



CODA

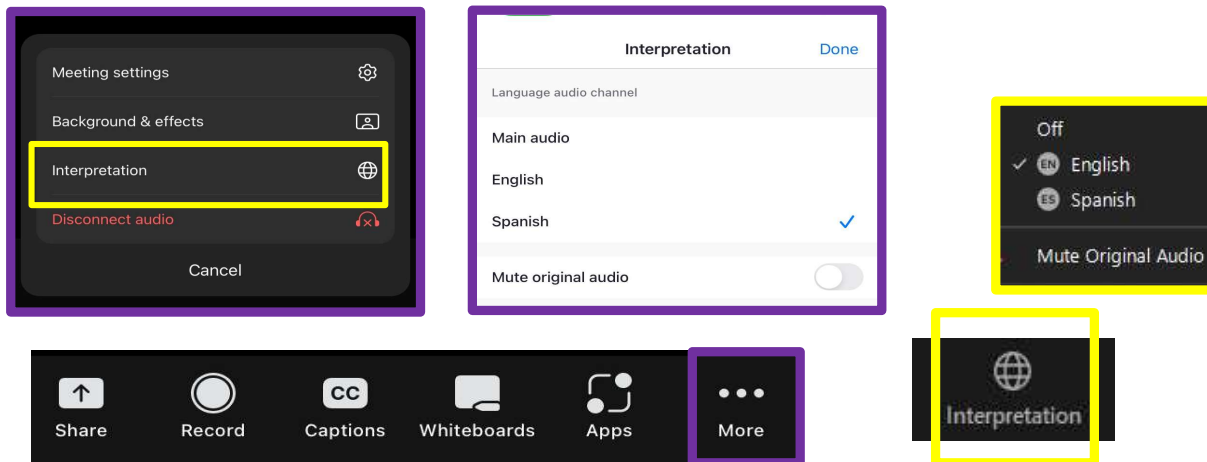
Transforming Nutrition Support Through Scalable Digital Solutions

Date: 22 July 2025
Time: 14:00 – 15:30hrs CEST

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Conditional On-Demand Assistance

CODA

Transforming Nutrition Support Through
Scalable Digital Solutions

Speaker Panel



Speaker
Lynnda Kiess
Chief of Learning and
Innovation
WFP Nutrition



Speaker
Mohamad Almalla
Nutrition Programme Officer
WFP South Sudan



Speaker
Hajra Hafeez-ur-Rehman
Team Lead, Monitoring
Evaluation, Research, Learning
and Innovations for Nutrition
WFP Nutrition



Speaker
Kassi Abdul-Latif Tuahir
Team Lead, Digital Innovation
WFP Nutrition



Facilitator
Tavimbanashe Zisengwe
Nutrition Integration Learning &
Documentation Officer
WFP Nutrition

Learning Objectives

1

Understand the purpose and functionality of CODA

2

Examine CODA's value proposition and technical architecture

3

Explore real-world application of CODA in complex humanitarian settings, with a focus on WFP's experience in South Sudan

4

Identify lessons learned and strategic directions for scaling and sustainability

Introducing CODA Conditional On-Demand Assistance (CODA)



Context

Wasting prevalence remains a significant challenge in many countries:

Conflict and insecurity, extreme weather events, and economic shocks continue to predispose the most vulnerable communities to acute food insecurity and malnutrition.

Management of wasting remains a critical intervention:

It prevents death, averts lifelong damage to health and learning, and is essential for restoring livelihoods and enabling recovery in crisis settings.

WFP supports 55 countries to prepare for and respond to malnutrition in humanitarian crises:

Directly reach approximately 30 million women and children each year with targeted support that prevents mortality and supports recovery.

Timely, high-quality data is critical for effective decision-making:

Frontline workers and governments need accurate, real-time information to track progress, identify bottlenecks, and prioritise resources where needs are greatest.



Data-Related Barriers to Effective Nutrition Response in Emergencies



paper-based systems that are fragmented, slow, and prone to error



gaps in tracking, weak follow-up of children, and delayed decisions on supplies, referrals, or scale-up.



multiple stakeholders often **operating in silos**, making it hard to coordinate, report consistently, or avoid double-counting



a pressing **demand for real-time, interoperable, and field-friendly systems** to manage nutrition service delivery and outcomes

Slide 9

TZ1

This slide and the next are slightly similar in content. Good to pick one

Tavimbanashe ZISENGWE, 2025-07-18T21:29:11.884

HH1 0

Lets pick this one. and delete 9

Hajra HAFEEZURREHMAN, 2025-07-21T07:19:41.512

What is CODA?

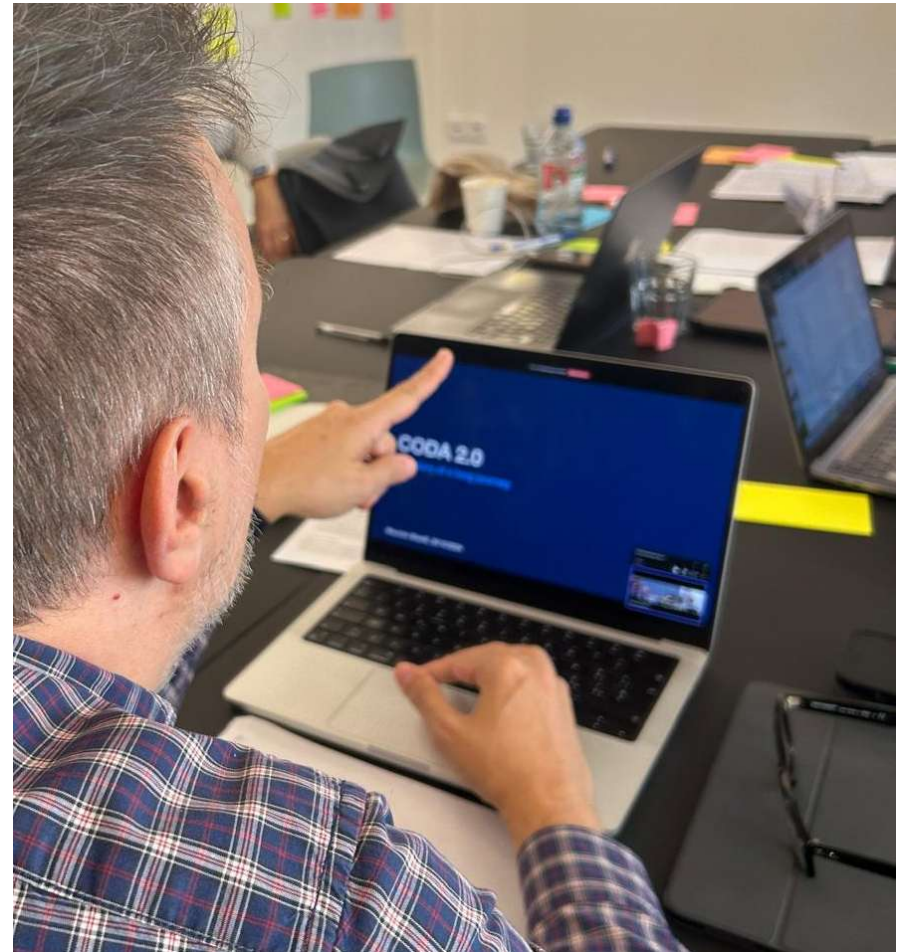
Secure, real-time digital platform designed to support nutrition and health programs

Simplifies data tracking and monitoring of severe and moderate wasting cases, addressing critical challenges in data quality and field efficiency.

CODA's offering

Informed programme decision-making and streamlined field operations for governments and organisations.

Enables impactful program delivery in humanitarian contexts, supporting better outcomes and efficient, integrated programming.

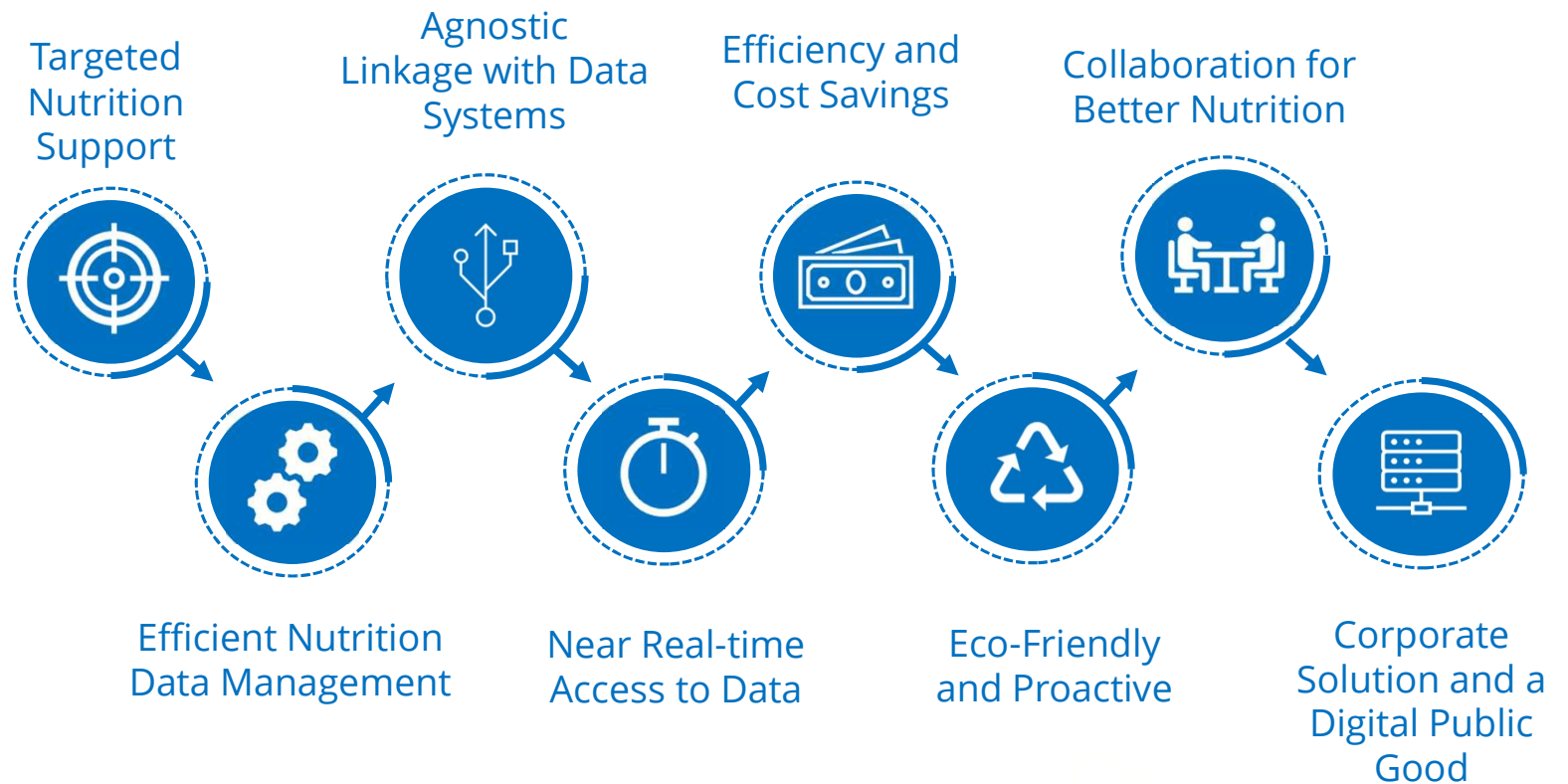


Value Proposition

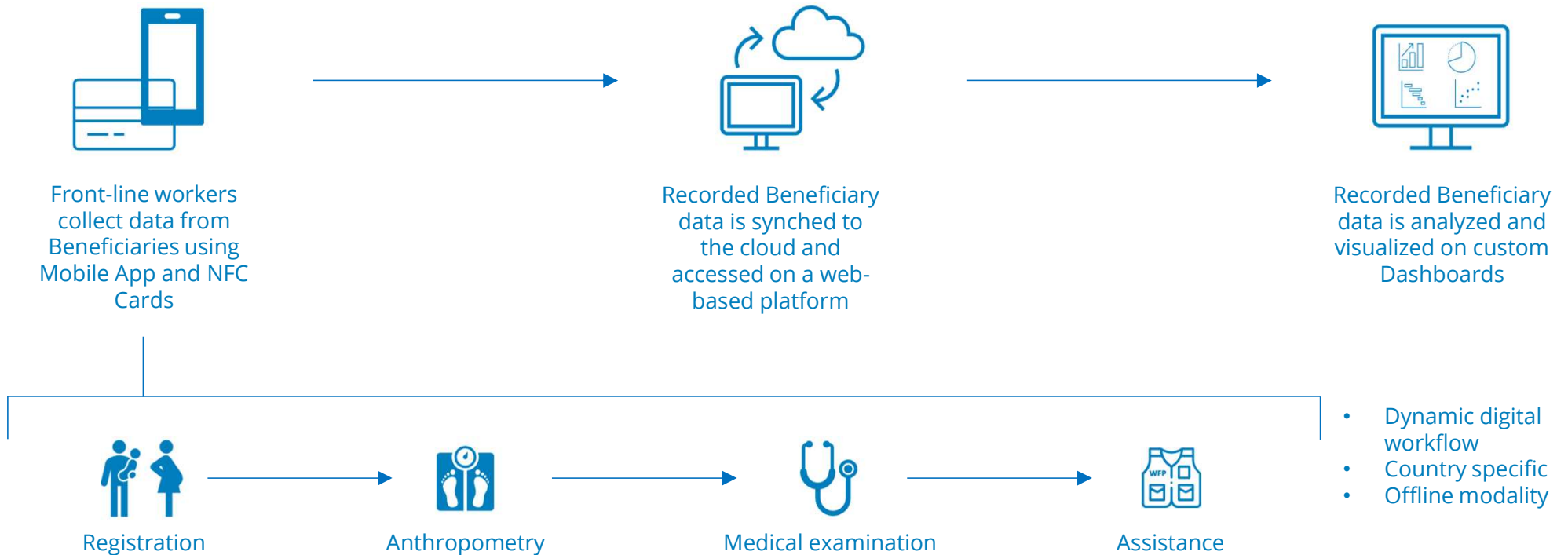
CODA VALUE PROPOSITION

Reduces reliance on paper-based recording, improving data efficiency.

Reduces errors, duplication and gaps in data and information improving decision-making for programming



How does CODA work?



CODA allows frontline health care workers to collect offline data via a mobile app, sync it to the cloud, and access real-time insights on dashboards. This streamlines registration, measurements, medical exams, and assistance, and serves as a job-aid for front-line workers for decision making and protocol adherence improving nutrition programme outcomes.

CODA 2.0 Global Implementation Status



Stronger, smarter CODA is here

A new version of CODA was re-developed to be open-source and interoperable in 2024



Operational in 3 countries

South Sudan, Nigeria, Ethiopia



Digitizes Treatment (SAM, MAM), Prevention, Supply Chain

CODA Programmatic Status



Better Quality Assurance & Real-Time Decisions
Integrated data ensured faster, more effective program delivery.



Efficiency-Driven Care Delivery
Digital job aid streamlined processes, saved time, and enhanced health worker productivity for consistent, high-quality care.



Operational Cost Efficiency
Significant cost savings for CO through digitization, replacing manual record-keeping



Sustainable Expansion
Scale-Up Strategy defined through 2026.

CODA Projected Cost Savings and Efficiency

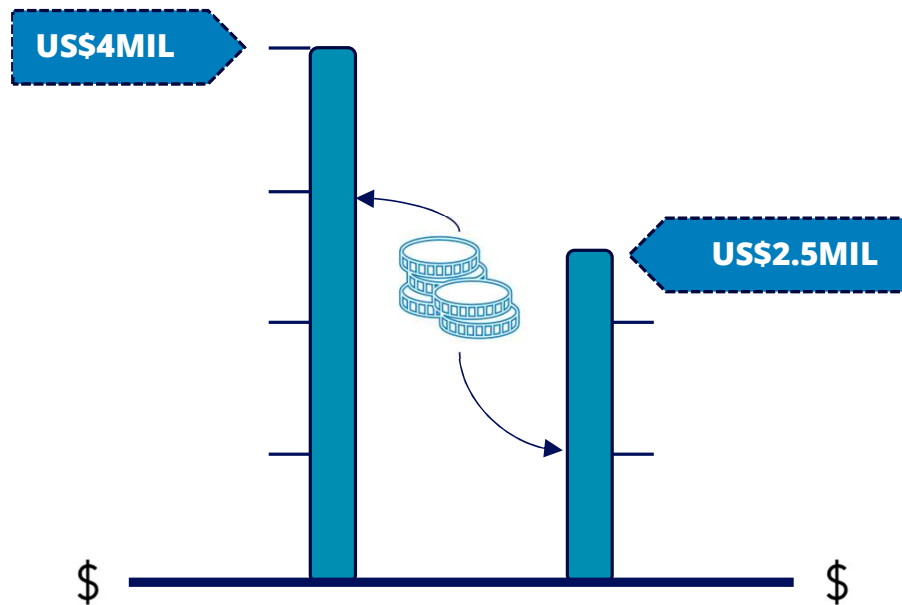
Cost Comparison: Manual Record Keeping Tools vs CODA Equipment (Over 5 Years in 900 Sites), South Sudan!



Manual Record Keeping Cost

- 800k yearly on OTP, TSFP U5 and PBWG tools (paper-based)

Total: \$4,000,000



CODA Equipment Cost



- Initial Implementation: \$2,000,000
 - Maintenance (5 Years): \$500,000
- Total: \$2,500,000**

Conclusion: Over 5 years, **CODA is more cost-effective**, saving **\$1,500,000** compared to manual record keeping.

CODA: Key Components & Features



Mobile Application

- Front-end deduplication
- Offline aggregated reports
- Follow-up action list
- Daily stock take
- Daily screening report
- Offline entity sharing

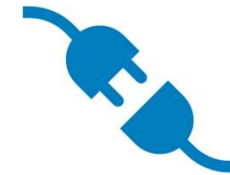


Web Application

- Beneficiary management



Analytics Dashboard



DHIS2 and other systems integrations

CODA: Advanced Analytics



Seasonal trend analysis : cure, default & LOS by rainy vs. dry seasons, AWG etc.



Referral flow analytics : Prevention \rightleftharpoons OTP/TSFP \rightleftharpoons SC tracking & completion rates



Performance benchmarking: identify sites below Sphere standards



Gender, age & geographic equity in treatment outcomes



Correlation analysis: WASH, food security, disease vs. malnutrition



Predictive modelling: default & relapse risk from weight/MUAC trends



SBCC impact: session attendance vs. recovery outcomes



Supply chain analysis: stockout alerts & delivery gaps

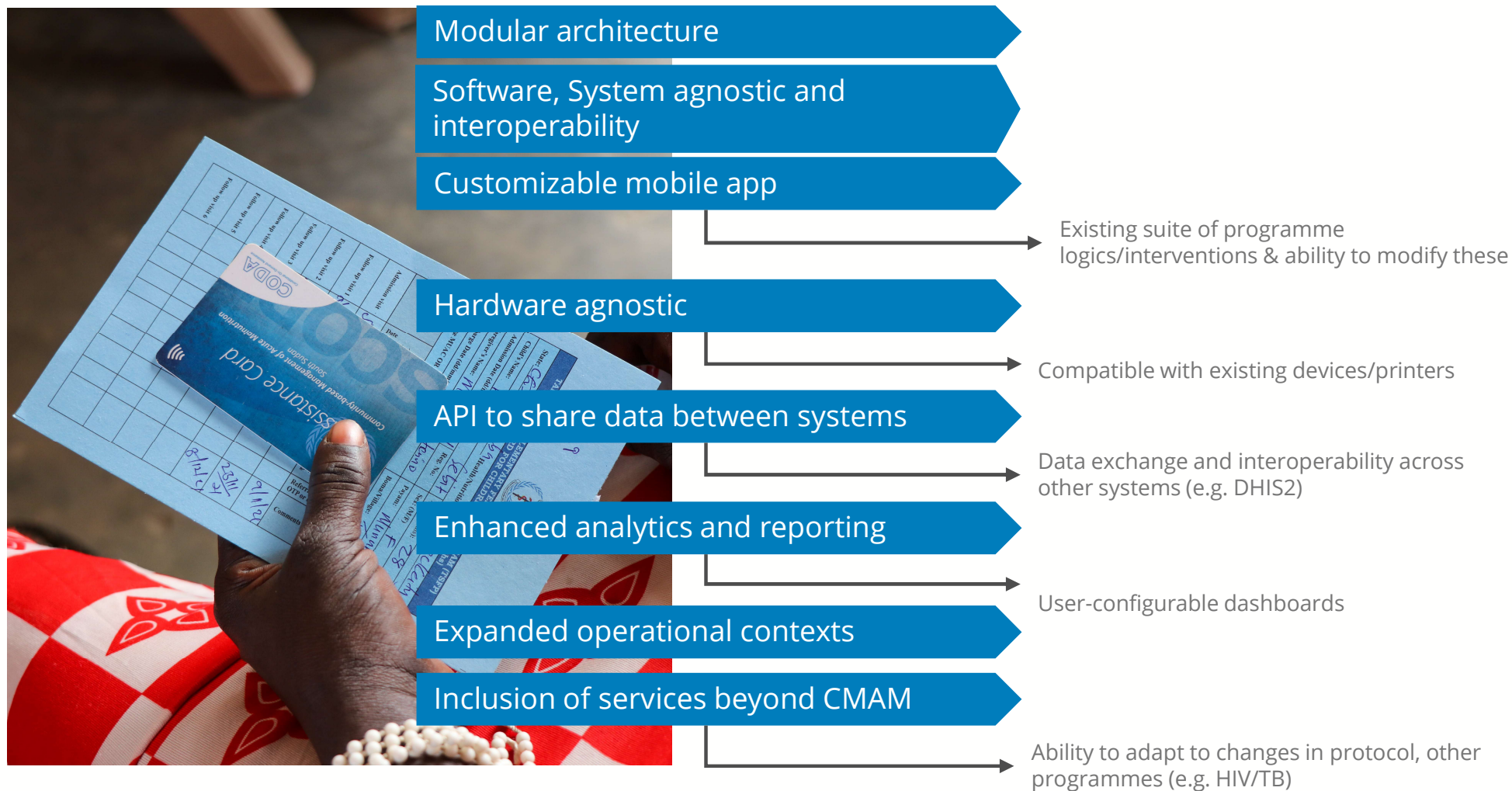


Admission forecasting: time/location/partner-based patterns



Cost-effectiveness per intervention & site etc.

Technical Features



Pre-CODA Challenges



Poor
information
management



High inclusion/
exclusion
errors



Weak referral
and
continuum of
care



Lack of real-
time data



Overstretched
workforce

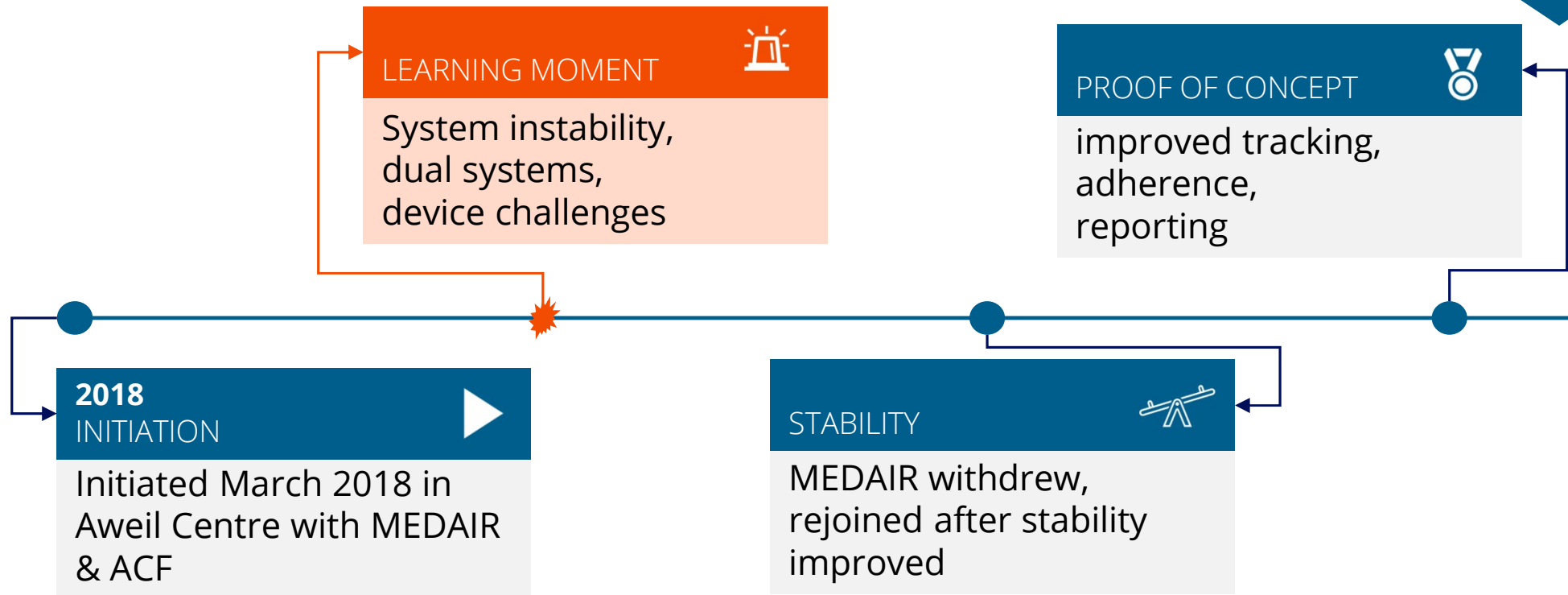
Use Case: South Sudan

Time-Saving for Beneficiaries and Health Workers

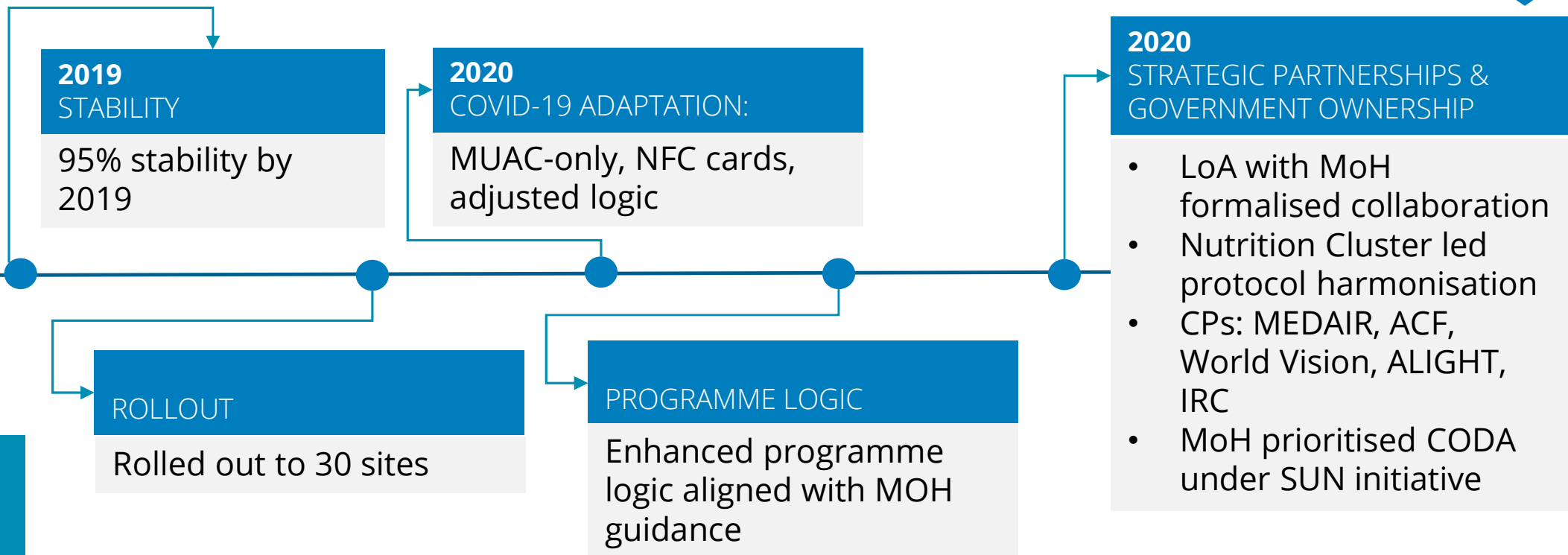


**WFP WORKS
TO TREAT AND PREVENT
MALNUTRITION IN
SOUTH SUDAN**

Pilot Phase: Early Implementation and Lessons 2018



Rollout & Adaptation 2019-2021



CODA Status South Sudan



Stronger, smarter CODA is here

A new version of CODA was re-developed to be open-source and interoperable in 2024 in South Sudan

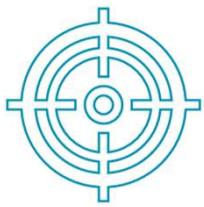


Adapted to new version of CODA 2.0 in August 2024 CODA has scaled up and reaching 30,000 beneficiaries already from 84 Health Centres.

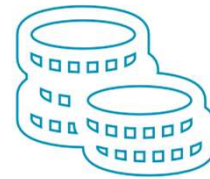


National scale up efforts accelerated in early 2025 to cover all health centres implementing the new WHO guidelines **reaching 200 sites, and over 300,000 beneficiaries in 2025**

Outcomes and Impact 2021-2024



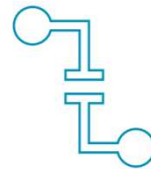
Improved **protocol adherence** and reduced **errors**



Cost per beneficiary drops as CODA scales up in more sites



Service time reduced by **19 mins to on average 4 mins** per beneficiary excluding waiting time.



Identified **data gaps** in NIS

CODA Alignment with Global Guidance

Simplified Protocol for Acute Malnutrition

A simplified, combined protocol is intended to simplify and unify the treatment of uncomplicated severe and moderate acute malnutrition for children ages 6-59 months into one protocol in order to improve the coverage, quality, continuity of care and cost-effectiveness of acute malnutrition treatment in resource-constrained settings. The simplified, combined protocol tested in COMPAS uses only ready-to-use therapeutic food (RUTF) at doses tested to optimize growth and minimize cost at each stage of treatment. Admission, progress and discharge is assessed using mid upper arm circumference (MUAC) and oedema only.

When resources are spread thin, this approach may:

- Eliminate the need for separate products, infrastructure, and administrative procedures for MAM treatment;
- Enable earlier treatment of cases before deterioration into more costly SAM treatment; and
- Enable better continuity of care

In the context of COVID-19, delivery of a simplified acute malnutrition treatment protocol by community health workers could relieve the burden on health facilities and reduce risk of viral transmission between patients. The simplified, combined protocol on the right was tested in the COMPAS trial; different countries should adapt the protocol to local context as needed. Ready-to-use Therapeutic Food (RUTF) was used in the COMPAS trial; different ready-to-use foods (RUF) designed to treat SAM and/or MAM could be used according to supply availability.




< 115mm	115 - < 125mm
2 RUTF a day 1000kcal	1 RUTF a day 500kcal

Simplified, Combined Protocol tested in COMPAS	
Admission criteria	<125mm MUAC AND/OR bipedal oedema (+/+ +) AND clinically uncomplicated (i.e. passes appropriate test, no Integrated Management of Childhood Illness (IMCI) danger signs/no serious medical complications)
Treatment frequency	<115mm: Weekly 115-125mm: BI-weekly
Dosage	<115mm and/or oedema (+/+ +): Two 92g sachets RUTF/day (1000 kcal/day) 115-125mm: One 92g sachet RUTF/day (500 kcal/day)
Transition from 2 RUTF to 1 RUTF	Two consecutive weekly measurements at or above 115mm and no oedema
Cured	>125mm for 2 consecutive measurements and no oedema, with 3 week minimum stay
Default	Absent for 3 consecutive visits
Non-recovered	Has not achieved discharge criteria within 16 weeks
Discharge procedures	Discharge ration of 7 RUTF sachets
Routine medical treatments (as per national protocol)	For all children with MUAC <115mm and/or bipedal oedema (+) on admission: Amoxicillin: Give first dose at health facility and then give remainder to caretaker with instructions to give twice daily for 7 days For all children with MUAC <125mm and/or bipedal oedema (+) on admission: - Measles: according to national protocol - Measles: one vaccine on 4th visit (4th week) (children <8 months) (unless already vaccinated) - Deworming: one dose (albendazole or mebendazole) on the second visit (second week) (children <1 year)
Referral procedures (as per national protocol)	Any child who develops medical complications and/or is not responding to treatment will be referred for a medical evaluation and/or to the Substitution Center. "Not responding to treatment" will be defined in the following way: - Failure to gain any weight (non-oedematous children) - Failure to start to lose oedema - Oedema still present - Weight loss since admission to program (non-oedematous children) - Failure of appetite test - Weight loss of 5% of body weight - Weight loss for two successive visits

Adapted to **COVID-19** simplified protocols

Updated for 2023 WHO Wasting guidelines:

- MUAC-based diagnosis
- SAM/MAM integration
- Community-level delivery

WHO guideline on the prevention and management of wasting and nutritional oedema (acute malnutrition) in infants and children under 5 years



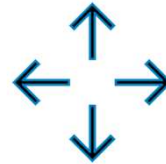
Key Lessons



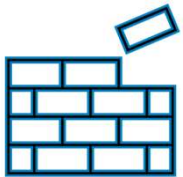
Key Lessons Learned from South Sudan



Co-creation with users is critical



Flexibility enables adaptation



Infrastructure is foundational



Transitioning requires **trust & training**



Partnerships drive sustainability

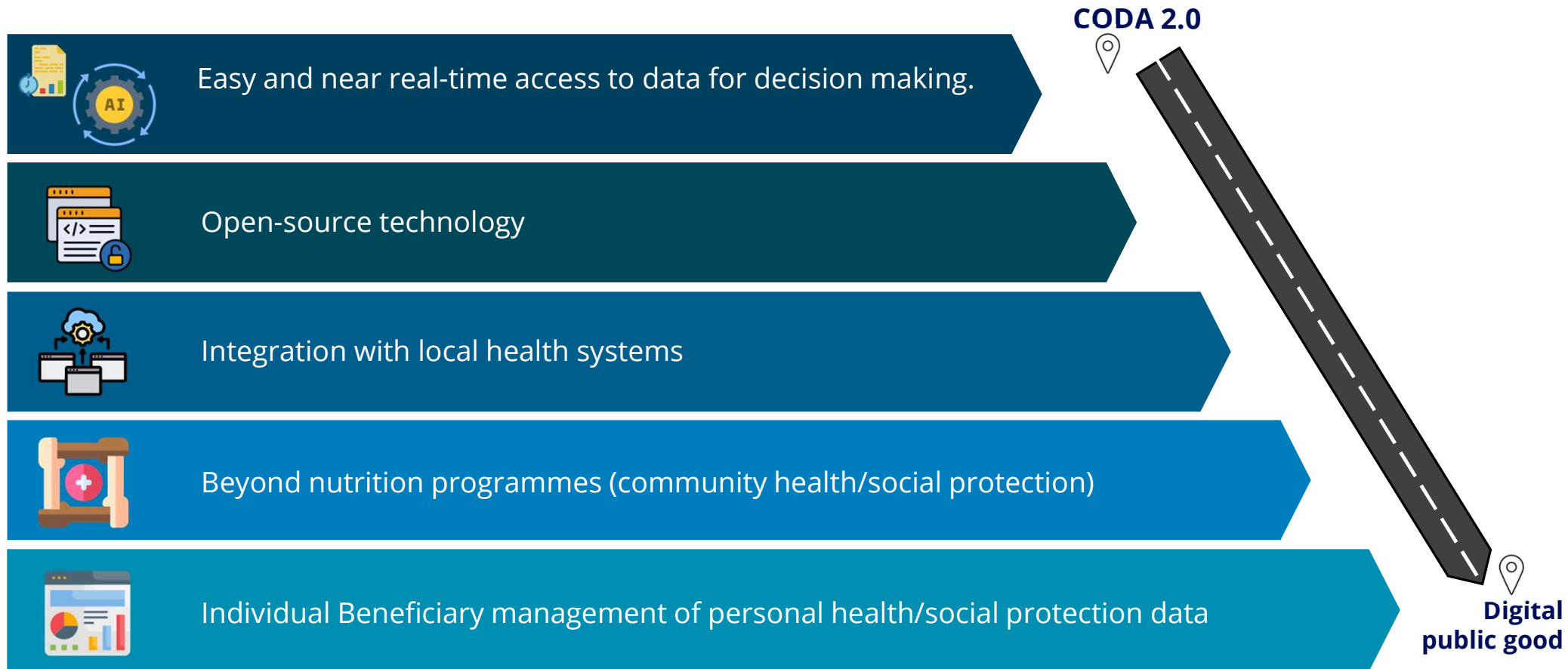


Open-source enables scale

Way Forward



Vision & Journey Towards a Digital Public Good



Way Forward

The Vision and 2025-2026 Plans

Vision 2030

50 aspirational Countries

15 priority countries

5+ full scale-up with Country: 5+ (enrolling over 60% of the caseload in 2 countries)

2026

Scale up : 2-4 additional countries

CODA Deployment countries: 6-12

Facilitate learning and socialization from CODA

Costing and resource mobilization

2025

Deploy in 3 countries in 2025, scale in 1-2

Way Forward

A Collective Opportunity to Transform Nutrition Delivery



From Pilots to Systems Change

CODA has proven it can reduce costs, save time, and improve care. The next step is embedding it into national systems, transforming how nutrition services are delivered at scale.



Partnerships Are the Engine of Scale

Scaling CODA requires joint leadership across governments, implementing partners, and donors. Shared ownership ensures relevance, reach, and resilience.



Invest in What Delivers

With cost savings and improved program outcomes, CODA offers a compelling case for sustained investment in digital transformation.



Link and Strengthen the Ecosystem

CODA is part of a larger shift toward interoperable, digital public goods that work together, from stock management to social protection and beyond.



The Road Ahead

By 2026, we aim to scale CODA to countries, deepen integration, and generate global learning.

Questions





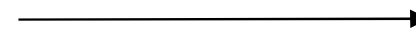
**Next steps
and closing!**



Looking for support in Nutrition in Emergencies?

	Type of supported needed	Provider
1	I want remote or in-country technical support	GNC
2	I want to hire a consultant directly	GNC
3	I want quick technical advice	GNC
4	I want peer support	www.en-net.org

Visit: <https://nutritioncluster.net/> to Request Support or scan the QR code



How to Access Support

Request support on coordination, information management, integration for nutrition outcomes or technical nutrition in emergencies assistance.

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 nutritioncluster.net



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it will take less than 5 minutes
(it will pop up when you close the webinar)

Current Status and Scalability

2024-2025



Device/system agnostic, Android-compatible



Present in **84** health centres
AIMING FOR 180 by August



Open source
and **scalable**



Interoperable with
DHIS2, SCOPE, NIS

Questions?