreta and household waste disposal were all significantly associated with acute undernutrition.

Poor WASH is therefore recognised as a significant cause of undernutrition in South Sudan.

Why WASH' Nutrition Integration?

Lack of access to WASH can affect a child's nutritional status in many ways. Existing evidence supports at least three direct pathways: via diarrhoeal diseases, intestinal parasite infections and environmental enteric dysfunction (EED). WASH may also impact nutritional status indirectly by necessitating walking long distances in search of water and sanitation facilities and diverting a mother's time away from child care (Fenn et al., 2012). These multiple pathways between WASH practices and malnutrition are illustrated in the diagram below

FIGURE 2. PATHWAYS LINKING WASH AND NUTRITION OUTCOMES



Adapted from Chase and Ngure (2016).

Much of the evidence of links between WASH and Nutrition focus on the reduction of chronic malnutrition (stunting) whereas the humanitarian action in South Sudan is primarily aimed at reducing mortality associated with acute malnutrition. However, the causes of chronic and acute malnutrition, including WASH related causes, are often the same for either type of malnutrition and, based on nutrition causal analysis (NCA) in multiple countries¹, the pathways above hold true for undernutrition, both chronic and acute malnutrition.

Existing Good Practice and Supporting Policies

Globally, there is increasing interest in integrating WASH and Nutrition. Whether in the form of guidelines, strategies or toolkits, several agencies have strategic tools to support integration. In 2012, the Regional WASH Working Group in Western Africa developed the “WASH in Nut” Strategy to respond to the Sahel Nutritional and Food Crisis. At a regional level UNICEF has developed toolkits for supporting synergy between WASH and Nutrition in both the East and Southern Africa Region as well as the East Asia and Pacific Region. Specific NGOs, have also developed their own approaches. Action Against Hunger developed their own WASH’Nutrition guidelines to support integration in country offices. Concern Worldwide produced a document describing how to better link WASH and nutrition programmes.

In South Sudan, some actors (including Action Against Hunger) are managing to deliver a multi-sectoral ‘package’ of services especially at health facility and nutrition sites with WASH messaging, especially good handwashing practice, incorporated in Community Management of Acute Malnutrition (CMAM) activities. This suggests that a strategy for integration that starts with a basic minimum package of integrated services, and including promotion of ‘small doable WASH actions’ for households to adopt during implementation of health and nutrition programming may be the most effective. There is also potential for more co-location of WASH and Nutrition programmes in some areas and better integration

¹ NCA reports can be found at <http://linknca.org/mediatheque.htm?typeContenu=etudeTerminee>

of mobile services implemented by multi-sectoral teams. Interviews with donors in Juba revealed that some of them require that the nutrition interventions that they fund are 'paired' with a WASH intervention, either within the same implementing agent or through partnership between organisations.

Many humanitarian organisations already target their WASH interventions based on 'hotspots' for Global and Severe Acute Malnutrition (GAM and SAM) and there are several rapid response mechanisms which operate with integrated (WASH, Nutrition, FSL and Health) teams providing joint assessment and coordinated interventions to meet immediate needs.

In South Sudan the WASH, Health, Nutrition and Food Security Cluster recently developed a responsibility matrix for WASH interventions to be implemented by different clusters for famine risk prevention. The matrix provides a key opportunity to develop a more detailed strategy for integrating WASH and Nutrition at a programme level. Within the matrix the identified areas of overlap are: to ensure safe water collection points as well as household water treatment for households with acutely undernourished children; resources for handwashing with soap for households with acutely undernourished children; and the provision of hygiene promotion and a pot for babies feces to reduce open defecation in households with acutely undernourished children.

2. Strategy

The strategy is expected to guide programming for a period of 3 years. In the highly dynamic socio-political situation in the country, strategies should be re-examined and revised at regular intervals.

Objectives

- Focus interventions both at the nutrition centre and at home toward breaking the “diarrhoea/nematodes/enteropathy -malnutrition” vicious cycle;
- Work towards more integrated WASH and Nutrition services to achieve maximum impact on health, nutrition and wellbeing of the most vulnerable households

Principles

I. Essential minimum package of integrated services

Integrated WASH and nutrition interventions focus on delivering a minimum package of services at the nutrition centre, at the household of patients, and in the community. Nutrition activities at household level include context specific WASH ‘small doable actions’ and establishing means for minimum standards of WASH. Joint teams deliver integrated messaging and behavior change promotion. The essential minimum package is intended to be light, flexible and adapted to rapidly changing context. An adapted package for different accessibility scenarios is suggested below. In addition to the minimum package, where feasible, WASH projects should be ‘nutrition sensitive’ based on the common pathways between WASH and nutrition outcomes, using a facility based WASH approach.

II. Joint assessment and analysis

Standard emergency assessment and surveillance tools (e.g. SMART surveys) include both WASH and nutrition indicators. Joint assessment team practice (including with RRM and MET) extend to jointly analyzing findings/data to identify hotspots for WASH and Nutrition needs. Share data and analysis across sectors through virtual common platform. Ensure inclusion of WASH indicators in the Nutrition Management Information System (NMIS). Roles and responsibilities for reporting against agreed indicators need to be established through an adapted cluster roles and responsibilities matrix².

III. Capacity development

There needs to be comprehensive and deliberated training on WASH’Nutrition in order to build cross-sectoral understanding and capacities for implementation and coordination. Managers and Programme staff need to know WHY they are doing something and have the authority to do it, in order to be motivated and interested in cross-sectoral programming. Additional capacity development is required with all stakeholders to ensure broader understanding. Training should focus on causal pathways between WASH and Nutrition for staff in field bases and use live webinars and online resources where possible. Where resources allow, online, self-paced training modules should be developed. This capacity development methodology is easily accessible, shorter, more

² Example of cluster responsibilities matrix can be found at <http://www.whatworks.co.ke/downloads/Tool%203D%20Responsibilities%20and%20Accountabilities%20Matrix-Final.pdf>

cost effective to update as needed, and less time intensive. To support capacity development across the sectors early learning reviews should be implemented, providing the opportunity for agencies to constructively share successes and challenges.

IV. Cross-sectoral coordination and planning

Joint planning and coordination of service delivery is essential for good integration. At programme level, WASH and nutrition actors should strengthen their cross-sectoral coordination to encourage teams to coordinate activities more comprehensively on an ongoing basis. More widely coordination should be cluster based within the duration of this strategy. It is suggested that the Clusters ensure twice-yearly joint meetings of the Strategic Advisory Groups (SAGs). Ideally the SAGs should guide joint analysis of assessment and ensure these are effectively used for planning. The global Cluster responsibility matrix should be adapted to eliminate confusion on the division of responsibility³. Cluster performance monitoring should be reviewed for inclusion of cross-sectoral indicators. There should be more discussion of the potential impact of WASH programming on nutritional outcomes, this can be done at a Cluster level but also at an individual programme level.

V. Advocacy

WASH and nutrition actors should work together to advocate for more integrated programming. This should start with targeted campaigns to decision makers to fund and plan integrated activities. Common advocacy tools presenting compelling evidence for linking WASH and nutrition should be developed for use by cluster members⁴.

Targeting

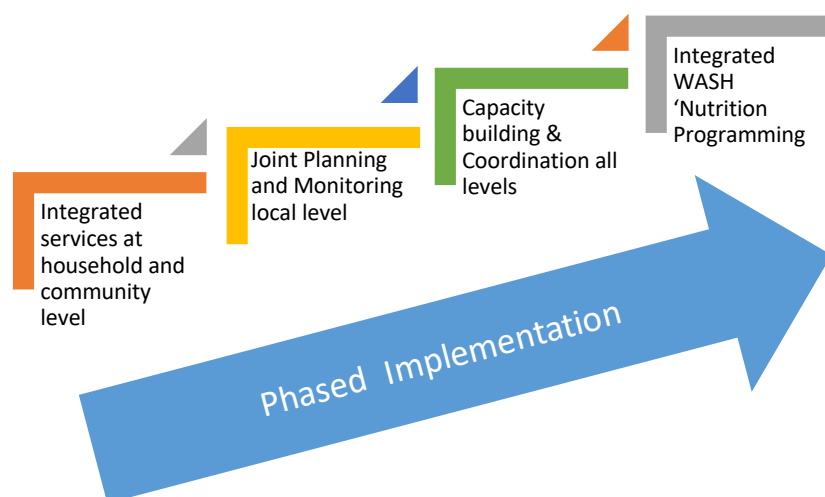
Adherence to Cluster strategy to target WASH activities in areas with high SAM and GAM rates will be encouraged and more donors will be lobbied to promote co-location of WASH and Nutrition interventions. Clusters will work together to identifying 'hotspots' of AWD/Cholera, malaria and malnutrition where WASH interventions could reduce the incidence. In intervention areas nutrition and health workers can identify 'hotspots' of poor WASH through tracing of malnutrition, malaria and diarrhea cases to the home environment.

^{3 3} <http://nutritioncluster.net/resources/responsibilities-accountabilities-matrix-health-nutrition-wash-clusters/>

⁴ Accompanying advocacy materials are available for Action Against Hunger to use to promote this strategy. These present the evidence base for links between poor WASH and malnutrition, the arguments for integration and outline the strategy for integration in South Sudan

Phasing

The bottleneck analysis carried out during the consultation process indicated which integration steps can be implemented easily and which will face some constraints in the current South Sudan context of fragility. The implementation strategy will therefore be implemented in a phased approach with the easier steps put into practice first (see Strategy diagram) and more difficult steps, requiring more comprehensive change in systems and capacity started later.



This phased approach may be adapted by the different stakeholders depending on their needs, for example; joint planning and monitoring may be a first step for some organisations.

Measuring Progress

The strategy will use a 'Maturity Matrix' approach to measure progress towards the objective of more integrated WASH and nutrition interventions. The matrix identifies activities in four programme areas which represent steps towards integration. Organisations (and clusters) can identify where they are on the matrix in each program area and carry out periodic reviews to determine whether they have reached the next step (see Section 4).

3. Essential Minimum Package of Integrated Services

The package was developed with input from members of the cluster SAGs and represents the most appropriate and feasible package for the South Sudan context. The activities are not assigned to a specific sector or cluster. In most cases the activities could be implemented by a joint WASH/Nutrition team or by separate teams with strong collaboration & coordination depending on the programme structure. The package should be applicable across all nutrition and WASH programmes and not restricted to a specific emergency period or hunger season. In areas where the security situation allows only minimum, short term access for response teams the essential minimum package of integrated services has to be adapted. The following adaptations are appropriate for the two most common scenarios, and their recommended activities can be seen in the last two columns below:

1. Medium Access, multi-sector team on the ground for 8-12 weeks at a time (e.g. EPRT)
2. Poor Access, small, multi-sector team on the ground for 7 to 30 days (e.g. RRM)

Intervention Level	Activities	Indicators ⁵	Medium access	Poor Access
Health Facility and/or Nutrition Site (SC/OTP/TSFP)	OTP/TSFP Fixed sites: Adequate WASH hardware and soap	Presence of clean, fly-free and smell-free toilet/latrines (min 4) Presence of handwashing facilities with adequate water supply (min 5l/patient) and soap		
	OTP/TSFP Mobile sites: Adequate potable water and soap available at each distribution	Presence of handwashing facilities with adequate water supply (min 2l/patient) and soap	OTP/TSFP Mobile sites: Adequate potable water and soap available at each distribution	OTP/TSFP Mobile sites: Adequate potable water and soap available at each distribution
	SC: SPHERE Standard WASH hardware	% of SCs with WASH hardware meeting facility SPHERE standards		

⁵ The indicators are based on sphere standards where appropriate but in some cases have been adapted to be realistic in the South Sudan context

Intervention Level	Activities	Indicators ⁵	Medium access	Poor Access
		(30l/p/d & 1 toilet/20 beds)		
	WASH NFI kits for all SC/OTP beneficiary families (soap, water treatment ⁶)	% of SC and OTP beneficiary families receiving a WASH NFI kit	WASH NFI kits for all SC/OTP beneficiary families (soap, water treatment)	WASH NFI kits for all SC/OTP beneficiary families (soap, water treatment)
	Low-osmolarity ORS, and malaria testing+treatment available at all OTPs/TSFPs	% of nutrition sites offering testing and/or treatment for diarrhea and malaria	Low-osmolarity ORS, and malaria testing+treatment available at all OTPs/TSFPs	Low-osmolarity ORS, and malaria testing+treatment available at all OTPs/TSFPs
	Develop a standardized and integrated package of key behavior change messages which is delivered in a shock-responsive way	Standardized and integrated messages are developed and implemented at all centres		
	Apply cholera centre protocols for AWD/cholera outbreaks, including specific guidelines for SAM children	Center protocols and guidelines for outbreaks known and implemented	Apply cholera centre protocols for AWD/cholera outbreaks, including specific guidelines for SAM children	Apply cholera centre protocols for AWD/cholera outbreaks, including specific guidelines for SAM children
Community	Ensure a community or facility nutrition/health worker is a member of the local WASH Committee	% of WASH Committees with an active nutrition/health member	Ensure a community or facility nutrition/health worker is a member of the local WASH Committee	
	Ensure nutrition and health workers have basic knowledge on WASH related disease (including	% community health/nutrition workers able to identify WASH related disease risk	Ensure nutrition and health workers have basic knowledge on WASH related disease (including	Ensure nutrition and health workers have basic knowledge on WASH related disease (including

⁶ Appropriate NFI package agreed by cluster SAGs in strategy review workshop in February 2018

Intervention Level	Activities	Indicators ⁵	Medium access	Poor Access
	transmission routes)		transmission routes)	transmission routes)
	Develop a standardized and integrated BCC package ⁷ for community workers which is implemented in a shock-responsive way	Standardize and integrated package is in use by all promoters		
	Ensure community WASH agents are able to screen and refer for acute undernutrition using MUAC and oedema tests (when treatment is available)	% of community WASH agents who are trained on, and equipped with MUACs and oedema tests for screening and referral	Ensure community WASH agents are able to screen and refer for acute undernutrition using MUAC and oedema tests (when treatment is available)	XXX
	Ensure community WASH agents distribute diarrhea treatment kits (DTKs: comprised of zinc tablets and ORS) during AWD/cholera outbreaks	# of DTKs distributed by WASH agents during AWD/cholera outbreaks	Ensure community WASH agents distribute diarrhea treatment kits (DTKs: comprised of zinc tablets and ORS) during AWD/cholera outbreaks	Ensure community WASH agents distribute diarrhea treatment kits (DTKs: comprised of zinc tablets and ORS) during AWD/cholera outbreaks
Household	Ensure water supply within 30mins of HH	% HH with access adequate quantity water for drinking and to practice good hygiene	Ensure water supply within 30mins of HH	
	Promote, demonstrate and facilitate appropriate household water	At least two Small Doable Actions ⁸ for household water	Promote, demonstrate and facilitate appropriate household water	Promote, demonstrate and facilitate appropriate household water

⁷ Adapted from existing cluster/UNICEF materials where appropriate

⁸ To be defined by cluster SAGs

Intervention Level	Activities	Indicators ⁵	Medium access	Poor Access
	treatment and storage	treatment and storage are identified and supported	treatment and storage	treatment and storage
	Promote and facilitate appropriate handwashing behaviours	Identify and support at least one Small Doable Action for handwashing	Promote and facilitate appropriate handwashing behaviours	Promote and facilitate appropriate handwashing behaviours
	Promote and facilitate appropriate disposal of feces of babies, other household members	Identify and support at least one Small Doable Action for disposal of feces and separation of babies and animal feces	Promote and facilitate appropriate disposal of feces of babies, other household members	Promote and facilitate appropriate disposal of feces of babies, other household members

Delivering Integrated Services

Small Doable Actions

Small Doable Actions (SDA) is a USAID/WASHPlus⁹ initiative and describes “a behaviour that, when practiced consistently and correctly, will lead to household and public health improvement.” SDA’s are context specific and need to be negotiated with communities. To develop an SDA, a key optimal behaviour is first identified, then implementers work with community members to identify some intermediate behaviours which, although not necessarily ideal, are considered more “doable” when taking into account available resources and the particular social context. Since the action is more feasible within the local context, it is likely that a broader number of households will adopt it. South Sudan is fraught with contextual constraints to ideal practices, therefore an SDA approach may be a way to promote adoption of basic practices which have the potential to lead to further improvements in behaviour. A suggested list of SMA for the South Sudan context (developed by the joint SAG teams) is included in the Annexes.

Shock-responsive behaviour change communication approach

In a country with frequent shocks, both environmental and manmade, programmes need to have the flexibility to make changes in order to continue to support beneficiaries optimally in face of the shock. Changes do not necessarily have to be systemic in nature but can be small, such as focusing BCC on the prevention and management of diarrhea, refeeding during/after illness, and appropriate health-seeking behaviours during the anticipated/regular AWD surges. Another example is discussing malaria and/or

⁹ Case studies on use of SDA approach in USAID programmes can be found at http://www.washplus.org/sites/default/files/sda-learning_brief2015.pdf

cholera prevention and treatment during seasonal peaks and identifying 'safe' sanitation practices for people displaced by conflict. While a key recommendation of this strategic framework is to standardize an integrated BCC package, implementers need to have the flexibility to choose topics which are most relevant to the need of the population.

Secondary Actions

Nutrition Sensitive WASH

Beyond the minimum package there are several secondary suggestions for integrated actions that may be possible in the short term in South Sudan. For nutrition sensitive WASH this includes Community-Led Total Sanitation (CLTS) and School-Led Total Sanitation (SLTS) as well as potentially developing specific programmes to target Baby WASH. These programmes help promote a fecal barrier and thus influence the nutrition situation. They can also be implemented in such a way as to necessitate more involvement from the nutrition and health teams. For example, for CLTS the community triggering can come from the WASH team however the follow-up work including open defecation monitoring can come for the Community Health Worker.

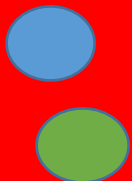
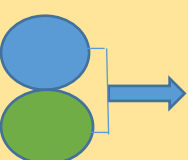



Facility Centred WASH

For organisations implementing WASH programmes only with limited opportunities for integrated programming with a nutrition partner/team. WASH could still use a facility based WASH approach which starts with WASH facilities at the health/nutrition centre and then moves on to providing services in villages in the catchment based on 'hotspots' of malnutrition and diarrhea (see diagram in Annexes) Where static nutrition services are provided at a permanent health facility, WASH facilities should meet SPHERE standards for health facilities with OTP or TSFP; providing WASH NFIs to families with children in TSFP (the minimum package includes only OTP); total integration of the community cadre to ensure a unified approach to BCC.

WASH in Schools

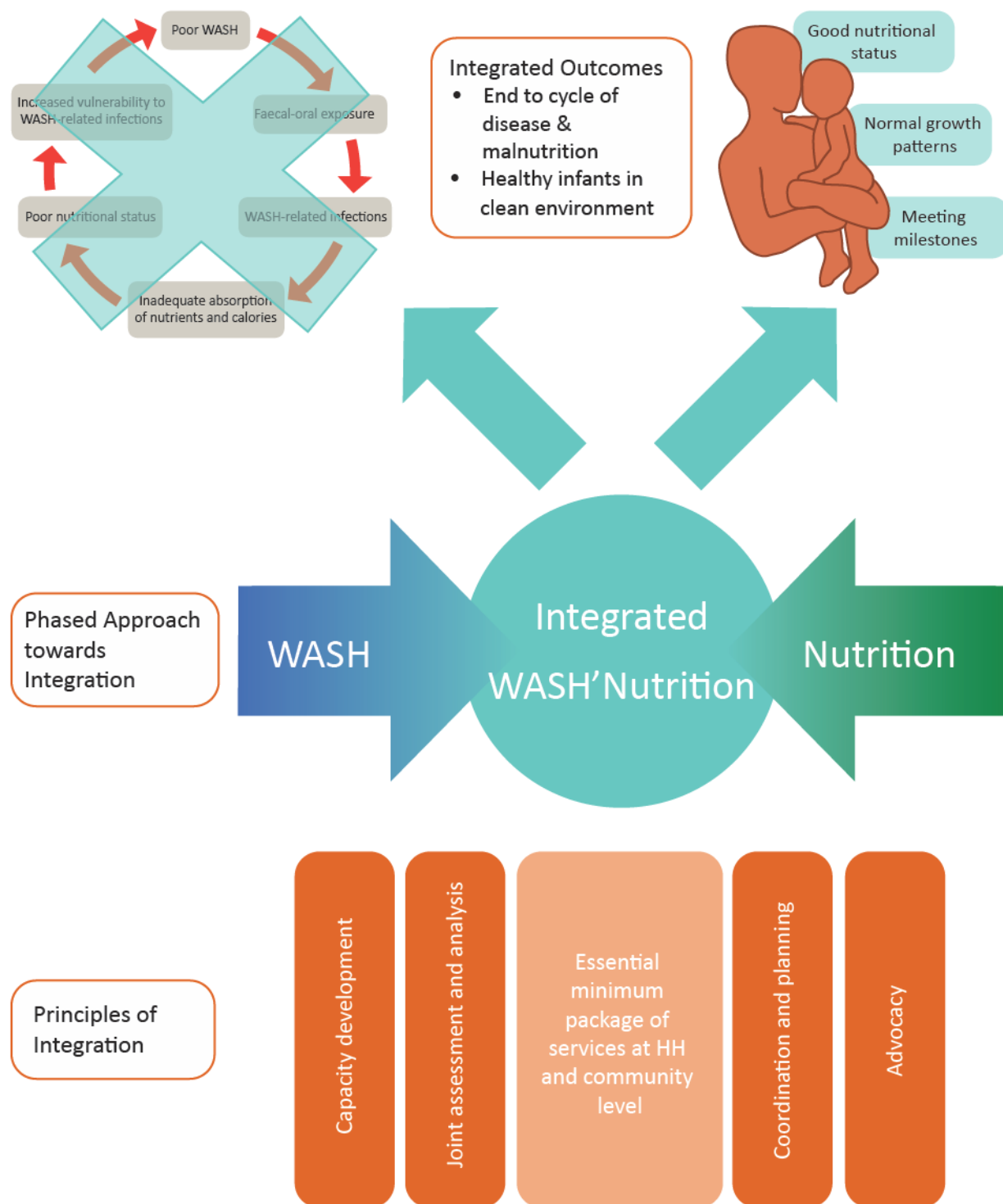
There are opportunities for Secondary actions for WASH 'Nutrition at schools which could follow a similar approach of delivering an integrated package of services and BCC. Adaptations to SLTS and other existing WASH in schools approaches can be developed which specifically address the causes of malnutrition and diarrhea in South Sudan.

4. Measuring Integration Progress

					
Maturity	Separate Sector Progs	Easy first steps	Medium term steps	Longer term steps	Achieving vision of integration
Implementing Minimum Package Integrated Services	WASH and nutrition interventions co-located in the same district	Hotspotting – targeting interventions based on overlapping problem areas	Development and use of integrated BCC materials	Multiple use water supplies developed & maintained	Integrated cadre of community workers
			Minimum WASH standards met at facilities	Integrated monitoring system & Joint analysis of monitoring data	Integrated mobile services
Joint Assessment & Planning	Joint assessment by RRM Cluster/sector assessments and planning	Identification of common set WASH-Nutrition indicators	Common assessment tools (inc for use by RRM, MET etc)	Shared data and coordinated planning	Joint reviews and common analysis platform
		Inclusion of WASH indicators in Nutrition surveys & vice-versa			Integrated response plan
Capacity Development	Skills training for sector professionals (e.g. SMART survey training)	Actor mapping & capacity assessment within organisations	Training packages developed	Joint advocacy & development of evidence base	WASH and nutrition staff have sound knowledge of both sectors
			Field staff doing online training		
Cross-sectoral Coordination	Cluster coordination & planning. IAWG for cross-sector issues	Institute Joint SAG meetings	Cluster response plans identifies priority integration areas	Joint donor proposals	Joint coordination at State and sub-state levels
			Adapt and use inter-cluster roles and responsibilities matrix	Joint learning forums	Strong advocacy on integration & priority actions

5. Annexes

Strategy Diagram



WASH kit content

The following contents were recommended for distribution to families of OTP* patients:

Item	Quantity**
Aquatabs	120 tabs (67mg, 12 strips)
PUR (to be provided where majority of water sources are turbid)	240 sachets (1 carton)
Filter cloths	1
Buckets with lids (20l) – one with tap	1
Collapsible jerrycan (5l)	1
Soap	2 bars
Small cup (for use for patient and appetite test at OTP)	1

* It is assumed that patients at stabilisation centres will be referred to OTP and will receive kits there. Kits could also be distributed to all STFP patients if common pipeline can provide the items in sufficient quantities

**Quantities were designed to be adequate for 3 months for a family of 6 except where practicalities of packaging dictated a different period

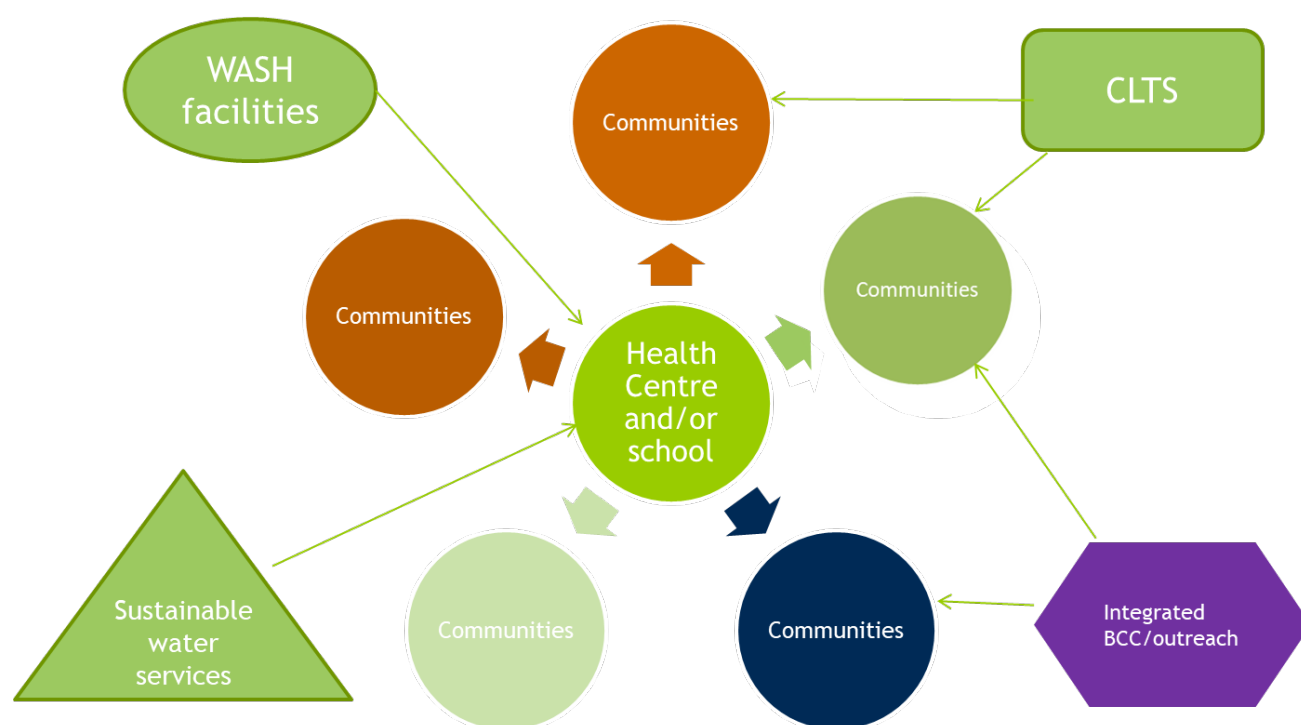
Recommended Small Doable Actions

1. Hand Washing
 - a. Handwashing with water and ash
 - b. Use of a 'tipitap' at household level
2. Disposal of faeces (inc child faeces)¹⁰
 - a. Use of the 'Cat' method (covering faeces)
 - b. Dig and dump method
 - c. Construct and use of local toilet/pit latrine
3. Treatment and storage of water
 - a. Sun exposure for 8 hours
 - b. Boiling water
 - c. Store drinking water inside the house
 - d. Cover the water container
 - e. Use a narrow necked container

¹⁰ Action (a) is seen as a minimum and HH should be encouraged to move to (b) and then (c) if possible

Facility Centred WASH model

Facility Centred WASH model



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