

INTER-AGENCY STANDING COMMITTEE  
63<sup>RD</sup> WORKING GROUP MEETING

**Cluster Working Group on Nutrition:  
Progress Report**

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## **Executive Summary**

*Key Strategic Actions:* Predictable, accountable, and effective humanitarian response in the Nutrition sector will be improved by the following strategic actions:

- Recognizing the critical role that nutrition plays in child survival and demonstrating inter-sectoral action to eliminate and mitigate the effects of undernutrition
- Replicating and strengthening the cluster approach at country level, and ensuring its focus on building national capacity
- Establishing mechanisms to draw attention and funding to countries that are in acute, as well as, a perpetual state of emergency nutritional status
- Clarifying structures and measures of accountability within the Clusters, and clarifying the relationship of accountability between national and global levels of cluster work

Improvements to humanitarian response will only be achieved with commensurate resources to implement.

*Costing:* The cost of providing a minimum package of nutrition interventions to a crisis-affected population of 600,000 children and 200,000 pregnant and lactating women, is US\$5.7 million (\$3.16 per capita per month).

*Capacities and Gaps:* An initial capacity and gap assessment was presented in the August 22, 2005 Nutrition Cluster Working Group report and has been used as an indicative guide to propose priority actions. A more comprehensive gap analysis is a planned activity in the Implementation Plan. Existing capacity has been recognized and identified, both within individual agencies in each of the 10 identified working areas, as well as within numerous working groups on emergency nutrition, including the UN Standing Committee on Nutrition (SCN), Emergency Nutrition Network (ENN), etc.

When addressing gaps, we must ensure we are building on the significant work that already exists in emergency Nutrition. Preliminary gaps have been identified in the areas of: sector coordination, assessment, monitoring and surveillance; emergency preparedness and response triggers, norms and policies, staffing and surge capacity, among other technical areas.

*Preparedness and Response:* The Nutrition Cluster has identified several critical action points for improved preparedness in 2006, as well as technical working areas for an improved response. Results have been articulated for 8 of the 10 working areas and will be further elaborated upon with timelines and accountabilities for presentation to the IASC Principles on 12 December.

*Cluster Participation:* The Global cluster has 10 actively participating agencies, including NGOs, the IFRC and the ICRC. We would like to see added participation of key emergency nutrition NGOs, bilaterals, and, as appropriate, liaison with existing emergency nutrition working groups such as the UN Standing Committee on Nutrition.

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## **I Introduction:**

Following the September 12 meeting of the IASC Principals, Cluster Leads were requested to undertake the following actions between September and December:

1. Decide how the cluster will substantially improve the humanitarian response within the sector for new emergencies
2. Complete assessment of capacities and gaps in the sector
3. Carry out specific capacity mapping and response planning in consultation with the Humanitarian Coordinators to improve response in a selected number of existing emergencies
4. Improve non-UN actor involvement in the process, building on regional/national capacities
5. Ensure integration of cross-cutting issues such as gender, age and diversity; HIV/AIDS; human rights
6. Undertake coordinated response planning and preparedness measures, build links between clusters and prevent duplication with other structures
7. Prioritize actionable recommendations for 2006 implementation
8. Develop recommendations on outstanding cluster specific issues, such as the broader protection framework
9. Develop a plan for a phased introduction
10. Prepare cluster-specific resource requirements

Since September, the Nutrition Cluster has continued to meet regularly through conference calls and has scheduled its first face-to-face meeting on December 5-7 to finalize the 2006 Cluster Implementation Plan, for ultimate submission to the IASC Principles on 12 December. The Cluster Lead has also had one face-to-face meeting with OCHA (Ms. Yvette Stevens) and the WASH Cluster.

The Global Cluster has been significantly involved in the response to the South Asia Earthquake, providing support and guidance, and serving as a conduit of information flow between country and global level. The South Asia Earthquake provided timely experience and a wealth of lessons learned to guide the Cluster forward, many of which are reflected in the recommendations and suggestions of this report. It was challenging to respond comprehensively to the South Asia Earthquake while simultaneously moving forward on conceptual issues in accordance with the agreed timeframe. Nonetheless, we feel we have made good progress in the 10 areas above.

It should be flagged that the de facto application of the cluster approach in Pakistan has generated significant discussion regarding process and realistic implications of the cluster approach. We would like to highlight the importance of ensuring participating agencies and organizations have been able to absorb the implications of the cluster approach, both as it impacts their individual agencies as well as the wider context of

humanitarian response and the way we do business. If one thing has been clarified, indeed it is the realization that business-as-usual will not be sufficient. We will have maximal success with the cluster approach if we move forward with realistic commitments from agencies that can be monitored and feasibly applied in practice.

We would like to ask the IASC Working Group to consider this report as a working document that reflects ongoing discussion and decisions that will continue to be refined and solidified as we collectively move forward with the cluster approach process.

## **II How to Improve Humanitarian Response in the Cluster Area**

Since the endorsement of the IASC Principals document in September, the Nutrition Cluster Working Group has continued work to develop an implementation plan with the aim to improve the predictability, effectiveness and accountability of humanitarian action in Nutrition. Experience with the Cluster approach to date has underscored the following underlying principles as essential for an improved humanitarian response in the Nutrition sector:

- Although undernutrition has proven direct and indirect impact on child survival, and is particularly critical in crisis contexts, it has been established that Nutrition has not been consistently and sufficiently addressed in prior emergencies. **The crucial role that Nutrition plays in child survival must be given more attention as a vital part of humanitarian response and strategies.** The nutritional status of young children is the outcome of i) access and utilization of adequate foods, ii) effectiveness of health services and healthiness of the environment, and iii) quality and level of maternal and child care. As such, Nutrition interventions are most effective when integrated inter-sectorally and require not only the commitment of the Nutrition Cluster (and Nutrition staff at regional and country level), but also of the Health, Water and Sanitation, Food and Education sectors and clusters. It will be the primary role of the global Nutrition CWG to advocate for and support the implementation of Nutrition activities through various working groups and channels--at global, regional and country level.
- Lessons learned from the South Asia Earthquake have demonstrated that in order to ensure a predictable, effective and accountable response in Nutrition, **the cluster approach must be replicated and strengthened at country level.** The cluster approach will be most effective with buy-in and commitment not only from global clusters and IASC members, but also from Government, bilateral, and non-UN actors at the national level who can leverage this approach to respond more efficiently within existing roles, structures and procedures nationally. Efforts must be made to ensure Country Teams are brought into the process and discussions as soon as possible, and that the approach remains focused on the building of Government and national capacity.
- While appeals and funding mechanisms exist for countries in which undernutrition is a direct consequence of conflict or natural disaster, almost half of all under-five deaths linked directly or indirectly to undernutrition do *not* occur in

acute emergency contexts. In addition to increasing funding dedicated to Nutrition in acute emergency contexts, **mechanisms must be established to draw attention and funding to countries that are in a perpetual, chronic state of emergency nutritional status.** The Nutrition Cluster welcomes the upgraded CERF proposal as a potential funding mechanism to do so. The Lead Agency for Nutrition has also requested resources for a Communication Officer to ‘sound the bell’ to the media, donors and general public on Nutrition emergencies globally. We look forward to continued work with the IASC to identify further mechanisms to bring attention and resources to these silent and forgotten emergencies.

- In order for the IASC cluster approach to be truly effective and to distinguish itself from existing or past initiatives with similar humanitarian objectives, **the Nutrition Cluster welcomes additional guidance from IASC on proposed structures and measures of accountability within the Clusters and to clarify the relationship of accountability between national and global levels of cluster work.**
- It is the intention and objective of all agencies to use existing funds in the most efficient ways possible. Efforts will continue to be made to enhance cost-effectiveness and efficiency, **but it is unlikely we will see a measurable impact in the Nutrition sector without injecting additional resources to upgrade action in this sector.** It should also be stressed that additional funding is required not only for the lead agency to coordinate and deliver in many technical areas for which it is leading, but also for the participating IASC members and NGOs who also manage and implement Nutrition interventions globally. It is unrealistic to expect immediate improvements without commensurate resources to implement.

### III Capacities and Gaps

An initial capacity and gap assessment of the Nutrition sector was presented to the IASC Working Group in the August 22, 2005 Nutrition CWG Report.<sup>1</sup> Although, as stated in the report, that assessment could not be considered comprehensive, the Cluster has used this preliminary identification of capacities and gaps as a basis to propose priority results and activities for 2006 (see annex 2).

Existing capacity has been recognized and identified, both within individual agencies in each of the 10 identified working areas, as well as through numerous working groups on emergency nutrition, including the UN Standing Committee on Nutrition (SCN), Emergency Nutrition Network (ENN), etc.

When addressing gaps, we must ensure we are building on the significant work that has been done and is ongoing in emergency Nutrition. A comprehensive assessment is still to be completed; however indicative gaps may include the following:

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<sup>1</sup> Page 10 and Annex 3

- **Sector Coordination:** Inadequate coordination at all levels (global, regional and country); no common definition of what it means to coordinate.
- **Assessment, Monitoring and Surveillance:** Lack of continuous and reliable data that is comparable between agencies and over time
- **Emergency Preparedness and Response Triggers:** Lack of standardized minimal indicators for response triggers; lack of standardized Nutrition early warning systems
- **Norms and Policies:** Too many different guidelines and protocols within UN and NGOs. There is a need to identify guidelines for compliance and harmonization.
- **Staffing and surge capacity:** Insufficiently trained staff with technical capacity to analyze and respond to nutrition data, inadequate number of trained staff in management of severe malnutrition

A thorough and credible capacity assessment is important for future planning and resource prioritization. It is, however, a significant task to conduct a global capacity assessment and as such the activity has been placed into the Nutrition Cluster's implementation plan as a priority action (pending resources), for completion by April 2006.

While each agency is mandated by specific core commitments in Emergencies and could assess sector performance based on agency-specific corporate benchmarks, **a sector-wide capacity and gap assessment would be maximized if measured against a context of benchmarks that are agreed to be the minimum standard by all IASC cluster members.** Thus we propose that a capacity assessment go hand in hand with a commitment to endorse, establish and/or agree upon emergency Nutrition benchmarks by April 2006. We are optimistic progress will be made in this area building on SPHERE standards, and following the WHO-led workshop on Assessing and Tracking Humanitarian and Health Outcomes (1-2 December, 2005). A follow-up discussion on benchmarks is scheduled to take place during the Nutrition Face-to-Face meeting on 5-7 December, where a decision is expected to be made.

#### **IV Response in selected existing emergencies**

The Nutrition Cluster is in agreement with the current position of the IASC to focus on a select number of existing emergencies to pilot and learn how to improve humanitarian response by the cluster approach. However, it is unclear what the agreed upon criteria have been to identify pilot countries to date. We would like to see the following factors taken into consideration to inform the choice of pilot countries:

- Potential for a synergistic response across sectors
- Balance between natural disasters/complex emergencies

- Regional parity<sup>2</sup>
- Attempted consistency with pilot countries selected by other global initiatives (e.g. Ending Child Hunger and Undernutrition Initiative and others) to capitalize on existing resources and multiply impact

## V Non-UN Actors Involvement

The following UN and non-UN actors are current active participants in the Nutrition Cluster globally:

- *UN*: WHO, UNHCR, WFP, FAO, UNICEF, UNFPA, OCHA
- *Non-UN*: IFRC, ICRC, Save the Children UK/SPHERE

In the South Asia Earthquake, a significant number of non-UN actors are involved, including bilaterals.<sup>3</sup>

We have made proactive attempts to increase non-UN participation at the global level, and will continue to make additional attempts to do so. At a minimum, we would like to see the participation of key emergency Nutrition NGOs such as MSF, ACF, GOAL, and OXFAM.

**Distinction of accountabilities and expectations of NGOs vis a vis UN actors in the global Cluster approach would likely clarify objectives of NGO involvement and improve participation.**

**The Nutrition Cluster considers bilaterals to be key actors in the general Cluster approach.** Related specifically to Nutrition, there are particular bilateral agencies that are actively involved in emergency Nutrition activities, strategic guidance and in some instances, implementation. We consider their participation crucial and would like to see the eventual inclusion of CDC, USAID, DFID and ECHO.

In addition, we do not want to create unnecessary duplication by this Cluster, and so must ensure complementarity with key existing working groups dedicated to emergency Nutrition, notably the UN Standing Committee on Nutrition (SCN), the Emergency Nutrition Network (ENN), and the SPHERE project. Before finalization of the Cluster Implementation Plan, we will review the SCN emergency nutrition workplan to ensure activities do not overlap.

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<sup>2</sup> Most under-five deaths are clustered in two regions of the world: sub-Saharan Africa, which accounts for 44% of deaths; and South Asia, which accounts for 32%. We would like to see a country focus that at a minimum represents these two regions.

<sup>3</sup> UNICEF, Netherlands Embassy, USAID, HIC, CRS, Caritas, IFRC, WASEP-AKPBS-P, WHO, Mercy Corps, Oxfam, LIFE, CIDA, JEN, DFID, THW, NCA, Islamic Relief, Save the Children, USAID, Interfaith League Against Poverty, World Bank, ACF, Concern, GOAL, IMC, INTERSOS, MERLIN, MSF, PSI, ACTED, ALISEI, CARE, ARC, CESVI. Coordinated effort with the Ministry of Environment and the Ministry of Science and Technology



## VI Cross-Cutting Issues

Several cross-cutting issues are integral to Nutrition security in emergencies:

- *Gender*: Nutrition security is impacted by gender roles and a woman's ability to access food safely and equitably, by her ability to safely access water, firewood or fuel, and by the amount of other demands placed on her that may detract from her ability to care for her children and prepare food (such as whether she must care for sick family members, whether she herself is sick or infected with HIV, whether or not she can control the number and timing of her children, etc). Gender is mainstreamed into many IASC member agencies' current mandates and demonstrated programmes in Nutrition, and is an area that provides further opportunities for cross-sectoral work between Nutrition and Agriculture, Health, and Education.
- *Nutrition and HIV/AIDS*: HIV/AIDS has devastating impacts on nutrition, at individual, household and community level. Undernutrition in turn increases both the susceptibility to HIV infection and the vulnerability to other HIV-related infections. Knowledge of the devastating interactions between HIV/AIDS and food and nutrition security has been growing in recent years, but the crucial next step - of using this knowledge to improve and scale up effective actions - has yet to be taken. Initiatives on mainstreaming nutrition in HIV/AIDS programming strategies in emergency situations do exist and it is important to build on and learn from them. Particularly, it is imperative that the HIV/AIDS-Nutrition work that has been undertaken in Sub-Saharan Africa is built upon and utilized for better preparation in other areas where comparable impacts of HIV and food and nutrition insecurity may soon be experienced, such as South Asia. More work needs to be done in this area, in terms of empirical evidence, increased action and scaling up, and monitoring and evaluation. **The IASC Nutrition Cluster has identified HIV/AIDS as a sub-cluster area, where WHO is leading. Key challenges and opportunities for integrating and systematically mainstreaming nutrition into HIV/AIDS emergency programmes have been identified and activities will be incorporated into the Implementation Plan for 2006.**

## VII Plan for a Phased Introduction and Recommendations for 2006 Implementation

### 7.1 Planning and Preparedness

*As mentioned in section II of the Report, it is imperative that the cluster approach be country-led. As such, the IASC must support country planning and preparedness to ensure that all countries are aware of the cluster approach and related accountabilities before an emergency strikes. Immediately following the South Asia Earthquake, UNICEF as lead agency advised agencies within the Cluster to communicate information regarding the cluster approach with their country offices and with Government, including sharing global and national TORs for the Nutrition Cluster.*

*These TORs will need to be revised in light of lessons learned from Pakistan and disseminated to all country teams.*

The Nutrition Cluster has identified several additional steps that should be in place for effective response planning and coordination:

- *Standardized rapid assessment and survey methodologies* that facilitate consistent Nutrition-related data collection and analysis among agencies. A uniform analysis of relief requirements will ensure a more coordinated and complementary response from agencies throughout all stages of an emergency. Version 1 of SMART (Standardized Monitoring and Assessment of Relief and Transition) protocol has been piloted in 3 countries<sup>4</sup> to date. **The Cluster has initiated a process to fast track the finalization of SMART, and aims to release version 2 for review and testing by January 2006. The Cluster is also drafting a proposed tool for standardized Rapid Assessment for review by January 2006.**
- *Identifying indicators for response triggers:* Once data has been collected and analyzed, a predictable and consistent response chain should be set in motion. This entails identifying a set of indicators to consistently monitor-- before, during, and in the transition phase of an emergency-- and mapping correlated roles and responsibilities among the major emergency Nutrition agencies. **This will be initiated during the Nutrition Cluster face-to-face meeting on December 5-7, 2005.**
- *Synergy with Health, Water and Sanitation, Food, and HIV/AIDS:* It is critical not only for these sectors to respond jointly, but also to plan jointly. **Information-sharing has taken place with both the Health and Water and Sanitation Clusters and a “triple-cluster” meeting has been tentatively agreed upon to review and identify areas of collaboration within the Cluster Implementation Plans.** We hope also that there will be an official IASC mechanism whereby the cluster approach and individual cluster workplans are reviewed with a lens of overall and inter-sectoral coordination.
- *Coordination Cell:* The Nutrition Cluster has identified a working area for Emergency Preparedness and Response Trigger whose objective is to ensure many of the above activities are completed. In addition, **UNICEF, as lead agency, has proposed to host a Nutrition Coordination Cell to coordinate overall humanitarian preparedness, response and transition for emergency Nutrition.** The DRAFT Terms of Reference will be to:
  - Serve as the secretariat of the Nutrition Cluster Working Group
  - Support the implementation of the Nutrition Cluster Implementation Plan including coordination, monitoring and reporting on progress
  - Organize and facilitate IASC Cluster processes, including preparing draft reports, organizing meetings, and sharing information

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<sup>4</sup> Chad, Nigeria, portions of Niger

- Ensure joint planning and response with the IASC Secretariat and other Cluster Secretariats (particularly Health, Water and Sanitation, and Food)
- Build relevant partnerships with organizations and individuals to ensure implementation of the Nutrition Cluster Implementation Plan and TOR
- Coordinate the development of capacity within the Nutrition Cluster (e.g. helping to standardize training materials, developing inter-agency standby arrangements, developing staff profiles, etc.)
- Identify the resources required for a predictable, speedy, and effective response in nutrition emergencies
- Maintain updated knowledge of nutrition crises globally, and mobilize awareness within the international community to ensure an adequate response for nutrition in declared emergencies (e.g. raising attention related to lack of access or limited resources, etc.), and raise early warning signals for imminent or foreseeable emergencies

## ***7.2 Recommendations for 2006 Implementation***

The Nutrition Cluster has developed a Draft Implementation Plan for 2006 (see Annex 2), which will be finalized on December 5-7 for submission to the IASC Principals by December 12<sup>th</sup>. Results and activities have been identified, for almost all working areas. Still pending is finalization of a precise timeline, and identification of activities for which additional funding is necessary beyond what currently exists.<sup>5</sup> Clarification on fundraising responsibilities of the cluster is welcome.

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<sup>5</sup> Activities for which additional resources are necessary, but are not funded will obviously not be able to take place. This includes overall coordination of the Cluster.

Key elements of the Implementation Plan include the following:

### **7.2.1 Sector Coordination**

*Results to be achieved:*

- IASC roles and accountabilities are clear at global and country level, and coordination mechanisms at all levels are well established
- Global capacity of the Nutrition sector is assessed and national capacity assessments supported
- Timely and systematic advocacy for Nutrition emergencies takes place during all phases of an emergency
- Appropriate staff are identified and rapidly deployed in the immediate onset of an emergency
- Staff are trained to effectively prepare for and respond to Nutrition emergencies

### **7.2.2 Emergency Preparedness and Response Trigger**

*Results to be achieved:*

- Consensus exists on what determines a Nutrition emergency (chronic and acute)
- Relevant information is collected systematically in order to prompt effective and timely action
- Inter-agency consensus on an effective and coordinated response to Nutrition at country-level
- New and existing staff have skills in data analysis and interpretation for response planning
- Relevant supplies are readily available during the immediate onset of an emergency
- Agencies and country offices have tools to monitor their preparedness

### **7.2.3 Assessment, Monitoring and Surveillance**

*Results to be achieved:*

- Timely, accurate and standardized data exists for an appropriate and rapid response
- Information is disseminated systematically
- Performance quality and programme impact is monitored and evaluated

#### **7.2.4 Norms and Policies:**

*Results to be achieved:*

- Existing guidelines for compliance and harmonization are identified
- Guidelines/Policies/Operational Guidance that need to be developed are identified and in process of development

#### **7.2.5 Infant and Young Child Feeding**

*Results to be achieved:*

- Immediate protection, promotion and support for breastfeeding and relactation is a demonstrated part of emergency Nutrition response and guidance
- Staff and Government are aware of and trained in Infant and Young Child Feeding protocols and commitments (3 pilot countries initially)
- Standardized process exists to control excess donations of commercial formula and its safer use for those few infants who are identified and supervised by trained personnel.

#### **7.2.6 Micronutrients**

*Results to be achieved:*

- Iodized salt and fortified food is provided to beneficiaries in all new emergencies in 2006
- Minimum standards and tools exist for assessment of MN status in emergencies
- Concise operational guidance exists for implementation of MN activities in emergencies
- Clear indicators agreed upon to be used in monitoring of MN situation including outbreaks
- Clear guidance exists for how and when to use Multi MN and fortified food based in emergencies
- Better understanding of MN policies implementation already exist prior to emergencies (e.g supplementation)

#### **7.2.7 Nutrition and HIV/AIDS**

*Results to be achieved:*

- Nutrition is mainstreamed in all HIV/AIDS programmes during emergencies, and HIV/AIDS is streamlined in Nutrition programmes

- Standard guidelines exist and disseminated
- Agreed indicators for monitoring exist

### **7.2.8 Therapeutic Feeding**

*Results to be achieved:*

- Guidelines exist to standardize and improve the quality of existing and new CTCs
- Referral systems are strengthened and TFCs integrated into health facilities
- Staff are available and trained in management of severe malnutrition in countries and on surge capacity rosters
- Treatment of malnutrition is closely lined to preventive strategy

### **7.2.9 Supplementary Feeding**

*Results to be achieved:* To be determined during face to face meeting Dec. 5-7

### **7.2.10 Food Security**

*Results to be achieved:* To be determined during face to face meeting Dec. 5-7

## **VIII Recommendations on Cluster Specific Issues**

- In the August 22, 2005 Report it was agreed that UNHCR should continue to be responsible for Nutrition in refugee settings in accordance with its mandate. Therefore, we have decided there is no need to form a distinct working area for Nutrition in Refugee situations.
- On September 12, the IASC Principals agreed to change the name of the Cluster from “Nutrition and Feeding” to “Nutrition.”<sup>6</sup> Further clarity is requested on what the anticipated expectations of this name change were. In light of the name change, we are amidst discussions about whether or not food security and supplementary feeding should remain within the scope of the Cluster.
- During the South Asia Earthquake, we saw a combining/addition of Food into the Nutrition Cluster to form a Food and Nutrition Cluster. Increased clarity is needed on the balance to strike between agreed upon global Clusters and the autonomy/decentralization of Country Teams to determine an individualized response mechanism that is appropriate to their needs.

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<sup>6</sup> Outcome Statement of the 12 September IASC Principals meeting, pg. 10

## **IX Cluster-specific resource requirements**

It will be immensely valuable to have a figure on hand that quantifies what it will take to deliver on nutrition in emergencies. This can greatly assist in the rapid mobilization of funds to facilitate an immediate response to humanitarian crises. The Cluster has come up with an initial estimate of \$5.7 million for an initial phase of an emergency (first 3 months), which would provide assistance to a beneficiary population of 600,000 children under 5, and 200,000 pregnant and lactating women. This costing is based, of course, on numerous assumptions (detailed in annex 1) that can significantly alter the total required cost. Our current estimate of \$5.7 million amounts to a per capita cost of \$3.16.

*We believe the costing can be* further reduced with effective synergy and collaboration between the various clusters to reduce individual transaction costs and streamline activities so that standard mechanisms exist in areas such as assessment, surveillance, etc.

Prepared by Cluster Working Group on Nutrition – November 2005

### **Annexes and list of their content:**

- Annex I: Estimated Cost of Financing a New Emergency in 2006
- Annex II: 2006 Draft Implementation Plan for the Nutrition Cluster

## Annex 1

### Financing Nutrition Emergency Interventions: 2006

Assumptions for Ball Park Estimate:

- **An affected population of approximately 4 million people. Average proportion of children under 5 is 15%, beneficiaries are 600,000 children under 5**
- 10% of children under 5 suffer from moderate or severe acute undernutrition: 60,000 children.
- 25% of undernourished children are severely undernourished: 15,000 children suffer from severe malnutrition
- The emergency has been sudden<sup>7</sup> with little warning and no preparation
- Existing staff is not sufficient
- Security/terrain/weather is not a problem and there is sufficient access to children and women

Action	Cost (US\$)
Rapid assessment (+staff)	200,000
Cooking Supplies <sup>8</sup>	658,000
Multimicronutrients for children <sup>9</sup> , pregnant and lactating women <sup>10</sup>	400,000
Therapeutic Feeding Centres <sup>11</sup>	830,000
Vitamin A supplementation through measles vaccination campaign <sup>12</sup>	100,000
Training/capacity building of all Health Care Providers and Community workers on key health and nutrition messages with focus on safe infant feeding practices	1,500,000
Baseline for Health and Nutrition situation followed by a functional monitoring and surveillance system	1,000,000
Surge Capacity <sup>13</sup>	1,000,000
<b>Total for one emergency</b>	<b>5,688,000</b>
<b>Total for three emergencies</b>	<b>17,064,000</b>
<i>Unit cost per beneficiary per month</i>	<i>3.16</i>

<sup>7</sup> Assumption is an acute emergency

<sup>8</sup> Assuming 700,00 affected families, 10% dependant on external assistance, and \$9.40 unit cost per cooking set

<sup>9</sup> Assuming 2 RDAs weekly for 600,000 children under 5 for 3 months. \$8/1000 tablets=\$250,000

<sup>10</sup> Assuming 1 RDA/daily for 170,000 pregnant and lactating women for 3 months. \$8/1000 tablets=\$150,000

<sup>11</sup> Given above assumptions and 80% programme coverage, 12,000 children would be covered by TFCs. Assuming each TFC would have the capacity of 100 children, 20 TFCs would be required. Cost estimates include supplies, logistics, and staff to run TFC for 3 months

<sup>12</sup> Including logistics, distribution, etc

<sup>13</sup> Includes capacity for sector coordination and consists of at least 1 IP, 2 National Professionals or IPs in 4 field offices, 4 admin assistants, as well as costs of travel, meetings, technical assistance. Also assuming high-quality staff would be less inclined to work for <6 months, so costs are based on a 6 month period.



## Annex 2

### Preliminary Gap Analysis and Recommendations 2006 Implementation Plan - Draft

#### 9.1 Sector Coordination

**Lead Agency:** UNICEF

Gaps Identified:

- No straightforward network through which to coordinate responses to nutrition in emergencies. There is inadequate coordination, management and accountability at all levels—HQ, regional, and country
- Not a clear and standard definition of what it means to coordinate at HQ, Regional and Country Level
- Staff resources--each agency asks for nutrition staff and does its own thing. Need better coordination and to share resources at the country level among partners and government
- Lack of sufficient information sharing within UN Agencies
- Lack of systematic inter-sectoral collaboration
- Unpredictable capacity for nutrition across regions, countries and agencies

Result	Activities	Organization Lead	Partners	Resources Required	Timeline
IASC roles and accountabilities are clear at global and country level	1. Finalize TORs for Nutrition sector coordination at country and global level	UNICEF	Cluster		
	2. Ensure IASC mechanism and commitments are communicated, accepted, and trickle down within agencies at country, regional and global level by end 2006	UNICEF	Cluster		

<b>Result</b>	<b>Activities</b>	<b>Organization Lead</b>	<b>Partners</b>	<b>Resources Required</b>	<b>Timeline</b>
Timely and systematic advocacy for Nutrition emergencies takes place during all phases of the emergency	3. On behalf of all agencies, raise awareness of nutrition emergencies and potential emergencies to partners, media, donors, governments, etc.	<b>UNICEF</b>	Cluster		
Appropriate staff are identified and rapidly deployed in the immediate onset of an emergency	4. Develop inter-agency roster of surge capacity to be deployed in emergencies	<b>UNICEF</b>	Cluster		
	5. Develop generic TORs for emergency Nutrition officers to facilitate rapid deployment of staff	<b>UNICEF</b>	Cluster		
Global capacity of the Nutrition sector is assessed and national capacity assessments supported	6. Coordinate a capacity analysis of the international community's response to Nutrition emergencies	<b>UNICEF</b>	Cluster		
	7. Develop a national capacity assessment format/checklist	<b>UNICEF</b>	Cluster		
Staff are able to effectively prepare for and respond to Nutrition emergencies	8. Reinvigorate standardized inter-agency training curriculum for health and nutrition in emergencies	<b>UNICEF</b>	Cluster, Tufts		

## 9.2 Working Area: Emergency Preparedness and Response Triggers

### Gaps Identified:

- Lack of technical capacity to analyze and respond to information in a timely manner
- Lack of consensus on what classifies a “nutrition emergency”
- Lack of standardized monitoring systems of adequate preparedness; no test to see whether agencies are prepared (simulation exercises suggested)
- Lack of timely information and data to the appropriate people
- Insufficient stock on emergency commodities for nutrition due to constraints related to resources, logistics and security
- Lack of standardized minimal indicators for response triggers amongst international community once early warning signals are sounded
- Insufficient definitions of accountabilities and procedures for rapid response.
- Prioritization of emergencies often impedes ability to respond appropriately even when early warning signals are sounded
- Lack of internationally agreed mechanism for triggering appropriate response.
- The many guidelines/protocols for operational purposes need to be mainstreamed

Result	Activities	Lead Agency	Partners	Resources Required	Timeline
There is consensus on what determines a Nutrition emergency (chronic and acute)	9. Identify indicators/thresholds to identify and classify Nutrition emergencies		Cluster		
Relevant information is collected systematically	10. Assess existing Early Warning Systems in 3 designated “pilot countries. ”		Cluster		

Result	Activities	Lead Agency	Partners	Resources Required	Timeline
in order to prompt effective and timely action	11. As required, strengthen/develop Early Warning System in 3 pilot countries and ensure EWS are monitoring indicators agreed to in point 1 above.		Cluster		
There is Inter-agency consensus on an effective and coordinated response in Nutrition emergencies	12. Endorse minimum IASC Nutrition sector response (e.g. Benchmarks) using SPHERE minimum standards for disaster response and Valid/DFID benchmarking process and ensure their application		Cluster		
	13. Map inter-agency roles and division of labour during the rapid response phase (6-8 weeks) and agree upon division of labour within IASC WG		Cluster		
New and existing staff have skills in data analysis and interpretation for response planning	14. Ensure competencies such as data analysis and evidence-based response are included in TORs and training materials		Cluster		
Relevant supplies are readily available during the immediate onset of an emergency	15. Investigate ways to revise/strengthen process for procuring prepositioned supplies (F-75, F-100, resomal, PlumpyNut and/or other ready-to-use therapeutic foods, Micronutrient supplements, etc)		<b>UNJLC, UNHAS, CWG on logistics</b>		
Agencies and country office have the tools to monitor their preparedness	16. Develop checklist/indicators to measure preparedness for IASC agencies		Cluster		

### 9.3 Working Area: Assessment, Monitoring and Surveillance

#### Gaps Identified:

- Lack of continuous flow of consistent and reliable data for decision making (e.g., early warning systems, nutrition surveillance). Information may be available but not shared which could be due to lack of trust and transparency amongst agencies
- Information gaps between HQs and Country Offices
- Too many assessments which are not coordinated
- Lack of coherent understanding of need due to the use of many methodologies, which make it difficult to compare results.
- Lack of technical capacity to collect and analyze reliable data
- Lack of comprehensive, long-term technical support for strategic and sustained capacity building
- Lack of standard indicators and tools to measure programme quality and evaluate programme impact in emergencies.
- Lack of equipment at country level for assessment and use of faulty equipment

Result	Activities	Lead Agency	Partners	Resources Required	Timeline
Timely, accurate and standardized data exists for an appropriate and rapid response	17. Agree upon rapid assessment tool endorsed by all agencies as the standard tool to be used		Cluster		
	18. Accelerate SMART protocol pilot and ensure its use and adoption by all UN agencies, by end 2006		Cluster, DFID, CIDA, USAID		
Information is disseminated systematically	19. Sector coordinator ensures data is disseminated widely to partners immediately (including implementing partners, donors and the media)		Cluster		

Result	Activities	Lead Agency	Partners	Resources Required	Timeline
Performance quality and programme impact is monitored and evaluated	20. Tool is developed/endorsed to monitor performance against agreed benchmarks		Cluster, Valid International, DFID		

#### 9.4 Working Area: Norms and Policies

**Lead Agency:** WHO

##### Gaps Identified

- Too many different guidelines and protocols within UN and NGOs. Need to identify priority guidelines and ensure compliance.
- Community therapeutic care is a promising option for increasing the numbers of severely malnourished children who have access to treatment. However, although programmes are in place in some countries, no international standards and guidelines in the area exist. An issue is also how activities can be integrated into basic health care interventions.
- Standard guidelines are yet to be developed for the management of severe malnutrition and HIV&AIDS and for severely malnourished infant under 6 months of age.
- Micronutrient deficiencies: Absence of clear guidelines on micronutrient supplementation in emergencies and other ways of addressing micronutrient deficiencies in emergencies. Need also for simple field-friendly guide on assessing micronutrient deficiencies.
- Need for developing guidelines (implementation tool) on complementary feeding of infants and young children in countries affected by conflicts and crises.
- No comprehensive field handbook on management of nutrition issues in emergencies including HIV/AIDS (field friendly updated version of WHO manual "The management of nutrition in major emergencies").
- It has been difficult to raise funds to carry out the necessary normative work.

*Activities related to Norms and Standards have been integrated into the technical workplan areas*

### **9.5 Working Area: Infant and Young Child Feeding**

**Lead Agency:** UNICEF

Gaps Identified:

- While policies and training modules exist, it is unclear that they are regularly utilized
- The protocols for procurement of BMS are not well known, and demand support of technical expertise from legal counsel or other expert on Code issues.
- Baby-friendly must be in place prior to an emergency in order to have expertise on hand for emergencies, but BF has not been well resourced of late, and the numbers of trained health workers has probably diminished
- Training specifically in the content of the IFE modules has been spotty, and there is no consistent training in relactation among the agencies that respond in emergencies
- While there is general understanding among the lead organizations that breastfeeding is useful, there has been little to no demonstrated changes in how this is addressed in the first days of the emergency; For example, the universal recommendation of safe spaces for pregnant and lactating women, so that they may receive the special rations and so that lactation may be supported, are often only established at a later date.
- While some countries have tried to control excess donations of commercial formula, there is no consistent process or guidance currently in use across agencies.
- It is rare to find skilled relactation support in therapeutic feeding centers, and this skill must be taught prior to emergency occurrence so that it is readily available when an emergency strikes.
- Greatest gap is that this vital emergency nutrition and health intervention is not covered under emergency nutrition and health.

Result	Activities	Lead Agency	Partners	Resources Required	Timeline
Immediate protection, promotion and support for breastfeeding and relactation is a demonstrated part of emergency Nutrition response and guidance	21. Actively work with Emergency Nutrition and Health partners, especially WHO and WFP, to ensure that these policy-makers fully integrate support for immediate protection, promotion, support of breastfeeding and relactation in all emergency guidance	<b>WHO</b>	UNICEF, WFP, Cluster		
	22. Integrate active infant feeding protection and support as a priority for the first days of an emergency. <sup>14</sup>				
Staff and Government are aware of and trained in Infant and Young Child Feeding protocols and commitments	23. Disseminate the Global, or National IYCF policy if such exists, and assure it is endorsed by all emergency agencies	<b>UNICEF</b>	Cluster		
	24. Develop capacity, using the Training Modules developed by the Emergency Nutrition Network and approved by UNICEF, UNHCR, WFP and UNICEF.	<b>UNICEF</b>	Cluster		
	25. Implement the <i>International Code of Marketing of Breast-milk Substitutes</i> and the BFHI in ongoing and in emergency setting; and ensure adequate availability of trained and skilled breastfeeding and relactation support personnel	<b>UNICEF</b>	Cluster		
Standardized process exists to control excess donations of commercial formula,	26. Develop a standard process to prevent donations of commercial infant feeding from reaching emergencies, and where this does occur, to ensure alternative uses or disposal <sup>15</sup>	<b>UNICEF</b>	Cluster		

<sup>14</sup> These services may be set up as part of the safe areas for the feeding of pregnant and lactating women, or may be integrated into other services for the mothers and infants at the earliest stage of emergency, especially in the establishment of safe spaces where pregnant and lactation mothers can receive their special rations, and ensure that the basic needs of mothers and infants are addressed

<sup>15</sup> On the rare occasions when commercial infant formula is needed, it is not UNICEF's role to procure or purchase it; however in rare situations when UNICEF is the only source of finance, then the exact amount needed for the infant in need should be purchased from normal channels. This may be the same source as that for HIV positive mothers and for orphans.



<b>Result</b>	<b>Activities</b>	<b>Lead Agency</b>	<b>Partners</b>	<b>Resources Required</b>	<b>Timeline</b>
Governments, staff and communities are aware of complementary feeding practices in emergencies	27. Develop guidelines on complementary feeding of infants and young children in countries affected by conflicts and crises based on the WHO "Guiding principles for feeding infants and young children in emergencies".	<b>WHO</b>	UNICEF, Cluster		
Relactation support is integrated into TFC/CTCs	28. Create community and facility-based therapeutic feeding approaches that may be scaled up for emergencies that include support for relactation.				

## 9.6 Working Area: Micronutrients

**Lead Agency:** UNICEF

Gaps Identified:

- Food aid is not consistently fortified
- Lack of operational guidelines on implementing micronutrient recommendations in emergencies. This is a particular constraint with respect to new products
- Role of micronutrients for prevention in emergencies is difficult to advocate for when the primary focus is on treatment. Lack of awareness that MN deficiencies can quickly evolve & the implications for survival often not well understood.
- Provision of MNs requires good communications with the community which is labor intensive requiring time & skilled staff. Not always feasible
- Often not clear in general what partners are doing in emergencies (HKI in Aceh)
- Limited recommendations & statements on micronutrient provision to women & children in emergencies. More comprehensive statement similar to the one prepared for Tsunami are required
- Recommendations to provide MNs are made in advance of supplies. Lack of a supply pipeline makes it difficult to implement recommendations (zinc sulphate with ORS not yet implemented through UNICEF). Poor understanding on part of some partners on the importance of micronutrients (e.g. iodized salt which is often left out, fortified flour is difficult to provide, local production is not always feasible & importing it is problematic since it has short shelf-life. Response from agencies is then to patch up with MN supplements (e.g. iodized oil supplementation).
- When assessing MN status, lack of field friendly tools & analysis which rely on labs and invasive methods

Result	Activities	Lead Agency	Partners	Resources Required	Timeline
Iodized salt and fortified food is provided to beneficiaries all new emergencies in 2006	29. Meeting with WFP/UNICEF to review global policy, identify bottlenecks at country level and agree on process forward	<b>WFP/UNICEF</b>			

<b>Result</b>	<b>Activities</b>	<b>Lead Agency</b>	<b>Partners</b>	<b>Resources Required</b>	<b>Timeline</b>
Minimum standards exist for assessment of MN status in emergencies	30. Fast track development of field friendly MN assessment tools that are most cost-effective & non-invasive.	<b>UNICEF</b>	WHO, PATH, CDC, MI, A2Z project		
	31. Agree on indicator and methodology to assess MN status and ensure its integration into SMART	<b>UNICEF</b>			
Concise operational guidance exists for implementation of MN activities in emergencies	32. Assessment undertaken of gaps/bottlenecks in implementing MN in emergencies	<b>UNICEF</b>			
	33. Develop operational guidance note/field manual	<b>UNICEF</b>			
Clear guidance exists for how and when to use Multi MN in emergencies	34. Continue work between UNICEF, WFP & WHO to establish final recommendations on multi-Micronutrients	<b>WHO</b>	UNICEF, WFP		
	35. Develop operational guidance note on implementing Multi-MN in emergencies	<b>UNICEF</b>	WHO, WFP, HKI, MI		

## **9.7 Working Area: Nutrition and HIV/AIDS**

**Lead Agency: WHO**

### Gaps Identified:

- Limited evidence (operations research, program evaluations) on what works and what does not work in emergency / humanitarian settings
- HIV/AIDS requires thinking beyond traditional emergency response
- Work with national governments from the outset
- Development approach to HIV/AIDS for sustainability
- Where refugees have been integrated into local communities, assistance should be through national systems
- National health and HIV/AIDS services
- Food security and self reliance: access to land, employment, mobility
- Include affected local communities in assessments, programs
- Most humanitarian organizations and agencies neglect responses to HIV/AIDS in conflict / crisis situations. Hence these humanitarian interventions can be modified to better account for HIV/AIDS, including in emergency nutrition interventions.
- Policy level: Include refugees in NACP and sub regional approach; revisit of IDP policies/guidance on HIV/nutrition in emergencies
- Coordination and ensuring engagement of all actors in emergency situations, coordination, including governments.
- Inadequate guidelines on HIV/AIDS and nutrition integration in humanitarian settings
- Misconceptions on HIV/AIDS among displaced populations
- Ensuring sustainable household and livelihood security.
- Key challenges and opportunities for integrating nutrition into emergency programmes
  - Resource constraints for nutrition and research in emergencies
  - Inclusion and integration of refugees, IDPs and surrounding populations in government policies and implementing them.

- Enhancement of food aid rations to meet nutritional needs (taking HIV prevalence into account)
- Managing underlying malnutrition before ART
- Accessibility of ART to persons in crisis situations and complex emergencies.
- Infant feeding (recommendations do not accord w/ real options)
- Capacity of governments (health and nutrition sectors) to address nutrition and HIV/AIDS in emergencies (e.g., treatment of malnutrition) is very low; these include infrastructure, human resources and equipment.
- Exit strategy: need criteria
- Better assessment, program design re: gender and HIV, re: equity
- Providing and ensuring sustainability of quantity and quality of nutrition / food for HIV infected and affected refugees and IDPs, both in the emergency, transition and stable phases, including in chronic emergencies.
- Linking short term relief with long term approaches.
- Relieving dependence, addressing SGBV, including sexual exploitation, stigma and discrimination
- Improving coverage and access to treatment, ARVs, other nutrition interventions
  - Operational modifications
  - During and post repatriations
- Getting credible, valid and documented information on these populations of the interaction between HIV/AIDS and nutrition
- Dealing with cultures, traditions and attitudes
- Inclusion of host communities

*Results to be achieved:*

- Nutrition is mainstreamed in all HIV/AIDS programmes during emergencies, and HIV/AIDS is streamlined in Nutrition programmes
- Standard guidelines exist and disseminated
- Agreed indicators for monitoring exist

<b>Result</b>	<b>Activities</b>	<b>Lead Agency</b>	<b>Partners</b>	<b>Resources Required</b>	<b>Timeline</b>
Standard guidelines exist and disseminated	36. Develop guidelines on the management of severe malnutrition and HIV&AIDS and for infants under 6 months of age. (This was discussed and a series of recommendations made for action during a consultation convened by WHO in September 2004).	<b>WHO</b>			
Agreed indicators for monitoring exist					
Nutrition is mainstreamed into HIV/AIDS programmes during emergencies and HIV/AIDS is streamlined into Nutrition programmes					

## 9.8 Working Area: Therapeutic Feeding

**Lead Agency:** UNICEF

Gaps Identified:

- Absence of trained staff in management of severe malnutrition
- Absence of national protocols in many countries
- High costs of staff, drugs, specialized foods
- Poor acceptability and low coverage
- Need for strategies for integration into longer-term health facility services and policies
- Community therapeutic care is a promising option for increasing the numbers of severely malnourished children who have access to treatment. However, no international standards and guidelines in the area exist although programmes are in place in some countries.
- Standard guidelines are yet to be developed for the management of severe malnutrition and HIV&AIDS and for the severely malnourished infant under 6 months of age.

Result	Activities	Lead Agency	Partners	Resources Required	Timeline
Guidelines exist to standardize and improve the quality of existing and new CTCs	37. Develop standardized guidelines on community-based treatment of severe undernutrition. (WHO is organizing a consultation on this in November 2005. A number of countries (Malawi, Zambia, Ethiopia and Southern Sudan) are piloting CTC based on valid international guidelines and materials.) The production of guidelines should be a priority.	<b>WHO</b>	UNICEF, Valid International		

<b>Result</b>	<b>Activities</b>	<b>Lead Agency</b>	<b>Partners</b>	<b>Resources Required</b>	<b>Timeline</b>
Harmonization & standardization of existing guidelines (so that Governments do not have to make choices).	38. WHO & UNICEF to write a brief note on how countries/governments can do this harmonization & standardization. A situation analysis in this regard would be useful.				
Referral systems are strengthened and TFCs integrated into health facilities	Tools developed for health-care facility analysis and at least 2 regional workshops held for roll out and capacity building	<b>UNICEF</b>			
Staff are available and trained in management of severe malnutrition in countries and on surge capacity rosters	Expand “Centre of Excellence for Treatment of Severe Malnutrition “ (Ethiopia and Sudan) at least to 3 pilot countries by end 2006	<b>UNICEF</b>			



## 9.9 Working Area: Supplementary Feeding

**Lead Agency:** WFP

Gaps Identified:

- Provision of a food basket that meets assessed need and on time.
- The evidence base for the effectiveness of SFPs needs to be reviewed
- Standardisation on entry and exit criteria for SFPs needs reinforcing
- Spheres new indicator for coverage needs to be mainstreamed
- Consensus on the amounts, types and fortification levels of the food provided is required
- Co-ordination:

Result	Activities	Lead Agency	Partners	Resources Required	Timeline
	39. Systems in place to prefinance operations and capture information on a timely basis		WFP	Co-operating partners	
	40. Review of the effectiveness of SFPs	SCF/UK ENN	SCF/UK ENN	All	
	41. Reinforce Sphere standards		Sphere	All	
	42. Continued to work on optimal fortification		WFP	Academia and Food Technology specialists	
	43. SCN working group on nutrition in emergencies, ad hoc nutrition in emergencies group		SCN,	All agencies	

**9.10 Working Area: Food Security**

Lead Agency: WFP

Gaps Identified:

- Lack of skilled staff to under take Food security assessment
- Lack of consensus on food needs determined by various agencies
- Number of beneficiaries needing assistance
- Lack of adequate resources to provide adequate food basket in timely manner, and security and logistics constraints
- Increased security risk including gender based violence
- Several guidelines and methodologies exist for assessment, but need harmonization. SMART made an effort to include Food Security methodology but not yet final.

<b>Result</b>	<b>Activities</b>	<b>Lead Agency</b>	<b>Partners</b>	<b>Resources Required</b>	<b>Timeline</b>