

ACF INTERNATIONAL NETWORK

EMERGENCY NUTRITION

**A HANDBOOK FOR DEVELOPING AN EMERGENCY NUTRITION
INTERVENTION STRATEGY**



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EMERGENCY NUTRITION

**A handbook for developing an
emergency nutrition intervention strategy**

Technical and scientific department
Nutrition and Health sector

Action Contre la Faim – International

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INTRODUCTION

USER GUIDE

This document provides a better understanding of the issues and clarifies ACF's stance in emergency nutrition response. It is intended for all people working at the headquarters as well as in the field, regardless of their level of expertise.

Over the years, as the emphasis on preventing acute malnutrition has grown, significant changes have been made to emergency nutrition programmes, particularly in the development of new products.. More specifically, ACF is working in partnership with healthcare structures, in order to strengthen their systems to reduce the number of ACF nutrition programmes. ACF also intends to develop its work in emergency preparedness, to ensure the fastest, most effective response possible.

These changes, however, raise issues about how to best guide these emergency preparedness and nutrition responses.

To address these concerns, this handbook was developed to guide ACF's emergency response strategy, as well as upstream preparedness, and provide a grid to be used as a decision-making aid. This handbook helps place emergencies into a general context and time continuum, because ACF's ability to develop a nutrition response to an emergency depends greatly on:

- Its relations with the Ministry of Health and with the various stakeholders active in nutrition and health within the country; and on
- Its ability to articulate emergency preparedness, response and rehabilitation smoothly.

This handbook will prove useful for Country Directors and Field Coordinators, to enhance their knowledge of ACF's stance on emergency nutrition response. They may also find it useful as *ad hoc* support for tasks such as preparing a meeting with a funding source or authority that may ask questions about our approach to emergency nutrition response. In this particular case, this handbook will offer a clear overview of ACF's issues, references and stance in this matter.

Heads of nutrition and health departments may also find it useful as a tool to assist them with the development of emergency nutrition preparedness and response strategies. We therefore recommend systematic use of this tool when drafting emergency response projects as well as projects to strengthen healthcare systems. It is also recommended that the handbook be used during the development and/or revision of country strategies.

At the start of this handbook, you will find a list of acronyms to help you understand the technical vocabulary used within ACF.

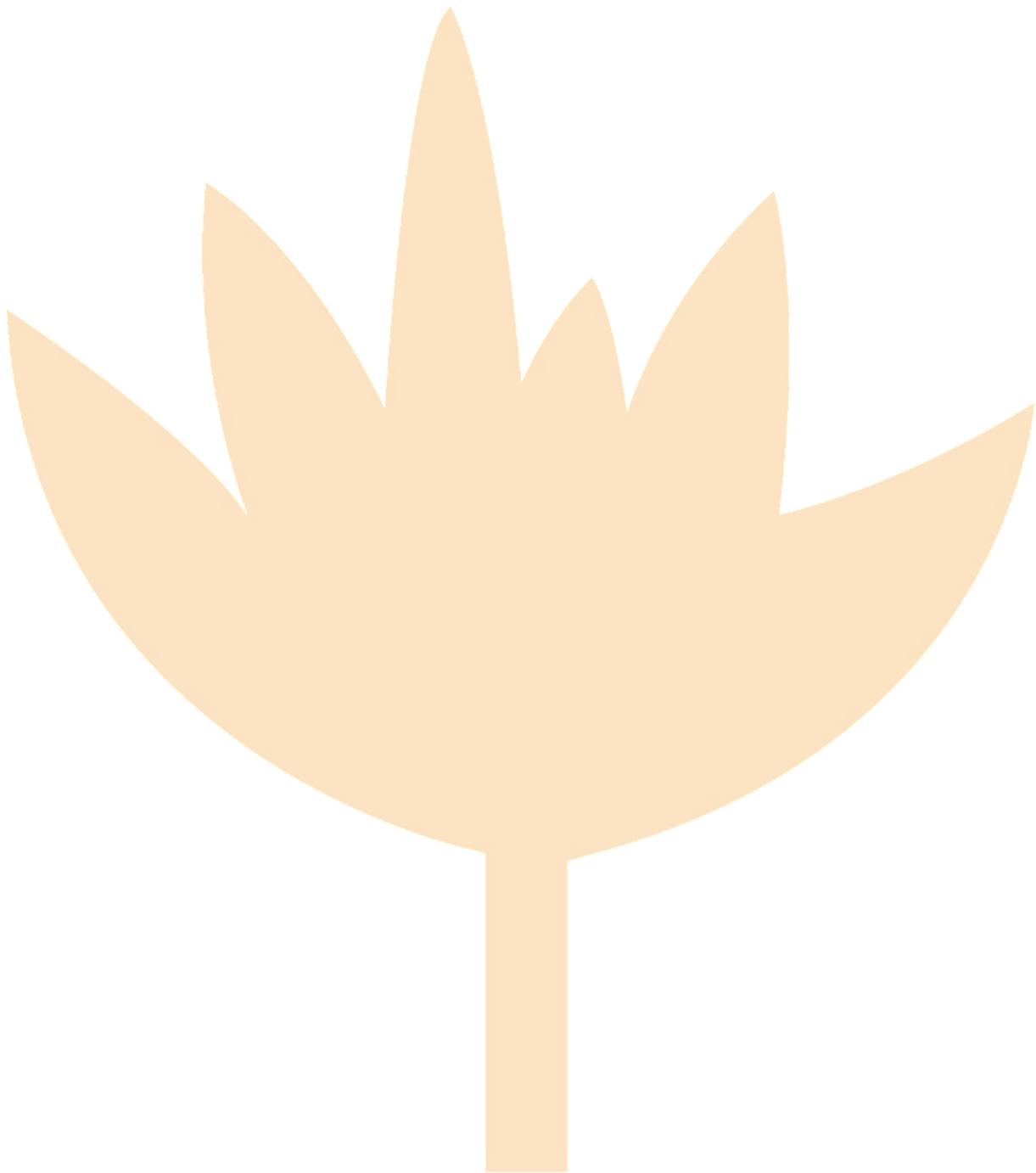
To facilitate the reading of this handbook, you may also refer to the "*ESSENTIAL IN NUTRITION AND HEALTH*" published by the nutrition health sector in late 2012, which provides more information on some of the topics covered.

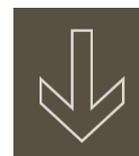
ACRONYMS

ACF	Action Contre la Faim
ALNAP	Active Learning Network for Accountability and Performance
CSB	Corn-Soy Blend
EPRP	Emergency Preparedness and Response Plan
FAO	Food and Agriculture Organisation
FSL	Food Security and Livelihoods
GAM	Global Acute Malnutrition
GNC	Global Nutrition Cluster
HIV/AIDS	Human Immunodeficiency Virus /Acquired Immunodeficiency Syndrome
HSS	Health System Strengthening
IASC	Inter-Agency Standing Committee
IYCF	Infant and Young Child Feeding
MAM	Moderate Acute Malnutrition
MHCP	Mental Health Care Practices
MoH	Ministry of Health
MUAC	Middle Upper Arms circumference
NGO	Non-Governmental Organisation
RUSF	Ready-to-Use Supplementary Food
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SCUK	Save the Children United Kingdom
SMART	Standardized Monitoring and Assessment of Relief and Transition
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UN-SCN	United Nations Standing Committee on Nutrition
WASH	Water supply, Sanitation and Hygiene Promotion
WFP	World Food Programme
WHO	World Health Organization

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THE HISTORY OF EMERGENCY RESPONSE

Emergency nutrition interventions have considerably improved since the late 1970s, specifically through the development of protocols and directives for therapeutic programmes¹ effective foods for treating severe acute sub-nutrition (F75 and F100 milk, ATPE), as well as standardised methods for nutrition studies²

The multiple lessons learned from various crises³ resulted in enhancing the quantity (kcal) and quality (micronutrients) of rations distributed as food assistance. Between 1986 and 1990, the daily ration for refugees rose from 1500 to 1900 kcals a day, and then up to 2100 kcals per person per day, from 1996-1999. At the same time, epidemics of pellagra, scurvy or beriberi among populations dependent on food assistance demonstrated the need to round out rations with micronutrients and supplements, especially vitamin A. An agreement was finally signed in the late 1990s to include fortified grains in daily rations.

During this same period, a link was established between the prevalence of acute sub-nutrition in children under five and the mortality rate. A connection was also gradually drawn between children's nutritional status and pathologies such as measles (1984-1985 measles epidemic among Ethiopian refugees in the Sudan, with fatality exceeding 30 per cent, especially among malnourished children) or diarrhoea (1991 diarrhoea epidemic among Kurdish refugees in Iraq, resulting in increased acute sub-nutrition among children under 24 months). Prevention of these pathologies therefore became a key component of nutritional programmes.

In parallel with the programme aspects, humanitarian coordination has also advanced over the past 30 years. Humanitarian coordination is the effective and consistent delivery of humanitarian assistance focused on saving lives and reducing suffering. Coordination is indispensable to make the most efficient use of available resources, with minimum delay and through actions that comply with existing standards. An IASC review in 2005 showed that until that time, there were significant shortcomings in humanitarian response: fragmented response, duplication, and insufficient involvement by national governments and stakeholders. In response, a "Humanitarian Reform" was proposed, to improve funding predictability and response leadership, accountability to the populations affected, and partnership between UN and non-UN humanitarian agencies. The development of the Cluster Approach gradually strengthened humanitarian response, by defining and implementing partnerships and accountability in key sectors (*cf* Chapter 4 on basic cluster concepts).

Despite the progress achieved in humanitarian response over the past 30 years, the most recent major catastrophes⁴ response mechanisms' assessment shows that inappropriate responses continue in the areas of:

- Emergency infant and young child feeding;
- Timely response to crises; and
- Considering the causes of malnutrition.

¹ Directives on emergency nutrition (MSF), selective feeding programmes (WFP/UNHCR), estimating emergency nutrition needs (WFP/UNHCR), and treating severe malnutrition (WHO) were all published between 1995 and 1999.

² There previously were considerable differences between sampling methods, anthropometric indexes and definitions of acute malnutrition used in various studies.

³ UN-SNC, *Report of the Meeting of the Working Group on Nutrition in Emergencies*, April 1998

⁴ Horn of Africa drought in 2011, Haiti earthquake in 2010, Cyclone Nargis in Myanmar in 2008, China earthquake in 2008, Lebanon conflict in 2006, Indonesia earthquake in 2006, Ethiopia drought (2003, 2006, 2008), Niger drought (2003, 2005, 2008, 2010)

Emergency infant and young child feeding (IYCF)

The study of IYCF responses to emergencies in recent years shows that, instead of protecting infants and young children, they **actually increase their vulnerability to undernutrition, disease and death**. Following the 2010 earthquake in Haiti for example, several reports pointed out that products distributed as humanitarian aid included powdered infant formula, nursing bottles, nipples and powdered milk. These were handed out by various humanitarian agencies (either local or international non-governmental organizations, including UN agencies), sometimes through national health structures, without checking the age of the recipients or ensuring the preparation conditions were safe and long-term needs covered. These activities were encouraged by massive donations (of products and materials by the general public or by the companies' marketing these products), which were in turn promoted by the media. These types of interventions are not only in breach of international recommendations⁵ and procedures⁶ but they also violate the International Code of Marketing of Breast-milk Substitutes (adopted by a resolution at the World Health Assembly in 1981). Following the earthquake in Haiti, a nutrition cluster was set up in order to address a joint declaration to all operators advocating for good emergency IYCF feeding practices and compliance with international recommendations and procedures. This consequently raised awareness among humanitarian aid providers in terms of the importance of IYCF interventions to protect infants and young children.

However, a recent study conducted by Save the Children-UK⁷ indicated that, although most players recognize that IYCF interventions should be a priority to protect infants and young children, they are still rarely implemented on a broad scale in emergencies. The reasons most often cited to explain this status quo are the difficulty to obtain funding for these interventions (especially if not backed by another programme), the lack of human resources and expertise in the field, the missing linkage with other technical fields, and the lack of evidence of the impact of these interventions (especially for funding agencies). As a result, **if IYCF interventions are actually implemented, they most often are fragmented and on a small scale**.

Timely response to crises

According to an article by Peter Hailey and Daniel Teweldeberha⁸ the management of severe acute malnutrition (SAM) is traditionally considered as an emergency intervention, with external aid coming almost exclusively from donors, UN agencies and NGOs. The result is that this external aid is provided and withdrawn based on the reported or perceived level of nutrition emergency, despite the constant presence of severely malnourished children throughout the year. This means that programmes open when the prevalence of acute malnutrition reaches emergency levels and close once the situation improves, often only to reopen in the next hunger season. This method of intervention results in a lag between the assessment of the situation and the moment when malnourished children are actually taken care of on the ground - the time required to declare an emergency and mobilise resources. During this initial delay, the state of an increasing number of children becomes critical as part of the crisis has been underway. In addition, there is a second lag between the moment when a new survey indicates the situation is improving and the moment when aid ceases.

This situation is even more pronounced in areas of chronic nutritional emergency where cycles tend to overlap.

5 WHO recommendations: breast feeding only up to 6 months and continuous nursing up to 24 months

6 Operational Guidance on IFE for Emergency Relief Staff and Programme Managers, February 2007

7 SCUK, *Infant and Young Child Feeding in Emergencies: Why are we not delivering at scale?*, October 2012

8 Peter Hailey & Daniel Teweldeberha, *Suggested New Design Framework for CMAM Programming*, Field Exchange n°39, September 2010

This phenomenon was evident⁹ during the Horn of Africa drought of 2011 where, despite early warnings of a pending crisis (the first forecasts came in August 2010), a large scale response only began in June-July 2011, after acute malnutrition rates had already reached critical levels.

The challenge is therefore to **trigger an early enough response so that the maximum level of resources coincides with the peak time of need**, particularly with slow-onset crises. This raises questions about **preparation and continuum** plans.

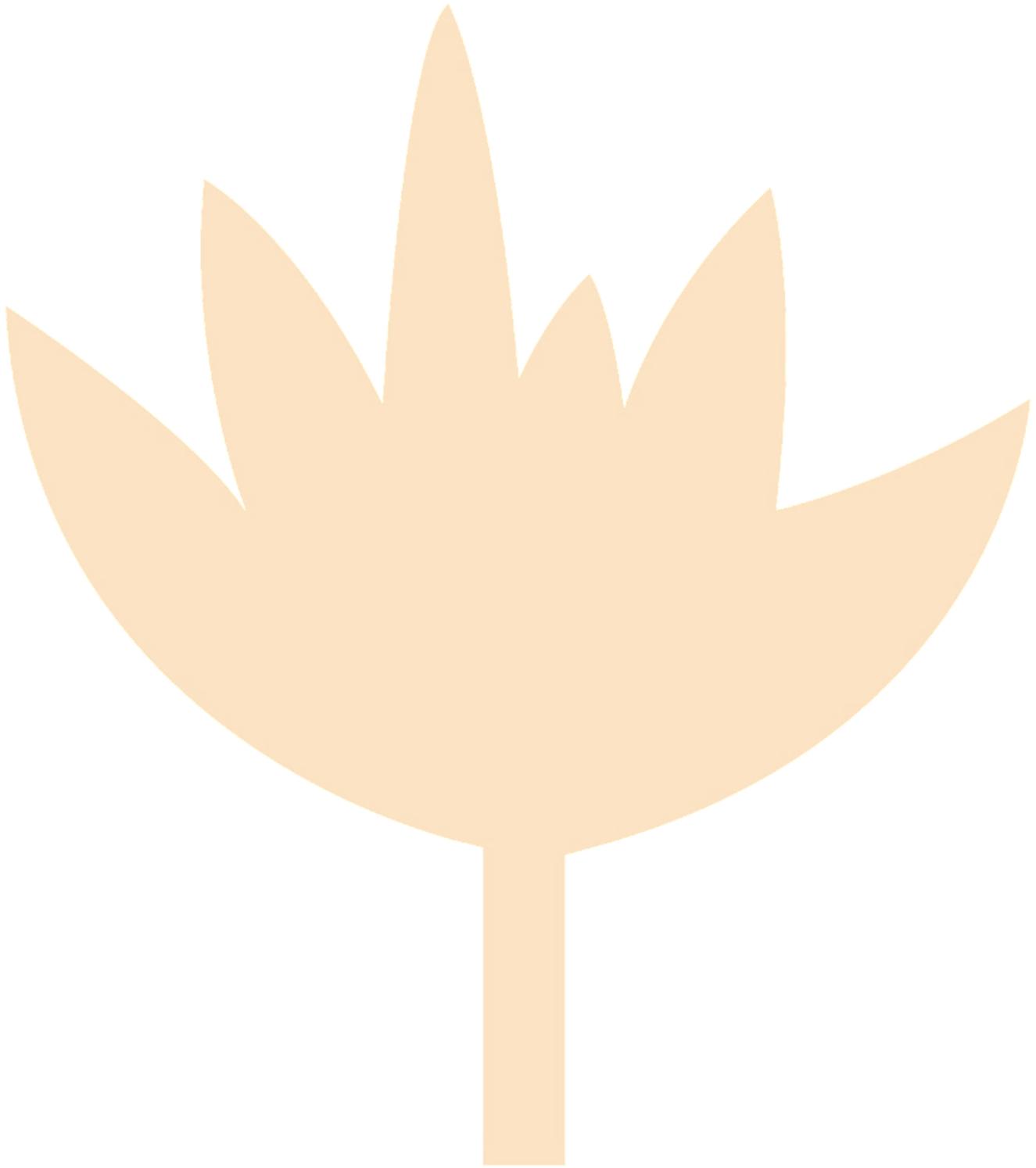
Considering the causes of malnutrition

Slow-onset disasters such as the droughts in Niger and in Ethiopia are generally characterised by acute malnutrition rates exceeding emergency levels. These nutritional emergencies are predominantly managed via the provision of emergency food aid. However, evaluations¹⁰ show that **improvements in nutritional status have a better chance of being attained through an integrated response based on a thorough understanding of the causes of malnutrition at a local level**, and not simply through food aid. This is particularly true when malnutrition is a chronic or structural problem – not only related to inadequate food consumption but also related to poor public health and sanitation systems and inappropriate care practices.

In addition, disasters are often perceived as an interruption in development rather than can be prepared for and mitigated. This is particularly problematic in countries which have experienced multiple droughts. Often the result is emergency programmes are duplicated and working in parallel. These may save lives in the short term but the gap between emergency assistance and development means the original causes of the disaster are barely addressed.

9 Oxfam & SCUK, A Dangerous delay. The cost of late response to early warnings in the 2011 drought in the Horn of Africa. January 2012

10 USAID 2003, SCUK 2004, REDSO 2004, CARE 2005, IRAM 2006





DEFINITIONS

An **emergency** is a sudden and unforeseen event that calls for immediate measures to minimise its adverse consequences.¹¹

A **disaster** is a serious disruption of the functioning of society, causing widespread human, material or environmental losses which exceed the ability of the affected population to cope using only its own resources. Disasters are often classified according to their cause (natural or man-made¹²)¹³.

A **rapid-onset disaster** could be defined as resulting from a unique, distinct and unforeseeable event such as an earthquake or a flood.

Conversely a **slow-onset disaster** unfolds gradually over time and is often the result of a concordance of various events such as drought.

The Importance of Emergency Food Aid

It is crucial to protect the nutritional status of vulnerable groups affected by emergencies. Individuals suffering from acute malnutrition are more likely to fall ill and die. Also, sick people are more likely to become malnourished. Emergencies impact a wide range of factors which can increase the risk of malnutrition, sickness (morbidity), and death (mortality).

Who are the most vulnerable?

Children under the age of five present an increased mortality risk linked to acute malnutrition. In particular, **infants aged six months or less are in immediate danger**. Infants over the age of six months will see their nutritional status worsen in the medium term. It is therefore fundamental to protect children under the age of five and, as a priority, babies under the age of six months, through preventative action while simultaneously preparing a remedial response.

At what point does an emergency become a nutritional emergency?

While there is no universally accepted definition of the term **nutritional emergency**, various attempts have been made to grade the severity of an emergency by using acute malnutrition or emaciation in a population as an indicator. Such a system implies emergencies could be divided into stages, as for example the Integrated Food Security Phase Classification of the FSAU/FAO¹⁴, the WHO's decision tree concerning the implementation of nutritional programmes¹⁵, or the IPC's integrated framework of food security classification presented in Annexes 1, 2 and 3.

These varying classification systems show how difficult it is to grade the severity of an emergency situation. However, what these systems have in common is they all use quantifiable figures such as malnutrition or mortality rates, and they link these figures with qualitative (or descriptive) indicators such as food security.

As for the matrix presented in this manual, it is based on the classification proposed in the Moderate Acute Malnutrition: A Decision Tool for Emergencies, drawn up by the MAM Task Force on Global Nutrition Cluster.

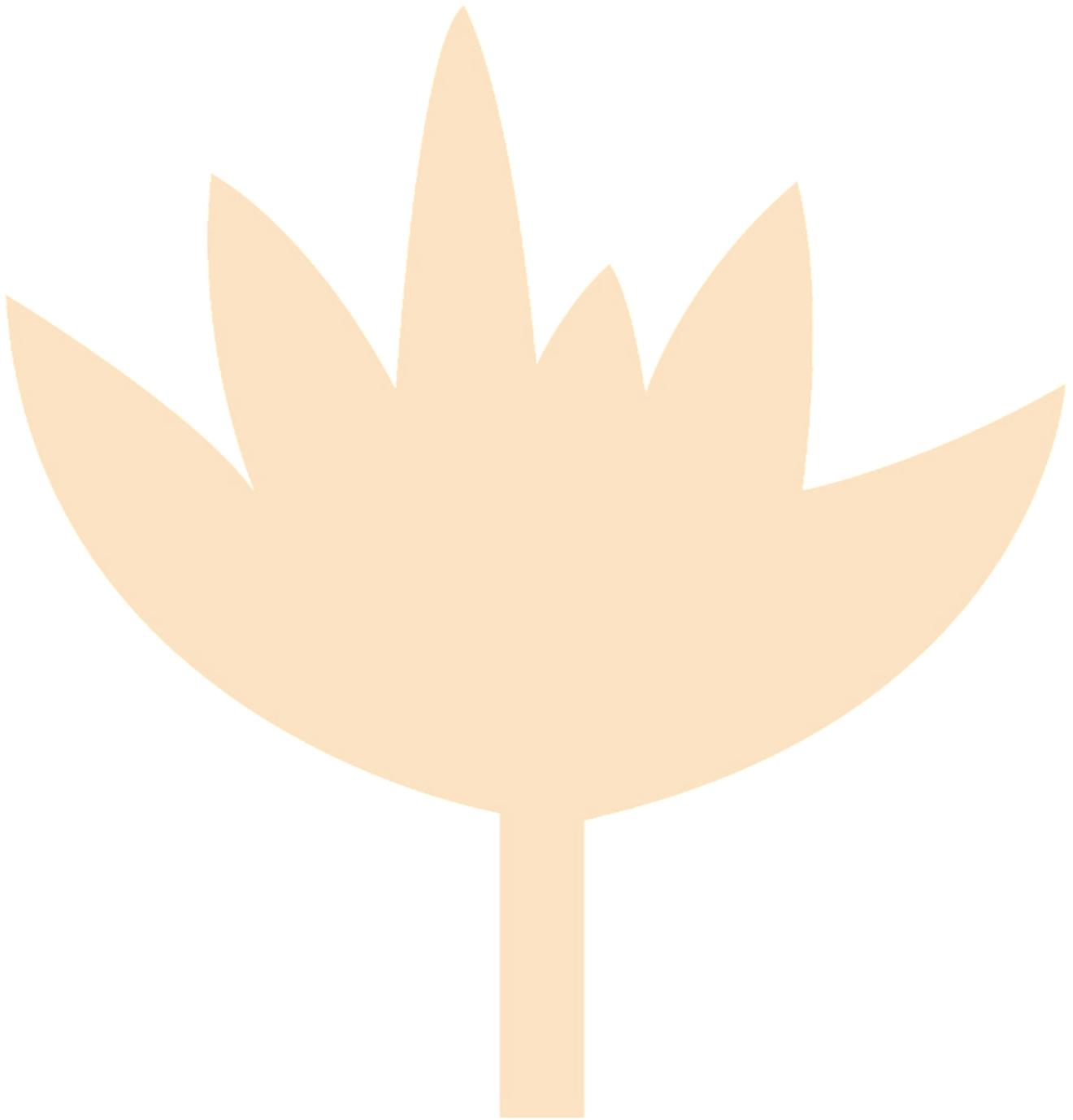
11 UNOG/DHA, Internationally agreed glossary of basic terms related to Disaster Management, 1992

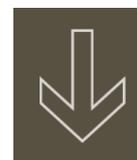
12 Relative to human activity

13 UNOG/DHA, Internationally agreed glossary of basic terms related to Disaster Management, 1992

14 IASC Global Nutrition Cluster, Introduction to nutrition in emergencies

15 WHO decision tree for implementation of selective feeding programme, WHO: The Management of Nutrition in Major Emergencies. 2000





I. INTRODUCTION TO THE MANUAL

1.1 Aim and Approach

The *Nutrition in an Emergency* manual aims to:

- Guide staff in their analysis of the situation and in putting contextual factors other than the nutritional situation into perspective in order to fully understand the response environment.
- Guide staff in drawing up a strategy for nutritional-health intervention that best meets the needs of a particular emergency.
- Coordinate decision-making regarding nutritional-health intervention in emergency situations.
- Guide staff in preparing for emergencies.

The aim of the manual is to help staff **develop a full understanding of the environment in which the emergency response will be taking place**, and to understand that an **emergency response is not an isolated event but part of a continuum**. The manual has also been designed to help decision-making regarding the type of nutritional programme to implement (diagnostic, prevention, treatment), the choice of programme, the groups to target, the duration of the programme and the modus operandi (health system support vs. substitution). Lastly, it highlights the key points of preparation.

1.2 Target Audience

This tool is primarily aimed at ACF nutrition-health staff whether on the ground or in the headquarters. The manual should guide them in drawing up a global nutrition response strategy to an emergency.

In the absence of a nutrition-health team, it may also be used to help all ACF staff involved in responding to an emergency, particularly country directors or on-the-ground coordinators.

Lastly, the manual will enable ACF to present its emergency response approach to various stakeholders, especially donors.

1.3 Warning

The matrix and the manual are a guide; however in-depth discussions and the analysis and interpretation of the context are still required in developing a response strategy to a particular emergency. One should still bear in mind that **an emergency response is not an isolated event but part of a continuum**. The notion of a continuum is further developed in Chapter 2 and the drawing up of an emergency response strategy is covered in Chapter 3.

An emergency response cannot be developed in an isolated way. *External coordination* with others involved must be improved, and in particular relations with the Public Health Ministry as well as other health operators must be strengthened. Chapter 4 takes a closer look at the basic notions of nutrition clusters.

In the same way, **in an emergency situation acute malnutrition cannot be managed in isolation**. Consequently, the decision-making process put forward in this manual must be considered as one element in a multi-sectoral response. Links with mental health, healthcare and food security

intervention or with water, sanitation and hygiene action are also important in ensuring the diverse causes of malnutrition are addressed simultaneously. In order to do that, *internal coordination* must be improved. Some of these potential links are put forward in Chapter 5.

This matrix constitutes a guide for selecting interventions to set in motion in the first month of an emergency. The nutritional response should however be adapted as the emergency situation evolves. So the matrix can also be used to re-evaluate the context and adjust the programmes accordingly.

The matrix may be used for different kinds of emergency, rapid or slow-onset, prolonged or acute in a chronic emergency situation. However, the extent of the disaster and the context in which it occurs will influence the location of the response (prioritisation of intervention zones) and the modus operandi if nothing else.



© ACF, Roselyne Monin – Ethiopia, 2011



II. EMERGENCY RESPONSE IN A GLOBAL CONTEXT or THE MALNUTRITION MANAGEMENT CONTINUUM

An emergency is not an isolated event. This means the emergency response cannot be isolated from the global context: it is part of an environment and a continuum.

2.1 ACF and health system strengthening (HSS)¹⁶

The scaling up of access to treatment for SAM is the goal that ACF has set in its International Strategy 2015 framework (pillar I). To reach this goal in situations where the health ministry is the primary access provider, ACF has been implementing health system support actions for many years. It should be noted ACF started out with little knowledge of the health system and therefore little understanding. After having worked to improve its knowledge, it is now easier for ACF to intervene to strengthen the healthcare systems without risking weakening it.

Developing the **health system strengthening (HSS)** approach is an absolute necessity in the treatment of SAM. We can no longer act in a vertical way. **We have to build a solid base within primary healthcare systems in order to develop access to SAM treatment.**

At every level of the healthcare pyramid, ACF aims to strengthen the technical and organisational capacity of healthcare professionals so they are able to include SAM treatment in their minimum healthcare services. ACF now operates in each of the building blocks of the health system: quality care, human resources, supply systems, healthcare information systems, management and finance.

A good understanding of the healthcare system, how it works as well as how to take into account its weaknesses when building its strategies are essential prerequisites.

Based on an initial systemic analysis of the healthcare system, **ACF staff must work together with local operators, including the health ministry in the heart of deliberations, towards strategies that will strengthen each pillar.** The strategies must take three elements into consideration:

- A. **Substitution Strategy/ Gap filling strategy.** This strategy is based on the healthcare system's initial capacity to cope with the number of acute malnutrition cases => the teams must devise a strategy ensuring the best possible access to treatment for those not covered. We will broadly identify the difference between the total number of patients expected and the number the structure can accommodate. This strategy supposes a certain level of substitution as a complement to the following strategy. It must not become an ongoing state. It should fade out as the system's capacity increases (progress in Strategy B).
- B. **Strengthening Strategy.** This strategy is based on an initial pillar-by-pillar diagnosis of the health system. ACF will think through its contribution to the strengthening of the system depending on the established role of all operators present. In this way, strengthening strategies drawn up by ACF will not necessarily attack each of the six pillars but will be a complement to other initiatives already in place (systematic approach). This strategy should not only target the delivery of SAM-related care but the entire minimum healthcare package and can work in conjunction with strategies A and C should the situation require.

16 Health System Strengthening, Essential Health and Nutrition, ACF 2012

- C. **Crisis Management Strategy:** Seasonal peaks should be identified and give rise to the preparation of a specific strategy in addition to the previous two strategies. Crisis situation support mechanisms should be predefined with operators present and negotiated with donors. They should aim to handle the number of cases caused by the crisis without destabilising strategies A and B. The *Multisectoral Seasonal Calendar* tool may provide further analysis.

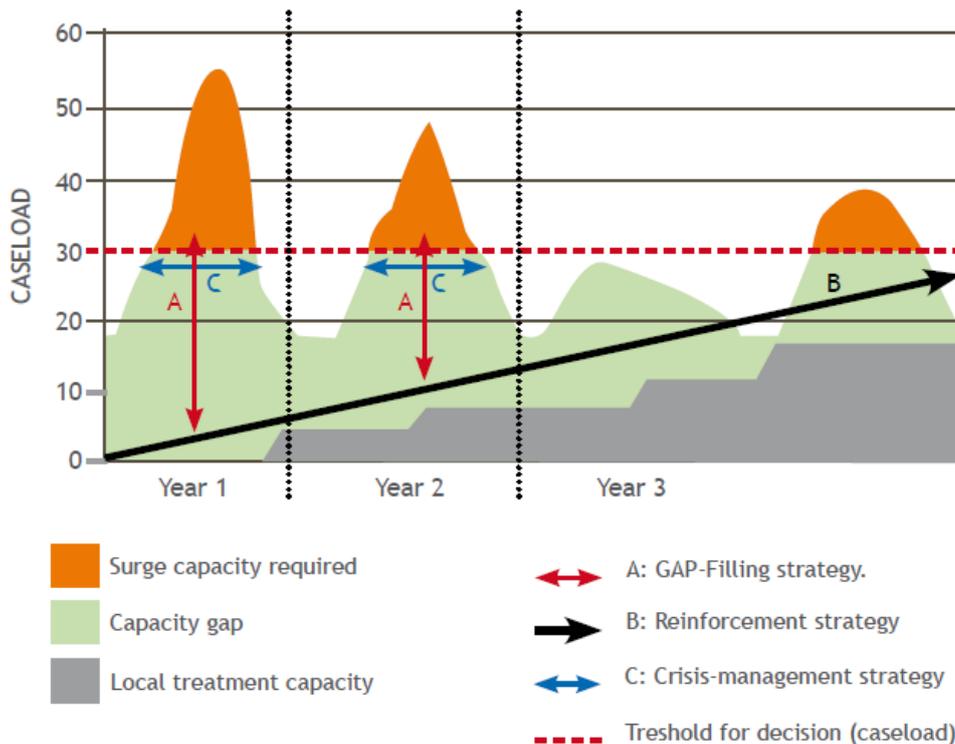


Figure 35: A+B+C Strategie illustration
 Modèle ACF adapté de Suggested New Design Framework for CMAM Programming
 - Peter Hailey and Daniel Tewoldeberha

IMPORTANT: A sound intervention strategy comprises A+B+C and proposes a long-term progression assumption in which the modus operandi proposed in A, B and C changes in parallel with the capacity of the systems.

Strategy C

The response to an emergency is at the level of crisis management strategy (Strategy C) and can be broken down into a number of sequences, which make up a continuum (illustrated below). In order to ensure that the response to the emergency is as relevant and efficient as possible so that it meets the needs of the affected population in good time and in the best manner without endangering the ongoing development strategies, it must be integrated into a continuum strategy. A certain number of key action points must be implemented in each of the 4 phases: preparation for emergency, occurrence of the emergency, response to the emergency and rehabilitation. These action points are summarised in the Continuum presented at the end of the chapter (figure 3) and are developed in the following paragraphs.

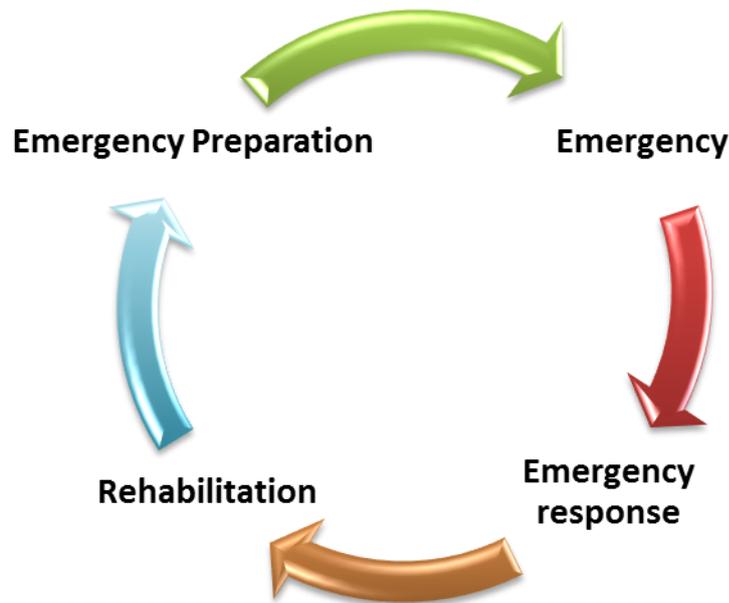


Figure: The Continuum

2.2 Preparation for emergency

Today, a large number of humanitarian emergencies can be foreseen because they happen on a recurring basis and/or because they occur in a progressive manner. If an emergency is foreseeable, this means it is possible to prepare for it. Furthermore, certain tools have recently been developed which allow emergencies to be anticipated and prepared for. That is why **it is now an absolute obligation for every ACF mission to develop a *multi-sectoral seasonal Calendar* and to draw up an *Emergency preparedness and response plan* as part of a development process.**

An Emergency Preparedness and Response Plan (EPRP) is an emergency operations planning and preparation tool which allows a permanent intervention capacity to be established to respond to humanitarian emergencies.

The operational advantages of an EPRP are the following:

- The humanitarian risks are identified clearly by ACF missions
- ACF staff (national and expatriate) are trained and prepared to respond to an emergency
- All evaluation and emergency response tools are provided
- Partnerships and contacts are formalised with the Ministry for Health
- Partnerships with other operational stakeholders are identified and formalised
- Contacts are formalised with sponsors (signature of pre-contracts)
- Concrete deployment capacity is in place, even in cases of remote management
- ACF emergency stocks (if necessary) or access to emergency stocks belonging to partner agencies are pre-positioned and formalised (e.g. UNICEF, PAM, Red Cross, etc.)

The main areas covered by an emergency preparedness programme are: regulation (law, authorities), management (policies, procedures, directives) and execution (plans, resources, knowledge, skills, awareness and attitude). The quality of the work carried out in each of these areas determines the level of preparation for managing an emergency.

In terms of emergency preparedness, it is important to know and analyse the previous situation (indicators and information to be collected), to anticipate the occurrence of the crisis (surveillance) and to prepare the response (pre-negotiations, evaluation, coordination).

The different steps involved in the development of an emergency preparedness plan include:

- Identifying the vulnerable areas and groups within the population
- Assessing the number of expected cases
- Monitoring the prevalence and number of cases of acute malnutrition
- Analysing the capacity of the ministry of health to cope with an increase in the number of cases
- Developing the crisis management strategy
- Defining the “thresholds” for the emergency response

INDICATORS TO COLLECT

The following indicators are to be collected and routinely monitored:

- GAM and SAM rates
- Mortality rate
- Incidence of measles, malaria, diarrhea and acute respiratory infections
- Measles vaccination coverage
- Infant and Young child feeding practices, particularly the exclusive breastfeeding rate

Knowing the level of these indicators upstream of the crisis provides a baseline and a yardstick for measuring the development of the situation. It is also useful for estimating the risks of the situation worsening.

2.2.1 Vulnerable areas and groups within the population

The various vulnerable groups within the population during an emergency must be identified. They can be categorised based on:

- Their physiological vulnerability: infants and young children, pregnant and breastfeeding women, people living with a chronic disease such as HIV/AIDS;
- Their geographical vulnerability: people who live in areas that are subject to drought or flooding, or in areas of conflict;
- Their political vulnerability: oppressed populations; and/or
- Their status as refugees or internally displaced persons.

2.2.2 Number of cases expected / Monitoring the prevalence and number of cases of acute malnutrition

The seasonality factors need to be analysed as the number of SAM cases can greatly fluctuate. This can be done using the Multi-Sectoral Seasonal Calendar,¹⁷ an ACF tool which illustrates and explains seasonal peaks of acute malnutrition.

The seasonal variations of acute malnutrition are caused by the deterioration of one or several major risk factors related to access to food or food consumption, care and feeding practices, diseases, access to health services and/or inadequate sanitary conditions. The seasonal fluctuations can also be caused by environmental and climatic factors (e.g. seasonal flooding) or by human or socio-economic factors (e.g. increases in the price of foodstuffs).

Finally, existing micronutrient deficiencies must be monitored in order to anticipate the risks of possible epidemics.

¹⁷ ACF, *Nutrition Multi-sectoral seasonal calendar*, March 2012

2.2.3 The capacity of the ministry of health to cope with an increase in the number of cases

An analysis of the health system encompassing the six building blocks must be carried out at a national, regional and local level (see questions to be asked in the Table 1 below) in order to evaluate the capacity of health structures to cope with an increase in the number of cases.

2.2.4 The crisis management strategy

The crisis management mechanism must be predefined through cooperation with the stakeholders involved (ministry for health and other stakeholders in the nutrition and health sectors): the type and level of support required shall be determined for each pillar (see examples in Table 1), with the objective of taking responsibility for additional cases without destabilising the substitution (A) and reinforcement (B) strategies in the process.

Lastly, this crisis management strategy should be pre-negotiated with the donors.

2.2.5 The “thresholds” for emergency response

This aspect involves determining, together with the Ministry of Health, the threshold beyond which the healthcare system can no longer manage cases without additional support.

Normally, this threshold should increase over the years as the capacity of the health system is reinforced.

Tools to analyse the healthcare system's capacity for coping with an emergency / managing a response strategy

How to use Table 1

The table below is designed to give guidance in analysing the six building blocks of the healthcare system with the aim of assessing that system's capacity for coping with an increase in the number of acute undernutrition cases.

First, the table sets out, for each building block, a series of questions to ask in order to identify the initial situation.

Next, for each building block, proposals are given for what can be done in an emergency. Each of the points mentioned must be discussed with the health ministry and, where possible, implemented during the emergency preparedness phase.

Ideally, this analysis should be conducted in collaboration with the different nutrition and health actors interacting with the health ministry.

This table is designed to help clarify thinking, however it makes no claim to be exhaustive. Adaptations should be made according to the context.

Table 1: Tool for analysing the capacity of the health system for managing an emergency and the response strategy

Building Blocks	What is the initial situation?	What can be done if an emergency arises?
Management and governance	<p>Are there laws, policies, plans and procedures that are relevant to the national management of multi-sectoral emergencies?</p> <p>Is there an operational body at national/regional level for managing multi-sectoral emergencies which coordinates and supervises a national preparation plan that involves all partners concerned?</p> <p>Are there provisions for registering foreign and national humanitarian agencies for the implementation of humanitarian operations and logistical mechanisms?</p>	<p>Regulation of health-related emergency assistance:</p> <ul style="list-style-type: none"> ▶ Provisions related to the entry of international health workers into the country to offer emergency assistance ▶ Medical products exempted from import taxes ▶ Provisions related to medical products <p>Coordination mechanisms and formation of partnerships:</p> <ul style="list-style-type: none"> ▶ Health authorities involved at all levels within the coordination mechanisms ▶ Agreements signed with bodies within the public and private sectors as well as civil society
Health workers	<p>Are enough qualified workers with the appropriate skills available to respond to a crisis?</p> <p>Is there an appropriate educational and further training programme?</p> <p>Is there a database containing details of workers trained in emergency response?</p>	<p>Training and education</p> <p>Cartography/database of available resources: qualified workers who have the appropriate skills.</p> <p>Procedures for integrating national and international volunteers into the provision of services in emergency situations.</p> <p>The procedures to be followed for mobilising workers and the information on the roles, responsibilities and authority of the people involved should be communicated to all departments and organisations concerned.</p>
Medication and vaccines	<p>Are there standard lists of emergency medical inputs and equipment (connected with the national directives and policies)?</p> <p>Is there an inventory process for ensuring that a minimum stock of essential inputs and medication?</p>	<p>Mechanisms for ensuring speedy delivery of products at a local level</p> <p>Procedures for exceptional access to medical products that are not included on the list of standard equipment</p>

<p>Health information system</p>	<p>Is reliable, up-to-date information available which would allow for risk assessment and for planning of emergency preparedness?</p> <p>Are there protocols and procedures for the collection, analysis and dissemination of data?</p> <p>Is there a monitoring system in place?</p> <p>Is there an early warning system in place?</p>	<p>Determination of thresholds for transition from routine reporting to emergency reporting (adaptation of frequency and content)</p> <p>Emergency reporting system : data collected from all partners involved</p>
<p>Financing</p>	<p>Are there funds available for emergency preparedness and response at national and regional level?</p> <p>Does the ministry of health's financial strategy cover emergency management activities, including risk reduction and emergency preparedness activities?</p>	<p>Financial mechanisms including contingency funds for emergency response and recovery</p> <p>Financing of activities aimed at determining the level of resilience of the critical medical structures (hospitals, warehouses, etc.) and making the necessary improvements</p>
<p>Provision of services</p>	<p>Are there regional emergency response plans in place, based on the national plan?</p> <p>Are these plans based on the available resources?</p> <p>Are these plans revised with regard to lessons learned?</p> <p>Are these plans communicated to all partners?</p> <p>Are there directives and procedures concerning temporary health structures? Is the role of mobile clinics clearly defined?</p> <p>Have transportation and fuel costs been taken into account?</p>	<p>Mechanisms for rapid mobilisation of additional resources (workers, equipment and materials)</p> <p>Procedures for the pre-positioning of essential inputs for the recipients of services and the affected population</p> <p>Temporary health structures or additional workers, the local health structures if local health structures are overloaded</p> <p>The health structures / temporary workers may substitute or complete the health system.</p> <p>Agreements with partners and/or private companies for the provision of logistical services so as to ensure the continuity of essential activities</p>

2.3 Once the emergency occurs

2.3.1 Collection of secondary information

The **collection of secondary information begins in the first hours** after an emergency. This is most often carried out remotely and enables to **illustrate a preliminary scenario**.

The type of documents and secondary sources of information vary which allows information to be cross-checked:

- ▶ Specialised sources: remote collection of information, media reports, etc.
- ▶ Monitoring and tracking systems
- ▶ Basic data, datasheets: country profile, lessons learned from past disasters, investigation reports, etc.

The collection and analysis of the secondary information then continues during the response phase, which allows an up-to-date analysis of the situation.

2.3.2 Collection of primary information

The collection of primary information (evaluation of the needs amongst the population) takes place in several phases:

- ▶ **The initial evaluation must be implemented during the first 72 hours.** This evaluation (MIRA¹⁸) is multi-sectoral and gives a first impression of the priority needs; the report should be finalised and published within no more than 2 weeks. The amount of the initial emergency funding will be assessed on the basis of this evaluation and will then be communicated to the donors (Flash appeal).
- ▶ Following the publication of the MIRA report, each cluster/sector shall undertake a **detailed sectoral evaluation in order to determine the needs more precisely**.

At this point, it is important to organize these evaluations at the cluster (or any other coordination mechanism) level, so as to prevent gaps and duplications. Similarly, sharing the results of the evaluations will facilitate the launching of a global nutritional response to the emergency.

2.4 Emergency response

2.4.1 Response strategy

To develop a solid response strategy, both the situation and the risks of its deterioration must be considered and analysed. Chapter 3 of this manual explains the decision-making process and the factors to be taken into account in elaborating the response: selection of the type of assistance (using the matrix), choice of *modus operandi* and determination of the programme components.

The response strategy must be:

- ▶ Based on local structures and give prominence wherever possible. The objective is to build on what exists (even if it isn't perfect) in order to reinforce local capabilities.
- ▶ Viewed in a long-term perspective, looking to early recovery, in order to not undermine long-term programmes or national structures. In other words, rehabilitation considerations should be addressed.

Wherever a mission has elaborated an emergency preparedness plan and a crisis-management strategy (with the health ministry), the scheduled response plan should be adjusted as necessary.

18 Multi-cluster / sector Initial Rapid Assessment

2.4.2 Coordination

Coordination is key to an international global response to humanitarian emergencies. The lack of coordination causes delays and hinders the coverage of needs.

The cluster approach is designed to strengthen humanitarian response by defining and reinforcing partnerships and accountability in key sectors. The cluster approach is not designed to undermine national authorities or supplant them. **National authorities are ultimately responsible to provide humanitarian relief.** They must be involved in discussions about activating the cluster approach and decide what commitments they are ready to make within the cluster.

Depending on the commitment they wish to make, three partnership options are available:

- ▶ The government is the cluster Lead or Co-Lead;
- ▶ The government is willing to provide coordination but chooses to delegate its coordinating authority to the Cluster Lead Agency while maintaining the power to make decisions. This is the most common situation;
- ▶ The government is unwilling or unable to provide coordination, but is kept regularly informed of the progress of the cluster.

As a rule, the more the cluster's structure is able to reflect and reinforce the national authorities' coordinating mechanisms, the less likely programmes will be duplicated. This interoperating approach also works in favour of transferring the coordinating function to the national authorities when the emergency phase has ended.

It is essential not to confine the approach to the nutrition-sector coordinating mechanisms, but to work in with the health-care sector as well. Nutrition and health interact at all stages in the continuum: health indicators are collected and used during the preparation phase (see page 20), optional assistance in the health field (parasite-disinfestations and immunisation campaigns), etc.

2.5 Rehabilitation

Knowing when to bring an emergency response to an end can be just as important as knowing when to start it since as aid ceases, underlying causes of vulnerability may and often do persist.

The rehabilitation (or recovery) phase after an emergency provides the opportunity for improved reconstruction (i.e. working towards an appropriate, sustainable health system, developing preparedness systems, constructing the capacity for managing future crises, and instituting measures to reduce vulnerability). Improving the resilience of populations and institutions (particularly those of the health ministry) provides them with capacities for recovering better and sooner after a disaster.

Reinforcing response capabilities is the only means of ensuring that resources, processes and procedures are in place to save lives in an emergency, particularly in the earliest days when external aid is not yet available.

After an emergency, the experience must be capitalised-on to highlight the lessons learnt. The capitalising exercise must analyse the strengths / abilities, weaknesses / vulnerabilities, risks and opportunities, and lead to recommendations. Lastly, the preparedness plan must be adapted to take account of the foregoing.

In conclusion

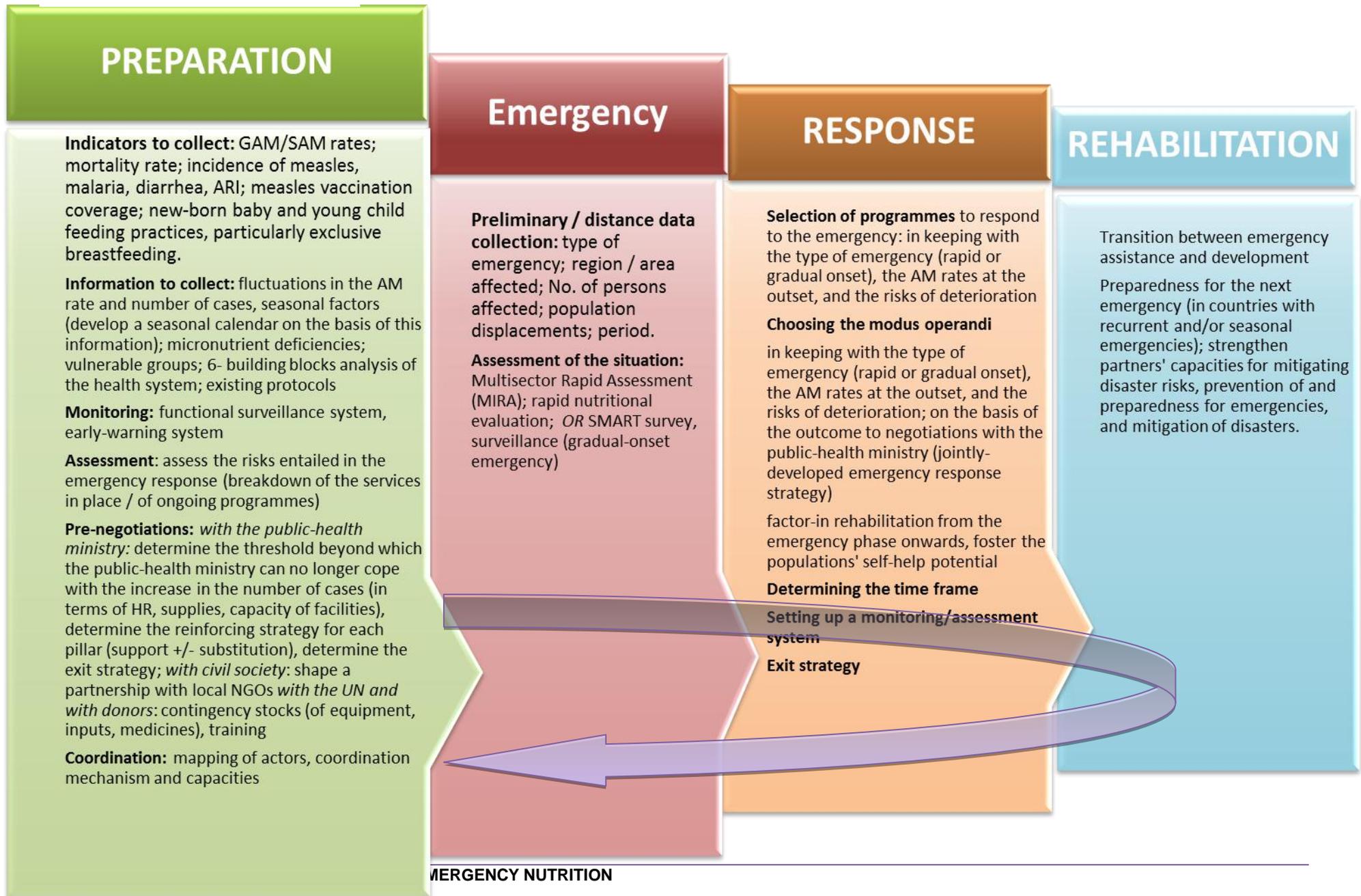
Including the response in a continuum means that catastrophes can be anticipated, and lessons learnt from past experience. With the increasingly high frequency of catastrophes, their causes and consequences have become better known; hence, this method of operation will improve the adaptation and effectiveness of an emergency response, with its impact maximised.

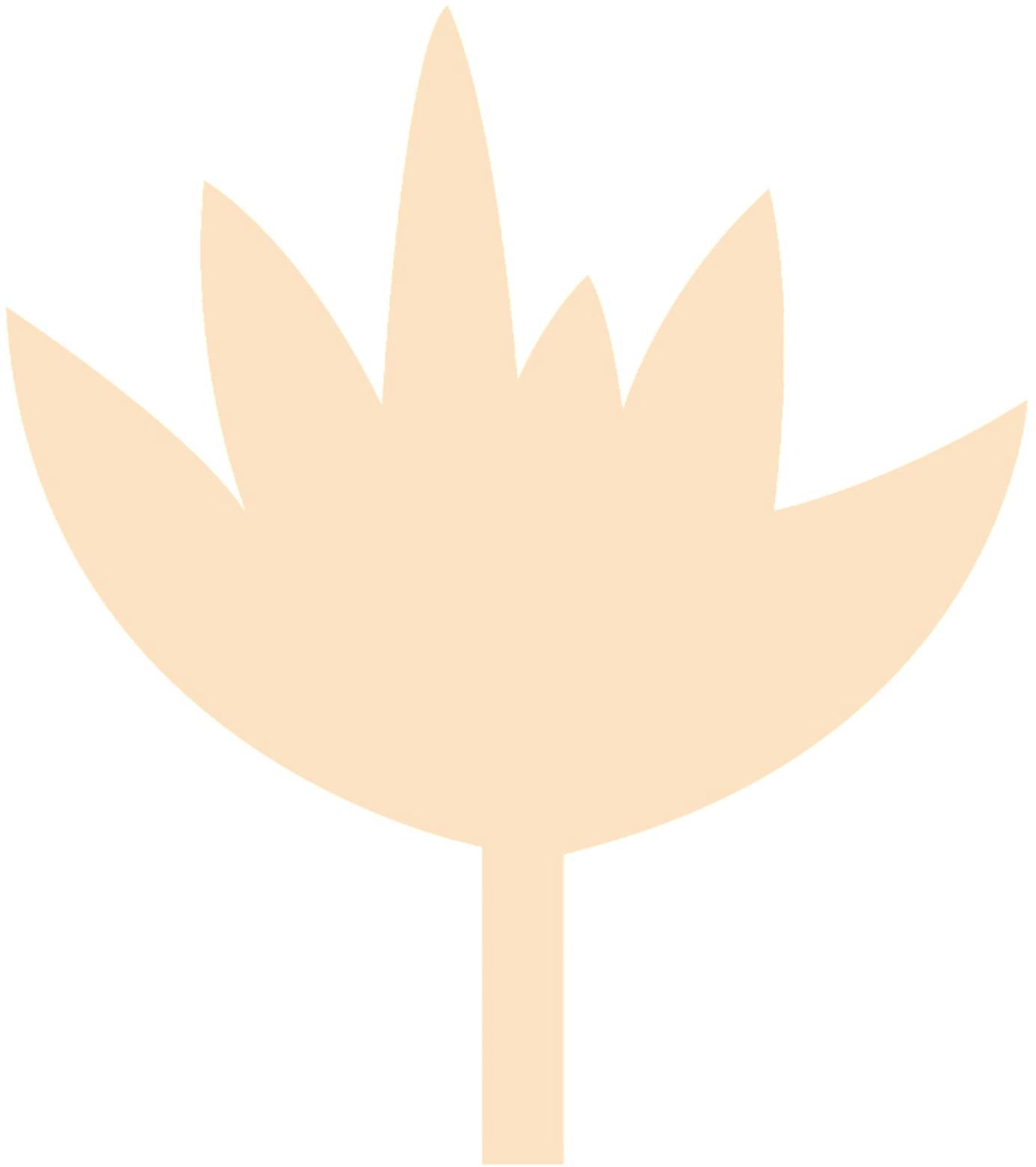


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Figure 3: The Continuum







III. HOW TO DETERMINE THE EMERGENCY RESPONSE STRATEGY¹⁹

3.1 Determining the most suitable type of programme

With the aim of determining the best-suited type of emergency-response programme, the matrix set out in Annex 4 divides the factors to consider into two levels:

- 1) The previous situation, and
- 2) The risk of deterioration.

On completion of this analysis, a programme recommendation can be formulated.

3.1.1 Analysing the situation

Prerequisites

Various information and data are required to use the manual and its matrix:

- ▶ GAM prevalence in the zone
- ▶ Information on the nature and severity of the crisis
- ▶ Health data on the affected area and expected impact of the crisis
- ▶ Food security analysis in the affected area and expected impact of the crisis
- ▶ Population density and population movement risk analysis

The first points of information to consider are those which shed light on the previous situation, particularly pre-crisis vulnerability. Present and previous GAM prevalence in the population affected provide a key indicator of vulnerability.

For decision-making purposes, a GAM prevalence above 15% will be considered high; a prevalence between 8 and 15%²⁰ will be considered medium, and below 8%, prevalence will be considered low.

To classify an emergency's severity, it is also of utmost importance to analyse trends, and to have a clear grasp of GAM seasonality in the population affected by the emergency.

GAM prevalence may be corroborated by the number of children in the GAM and SAM treatment programmes if the coverage is known, and if the needs are covered. If this information is unavailable or insufficiently recent, old data or screening data may be used to gain an idea of GAM prevalence. If no data are available, the decision-making process may be started by analysing the risk of deterioration.

¹⁹ According to *Moderate Acute Malnutrition: A decision tool for emergencies*, developed by the MAM Task Force of the Global Nutrition Cluster

²⁰ The MAM Task Force recommends 8% in preference to the 10% usually used.

3.1.2 Risk of deterioration

3.1.2.1 Risk assessment

Four key factors must be taken into consideration that can predict a risk of the situation deteriorating and hence, point to a probable increase in GAM prevalence:

- ▶ The morbidity trend,
- ▶ The food security trend,
- ▶ Population displacements, and
- ▶ Population density.

Increase in morbidity – Diarrhoea, acute respiratory infection (ARI), malaria and measles in unvaccinated populations are the most common diseases affecting children, and their incidence is liable to rise during an emergency. These diseases may additionally have a major impact on infant mortality and under-nourishment. Some types of emergency are more markedly liable to cause increased morbidity, such as floods or earthquakes: these situations promote, among others, the development of water-borne diseases, for example by polluted-water contamination of drinking-water sources, or the proliferation of various kinds of parasites in stretches of stagnant water. The type of habitat (vulnerability, capacity) in which the catastrophe occurs may also heighten the risk of morbidity (for example, an urban area where health conditions are already poor). Previous data on vaccination coverage, or the coverage of vitamin A supplement administration, may give an indication of increased probability of both the morbidity risk, and its impact on GAM. Assessing access to health services, access to water (quantity and quality), water-treatment and hygiene services, and population density, is also a key component in determining the risk of morbidity. The assignment of a score to increased risk of morbidity must be based on the probability of an increase in the incidence or outbreak of an epidemic. The three expected-risk categories are defined as follows:

- Epidemic: high score (2)
- Increasing incidence / high incidence: medium score (1)
- Stable incidence / low incidence: low score (0)

Decline in food security – A crisis adversely impacting food production, markets, households' incomes or foodstuff prices may have a significant impact on GAM. The amplitude, extent, severity and duration of the impact on food insecurity must be assessed using available data on the food security of households, their consumption, and market information. The expected trend in food security must be considered, including the proportion of households liable to suffer moderate or severe food insecurity. The three expected-risk categories are defined as follows:

- Major shortages in food consumption, decrease in households' assets, and irreversible adaptation strategies: high score (2)
- Significant shortages in food consumption, incipient decrease in households' assets, and irreversible adaptation strategies: medium score (1)
- Lowered food consumption but no nutritional deficiency, no irreversible adaptation strategies: low score (0)

Significant population displacements – Population displacement modes are another factor that can influence the type of programme to implement. Displacements may overstep national boundaries (in the case of refugees) or take place within the country (in the case of internally-displaced people). Types of shelter resorted-to also vary: dispersed shelters, collective shelters at centres (such as schools or religious buildings) or in dormitories, reception and transit camps, or improvised camps, which may or may not be recognised by the host government. Cases may also arise in which refugees

or displaced persons mingle with the host population, who may or may not be relatives. The 2 expected-risk categories are defined as follows:-

- Population displacements are increased and concentrated: high score (1)
- No displacement, or no increase in displacements, or sparsely populated area: low score (0)

Population density – Population density is an important decision-making factor since first, it often influences the risk of epidemic and secondly, the number of cases may be indicative of GAM prevalence. This is why population density must be factored-in when defining programme implementation mechanisms. For example, contexts exist in which, despite a low GAM prevalence, the number of cases to treat will be high, affecting resources required and liable to overburden the health system. Therefore, where population density is very high, despite the low GAM prevalence at the outbreak of the emergency, the number of children requiring treatment may be very high. The 2 expected-risk categories are defined as follows:-

- Urban area, high concentration of population: high score (1)
- Other area: low score (0)

3.1.2.2 Risk evaluation

Each of the risks described above is evaluated independently and assigned a score; the total score is then determined (see table 2).

Table 2: Evaluating the risk of deterioration.

Risk of deterioration	Analysis	Score	Total score	Risk category
Increase in morbidity (diarrhoea, ARI, measles, malaria)	High	2		Score 4-6: High Score 2-4: Medium Score <2: Low
	Medium	1		
	Low	0		
Unavailability of or disrupted access to food (markets, prices, production)	High	2		
	Medium	1		
	Low	0		
Significant population displacements	Yes	1		
	No	0		
Dense population	Yes	1		
	No	0		

3.1.3 Programme recommendation

The programme recommendation is based on the prevalence of GAM (high, medium or low) and on the calculated risk of deterioration (high, medium or low) as explained above.

The **matrix** of different possible recommendations based on the analysis of the situation and the risk of deterioration is presented in **Annex 4**.

The various proposed interventions in the matrix represent the range of nutrition interventions that ACF may implement in an emergency situation. They are categorized according to the nutrition and health sector priority axis²¹.

21 For further details on the priority sections, see *the essential in Nutrition-Santé* (ACF-International, 2012)

Table 3: Emergency nutrition interventions based on the priority sections of the Nutrition-Health sector

AXIS	INTERVENTIONS
AXIS 1: Diagnosis and analysis	Surveillance
	SMART survey
	Rapid nutrition evaluation
AXIS 2: Management of acute malnutrition	Treatment of severe acute malnutrition
	Treatment of moderate acute malnutrition
	Active screening
AXIS 3: Prevention of acute malnutrition	Infant and young child feeding
	Food assistance
	Blanket feeding
	Optional interventions*

* Optional interventions constitute an integral part of ACF's mandate, but are less commonly implemented. The conditions required for their implementation are explained further on.

As emergencies are not homogeneous (they don't affect all regions of a country or all population groups in the same way), the analysis and decision-making process must be developed zone by zone and according to the needs of key target populations. Moreover, the analysis must take into account different vulnerabilities and as a result the various potential impacts on women, girls, boys and men as well as on different ethnic and economic groups. This must then be integrated into the programme definition in terms of geographic targeting and target groups.

Finally the importance of working in coordination cannot be understated. The situation must be analysed jointly with nutrition and health partners (including the Ministry of Health) at the level of the coordinating national, regional or cluster or any other mechanism existing at the local level.



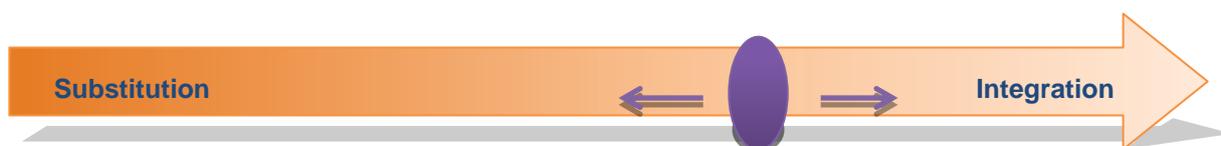
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3.2 Determining the modus operandi and programmatic elements

The onset of the emergency (rapid or slow) does not influence the selection of response programmes to be implemented except in a few cases. Instead, the difference takes place in the choice of modus operandi.

Selecting a programme is also influenced by other factors such as the number of expected malnutrition cases, the existence of a health system and its ability to completely or partially manage these cases, pre-existing nutrition programmes and their own modus operandi.

The choice of modus operandi can be depicted as a cursor on a scale that runs from total substitution (direct implementation by ACF) to total integration (implementation by health facilities without ACF's support); the intermediary steps consist of all the types of support offered to ACF to address gaps:



To determine the modus operandi, it is essential to analyse the capabilities of the health system in order to find its gaps. This must be completed jointly with the Ministry of Health. It is also critical to work in collaboration with various nutrition and health partners to ensure that ACF's support is not duplicated by other interventions or inversely that significant gaps are missed.

Some interventions may also be implemented by a local partner such as a local NGO or the national office of the Red Cross. This possibility must not be overlooked because in some cases it provides a continuity of interventions, or easier access to affected populations particularly in zones where security is not assured.

The analysis required to choose a modus operandi must be completed for each of the selected interventions. As a result, the implementation of these interventions will take place in the most suitable manner possible.

Once the interventions have been selected and their modus operandi decided, certain programmatic elements must be determined:

- ▶ Target group
- ▶ Choice of product (if necessary)
- ▶ Duration of the intervention
- ▶ Implementation mechanism

The decisions relative to these elements are influenced by the type of emergency and the context of the affected zone, as is outlined above in this document (prior situation, vulnerabilities leading to the crisis and risk of deterioration).

Emergency response: Choosing the right approach- *Chad example-2012*

Since 2008 ACF implements nutritional programs in the Kanem region, with a health system strengthening (integration) approach.

A strategy has been developed to cope with the increasing incidence of MAS due to the crisis, without destabilizing the existing support in health centers. It was therefore decided to implement a temporary mobile teams composed of ACF staff (direct implementation), with the aim of extending support to areas with little or no coverage, decongesting health centers already supported.

3.2.1 Programmes section 1: Diagnosis and analysis

3.2.1.1 *Modus operandi*

The diagnosis and analysis of a situation can be determined to varying degrees by three interventions:

- ▶ Surveillance
- ▶ Rapid nutrition evaluations
- ▶ SMART nutrition surveys

Surveillance consists of collecting certain amounts of data on a routine basis. The primary data to be collected pertains to nutrition and sanitation: admissions into nutrition programmes, screening data (active and passive), morbidity data, etc. The sources are varied: ACF programmes or other organizations and health facilities (health information system). Data collection regarding food security is also important (from institutions or from ACF's FSL teams) in order to analyse the situation on a global scale particularly in the case of slow-onset disasters: crop prospects, market price variations, household vulnerabilities, etc. In short, surveillance provides visibility to the evolution of nutrition, sanitation and food security.

When an **early warning system** is operative in a country, it is critical to monitor analyses in order to more efficiently foresee disasters and their probable impact. Maximum involvement serves to reinforce and improve the system.

Rapid nutrition evaluations are most relevant concerning rapid-onset disasters when little is known about the initial situation, or concerning slow-onset disasters when access is difficult (open only a few days).

In fact, in the case of rapid-onset disasters, the nutritional situation does not deteriorate significantly within the space of a few days. On the contrary, it takes a couple of weeks. If the nutritional situation of the zone or the affected population is already known when the disaster takes place, this evaluation is not required. If, however, the situation is not known, a rapid nutrition evaluation must be conducted.

! QUICK AND ESSENTIAL!
In order for the rapid nutrition assessments to retain relevance and interest, the results should be known very quickly. The report should be finalized and disseminated within 3 days of the end of the data collection.

In the case of slow-onset disasters, it is more relevant to plan for a bona fide nutrition survey to obtain more precise data. Rapid nutrition evaluations prove to be more suitable in cases where access to the zone or the population is complicated (unpredictable and/or short-term) because they provide a better understanding of the situation.

SMART nutrition surveys provide a very clear idea in an instant of the situation of the selected zone. These surveys provide the most precise and reliable information, but they require more resources (time, financial support and technical expertise).

3.2.1.2 Programmatic elements

Selecting a target group

Surveillance can apply to all population groups depending on the data that is collected.

Rapid nutrition evaluations target children aged from 6 to 59 months and/or pregnant and lactating women. These populations are both the most susceptible to malnutrition and those for which the MUAC can be measured. ©

ACF, Roselyne Monin – Ivory Coast, 2011

SMART nutrition surveys normally target children aged from 6 to 59 months; infants under 6 months can also be included or be subject to a survey where relevant.

Estimating the duration of the intervention

Surveillance is a long-term intervention that must exist leading up to the disaster, be in effect during the emergency response and be maintained during the rehabilitation phase.

Rapid nutrition evaluations are quick to prepare (a couple of days) and to implement. They can be conducted as part of the primary data collection during the in-depth sectorial assessment, that is to say, in the two weeks following the disaster (see Chapter 2.3.2).

SMART nutrition surveys require six to eight weeks from preparation to report completion. In light of the necessary time to prepare, a nutrition survey cannot be undertaken in a few days. In the case of slow-onset disasters, it is possible to foresee and plan the implementation of a nutrition survey. When it comes to rapid-onset disasters, the nutrition survey must be planned a couple of weeks or months after the emergency, taking into account the situation's risk of deterioration.

Determining the implementation mechanism

As explained previously, access to the affected population/zone determines, among other things, whether a rapid evaluation or a nutrition survey will be used. Furthermore, the area of the affected zone and/or the heterogeneity of the affected population must be taken into account during the planning: a very large zone or a very heterogeneous population requires a number of evaluations/surveys; otherwise the results cannot be used.

CAUTION : INFANT LESS THAN 6 MONTHS
Infants less than 6 months do not currently receive sufficient attention in terms of diagnosis and analysis.

- ▶ Monitoring data on them are few, if any, as they are not routinely collected;
- ▶ They are excluded from rapid nutrition assessments insofar as they are not eligible for MUAC;
- ▶ They rarely investigated nutritional SMART.

However, as explained previously infants less than 6 months are in immediate danger during an emergency. They must imperatively be evaluated and monitored.



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3.2.2 Programmes section 2: Management of acute malnutrition

3.2.2.1 Modus operandi

The management of acute malnutrition consists of three interventions:

-  Treatment of severe acute malnutrition
-  Treatment of moderate acute malnutrition
-  Active screening of cases

For the most part, the management of acute malnutrition is overseen either directly by the NGOs (international or local) or by the healthcare system. The degree of involvement varies depending on the context. In this case, international NGOs are responsible for developing capacity within the healthcare system and/or local NGOs for looking after its management. This leaves ACF to evaluate the need for support in different areas (see 6 pillars of the health system), in so-called normal situations and in crisis situations (see Strategies A, B and C, Chapter 2.1). The role ACF assumes positions itself on the curser of the “substation-integration” scale. This positioning must take into account not only the healthcare systems’ capabilities, but also the effectiveness and alignment of the other actors for each of the interventions.

For example, the following combination could be possible:

- ▶ Management of SAM cases by health facilities with support from ACF for input delivery
- ▶ Training and supervision of a local NGO to treat MAM
- ▶ And active screening of cases within the community by an ACF team

As explained in the Emergency Preparedness chapter (2.2), in cases where ACF is already working to reinforce the healthcare system, the crisis management strategy (Strategy C) will have been determined in advance with the Ministry of Health and will have been subject to pre-negotiations.

3.2.2.2 Programmatic elements

Selecting a target group

Standard target groups for the treatment of acute malnutrition are the following:

-  Malnourished infants under 6 months (only in programmes for the treatment of SAM)
-  Children aged from 6 to 59 months, acutely or moderately malnourished (following the programme)
-  Children aged from 6 to 59 months, recovered and released from the treatment of SAM (for MAM programme)
-  Pregnant women and malnourished lactating women

In certain exceptional circumstances other groups can be included such as children aged from 5 to 10 years old or the elderly. Their need must be justified by the results of the survey, evaluations or screening data. This was the case for the Somali refugees in Ethiopia and Kenya during the Horn of Africa drought of 2011.

In the case of active screening, since it is based on the measurement of the mid-upper-arm circumference and the diagnosis of oedema, eligible groups are children aged from 6 to 59 month or who measure 65 to 110 cm, and pregnant and lactating women.

Focus on infants under six months

In the absence of official recommendations, and while awaiting the findings of research in progress, ACF gives the following indications:

ALARM SIGNALS for case detection

- ▶ If the infant's mother mentions problems with breastfeeding;
- ▶ In the event of recent weight loss;
- ▶ Where there are visible signs of malnutrition.

ANTHROPOMETRIC CRITERIA for SAM ADMISSION

- ▶ Weight-for-height index < -3 z-score;
- ▶ Middle Upper Arm circumference < 110 for infants aged 2 to 6 months.

Selecting the correct product

The type of product selected depends on the nature of the programme, the target group, and the food security situation. Principal factors to consider when selecting products are:

- 🏠 Type of intervention and target group: products designed to treat GAM and MAM are different and very specialised; products can also differ across the same programme depending on the target group (RUTF vs therapeutic milk to treat SAM; RUSF vs CSB/CSB+/CSB++ to treat MAM) ;
- 🏠 Food preparation facilities: fortified flours like CSB (+/++) require access to a heat source, clean water and cooking materials; if these conditions cannot be fulfilled it is preferable to use ready-prepared foodstuffs;
- 🏠 Cultural practices and food preferences: available fortified flours are wheat or maize based; a rice flour is being developed. Ready prepared food products are peanut based, however alternatives with a chickpea or milk base have been developed. Community preferences should be taken into account as much as possible, balanced against the time it will take for the selected food product to become available.

Detailed advice about the products to use to prevent and treat moderate acute malnutrition can be found in a document produced by the MAM Task Force, *Moderate Acute Malnutrition: A decision tool for emergencies*, which can be found in Annex 5.

A detailed guide to the different types of nutritional products available as well as the position of ACF regarding the problems of using these products is available in summary form in the article *Nutritional Products in Nutrition-Health Essentials 2012*, or reproduced in full in the ACF positioning brief *Products are not enough: putting nutrition products in their proper place in the treatment and prevention of global acute malnutrition*.

Estimating the timescale of the intervention

A classic emergency acute malnutrition programme is carried out over at least six months. Scaling back or even ending these emergency programmes can be considered when the GAM rate has dropped, when there is no longer a risk of the situation deteriorating, and when the number of participants has dropped. However, stopping an emergency programme does not

always lead to the cessation of all programmes dealing with acute malnutrition: returning or transitioning to a programme of healthcare system support is desirable, to ensure that treatment for severe malnutrition is available all year round.

Deciding how the intervention should be carried out

A certain number of factors should be taken into account when deciding how to respond to a situation, such as access to the population, the extent of the catastrophe (number of zones affected etc.), the number and capacity of other agents, and the population density. For example, in densely populated areas, it may be necessary to increase the number of sites and/or the number of days these sites are operational in order to reduce waiting lists. Some interventions can be shared between them or offered on adjacent sites.



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3.2.3 Programmes section 3: Prevention of severe malnutrition

3.2.3.1 Modus operandi

Infants and Young Child Feeding (IYCF)²²

Breastfeeding is undoubtedly the best method to ensure optimal growth and development in infants; it also has important consequences for the health of the mother and the mother-child bond. **In an emergency situation, breastfeeding can mean the difference between life and death.** Studies prove that insufficient breastfeeding contributes massively to morbidity and mortality rates in infants (Lancet 2008).

Experience shows that breastfeeding can become difficult in emergency situations. This is due, amongst other reasons, to trauma, stress and other problems which interfere with milk production, but also to widespread myths and beliefs, lack of time on the part of the mothers, insufficient

²² ACF, *Care Practices in Emergencies Guidelines* (to be published)

maternal support, and to the distribution of free samples of breast-milk substitutes, bottles and other materials. However **in emergency situations, and with the right encouragement, most mothers can continue or recommence breastfeeding if appropriate technical and psychosocial support is provided, and a favourable environment is created.**

The objective of IYCF interventions is to protect infants and children within the family unit in an emergency situation, by optimising care and nurturing the mother and family psychosocial resources . Specific objectives include:

- ▶ Preventing an increase in acute malnutrition, morbidity and mortality rates;
- ▶ Helping families adapt the care they give in emergency and post-emergency situations;
- ▶ Improving the well-being of beneficiaries (infants, young children and those who care for them, pregnant women) by taking into consideration past life experiences and past and present sufferings, as well as emerging needs;
- ▶ Showing families how to support the infant's development and increase its chances of survival;
- ▶ Warning against or decreasing the negative impact of distribution of free breast-milk substitute samples; and
- ▶ Providing appropriate and sustainable solutions in cases where maternal feeding is not an option.

IYCF can be supported in different ways, which must always be adapted to suit the local culture, to the identified needs and the technical ability of the team. Different IYCF interventions can complement each other in an emergency situation: Baby-Tents, breastfeeding areas, mobile counselling services, integration of healthcare practices (in a SAM treatment programme, for example), and community healthcare practices.

In emergency situations, breast milk substitutes are even more dangerous than normal due to a lack of hygiene in storage facilities or in preparation and administrative practices, and a long-term lack of availability of age specific products labelled in local languages. The cessation of breast milk production (brought on by the distribution of substitutes) means an impoverished immune system, and a loss of nutritional value and well-being, all happening during a time where there is increased risk of infection, reduced availability of good quality food supplements, and increased risk of emotional problems brought on by the emergency situation. This proves that distribution of free samples of breast milk substitutes causes morbidity and mortality rates to rise.

ACF, in its position as signatory of the International Code of Marketing of Breast Milk Substitutes, must be actively involved in preventing distribution, following up and reporting on any violations of the code, as well as dealing with confiscated products. These interventions are generally carried out by Cluster Nutrition.

FOCUS ON READY-TO-USE INFANT FORMULA (RUIF)

The Haiti experience

Why distribute RUIF? The reasons for this strategic choice are: the low breastfeeding rate ahead of the earthquake; an urban environment with substitutes already widely present in the markets; a large number of orphans expected; the lack of acceptance of wet-nursing.

For what indications? The infants eligible for RUIF were infants aged under 12 months who had no possibility of being breastfed, for the following reasons: mother away from home long-term, or deceased; mother receiving treatment incompatible with breastfeeding; mother re lactating; mother an HIV carrier not breastfeeding before the earthquake; mother not breastfeeding before the earthquake.

What are the risks? The attractiveness of RUIF, which is liable to hinder breastfeeding ("false orphans"); misuse (new product, instructions had to be generated from scratch); the exit strategy (this type of distribution is not supposed to continue indefinitely).

Operating instructions

In the early emergency stages, RUIF has the advantage of not needing reconstitution with water. Its use can limit health risks while awaiting the establishment of services capable of supporting the use of powdered infant milk. RUIF is not a guarantee of safety – proper use, equipment hygiene and proper storage conditions remain essential. RUIF procurement is very costly, and the storage implications entailed need careful consideration in each context. Where RUIF is indicated, supplying it to infants aged under six months should be given priority.

Food Aid²³

Food aid interventions are varied and aim to prevent deterioration in the affected population's nutritional state, by guaranteeing access to specially adapted sources of nutrition.

Food aid can take different forms, such as general food distribution targeted at the whole population of a given zone, targeted distribution to a given group within that population (i.e. under 5s, pregnant or breast-feeding women, *see Blanket feeding*), work-for-food programmes, or food coupons which allow recipients to purchase food in designated shops. The ration can be comprehensive, covering all the energy needs of an adult, or complementary (to complement existing food sources, only responding to some needs). In both cases the foodstuffs must correspond to the nutritional needs of the target population.

However, given that these foodstuffs are often "dry", containing no fresh products such as vegetables, fruits or animal products, they are virtually free of key micro-nutrients. Foodstuffs are sometimes prepared and distributed in canteens (*see blanket feeding*).

Monetary interventions are recognised to have great potential to improve nutrition and in preventing the deterioration of the nutritional state. They take a wide range of forms, including cash-for-work programmes, direct transfers and coupon schemes.

Experience has shown several times that monetary transfers increase considerably food consumption and food diversity in households.

23 ACF-International, *Optimiser l'impact nutritionnel des interventions sécurité alimentaire et moyens d'existence – Manuel pour les professionnels de terrain*, Décembre 2011

Coupon usage aiming to promote access to certain types of foodstuffs and services is appropriate in every environment where these goods/services are readily available, but where access is limited or out of reach to those with poor buying power. Coupons can be used to ensure access to fresh food rich in micronutrients (fruit, vegetables, animal products) which are expensive and difficult to include in food programmes. Food coupons can also be used to access fortified products and complementary foodstuffs available in the local market.

Blanket feeding²⁴

Blanket feeding is a targeted aid intervention which can be added to other food aid operations, or rolled out separately. It can be a part of the first stages of an emergency response, as it can be set up more quickly than a general distribution, programme and targets the most vulnerable (under 5s, pregnant and breast-feeding women).

The foodstuffs, distributed dry or ready-mixed, are calculated to meet the nutritional needs of a 5 year old (1250 Kcal/day) taking into account the risk (high) that it will be shared with the rest of the family; it contains thus 1500 Kcal.

In situations where families are not able to cook, or where we wish to be certain that the target populations are properly benefitting from the foodstuffs, it is possible that these foodstuffs will be distributed via canteens.

Optional interventions

Optional interventions are those which play an integral part in the ACF mandate, but which are less frequently carried out. They will be implemented if the following conditions are present:

-  Distribution of micro-nutrients: if the population is dependent on a general food distribution programme;
-  Targeted food supplement distribution (vitamin A, vitamin C or zinc) : 1) an endemic vitamin A deficiency, 2) there is an epidemic or risk thereof of the following diseases: measles, scurvy or diarrhoea, 3) no medical agents are present to ensure supplementation ;
-  Anti-parasite campaign : 1) serious problems with water access, 2) endemic anaemia, 3) endemic parasitosis ;
-  Immunisation campaign: 1) immunisation coverage is low 2) there is risk of epidemic, 3) no medical agent present to ensure the success of the campaign.

3.2.3.2 Programmatic elements

Selecting the target group

IYCF interventions target infants and young children up to the age of two and their immediate family (parents, brothers and sisters, etc.) and pregnant women. Certain interventions, such as Baby-tents, specifically target breastfeeding women with children under the age of two, as well as pregnant women. Non-targeted food aid interventions benefit the general population, whereas monetary interventions benefit a section of the population, chosen according to vulnerability criteria.

Blanket feeding targets the most vulnerable groups in a population suffering from severe malnutrition, meaning children aged between six months and five years of age, pregnant and breast-feeding women. Depending on the situation, participation can be limited to children under three.

Target groups in **optional interventions** are specific to each intervention, and can vary according to the situation.

24 ACF-International FSL, *Food Aid Interventions, Programming ... A blanket distribution intervention & Programming ... Canteens interventions*

Selecting the right product

The selection of products is intrinsically linked to the nature of the programme, the target group and the context of food safety. The main factors to take into consideration for the selection of products are:

- ✚ The intervention and the target group: the products aimed at a general distribution of food or the distribution of cover are different; on the other hand, for the same programme the products can differ according to the target group (RUSF vs. CSB/CSB+/CSB++ for blanket feeding for example);
- ✚ The abilities of the households to cook: for the enriched flours such as CSB (+/++), you need to have access to some kind of fuel, clean water, cooking utensils; if these conditions are not fulfilled, it would be better to use some readymade food (RUSF or energy biscuits for example);
- ✚ The cultural practices and the food preferences: enriched flours that are already available are wheat- or corn-based, and a type of rice-based flour is being developed. On the other hand, the ready-made foods are for most of them peanut-based, but alternatives which are chickpea- or milk-based are being developed. The preferences of the communities have to be taken into account as much as possible, but should be balanced taking into account the time necessary for the food to be available.

Detailed recommendations on the products to use for the prevention and the treatment of moderated acute malnutrition (MAM) can be referred to in the document produced by the MAM Task Force, *Moderate Acute Malnutrition: A Decision Tool for Emergencies* (Annex 4).

On the other hand, a detailed briefing on the various types of nutrition products as well as on the position of ACF about the problems surrounding the latter are available in a summary form in the paper *Nutritional Products from The Essentials on Nutrition-Health* or a full version in the document from the briefing and the views of ACF: *Products are not enough: putting nutrition products in their proper place in the treatment and prevention of global acute malnutrition*.

Finally and generally speaking, the composition of the food intakes distributed is calculated to cover the energy needs of the targeted population, keeping in mind their composition in micro-nutrients. Those calculations can be easily done thanks to the software NutVal of the PAM.

Estimating the length of the operation

Usually, an emergency program for the prevention of acute malnutrition is often put into place for at least three to six months. The reduction or even the closing of the emergency programmes can be considered when the levels of GAM have diminished, that there is no risk of worsening and that the number of cases has diminished in the health care programmes.

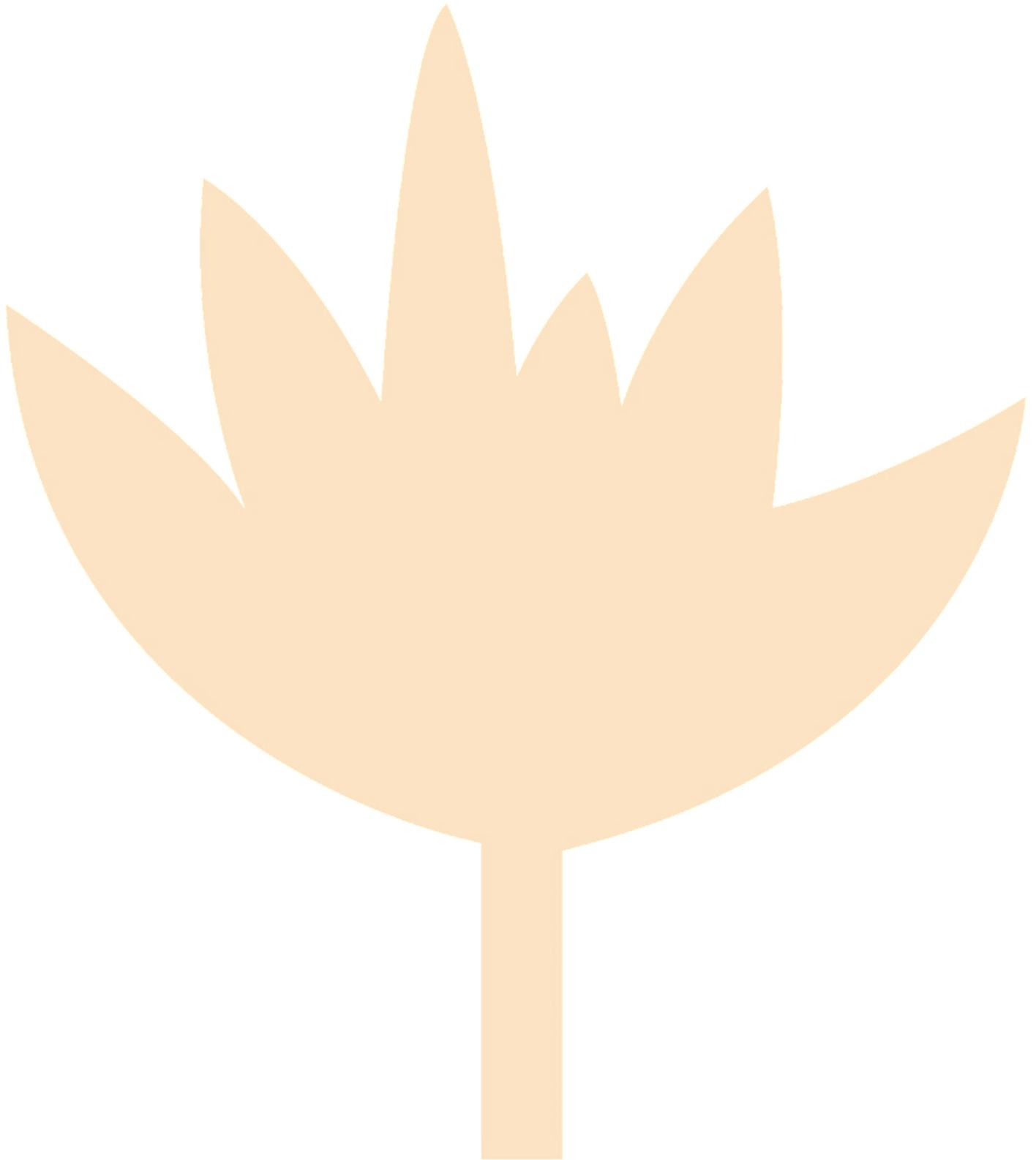
However the stopping of an emergency intervention does not mean the disappearance of all the programmes to prevent acute malnutrition: a transition towards longer-term programmes is desirable, so that the prevention of malnutrition can be provided all year around with programmes addressing the causes of undernutrition.

Determining the setting-up mechanism

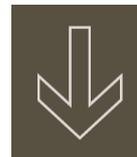
A number of factors have to be taken into account when determining the setting-up mechanism for the answer, such as the access to the population, the spread of the disaster (number of affected areas, etc.), the number and abilities of the actors and the population density. For example in areas where the density is high, it will be necessary to multiply the sites and/or the opening days so as to reduce the waiting time. Some interventions can be integrated between themselves or delivered in adjacent sites.



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IV. THE NUTRITION CLUSTER: BASIC NOTIONS



Humanitarian emergencies can have various forms. They can be the result of natural disasters, such as flooding or earthquakes, or of conflicts. The beginning of an emergency can happen very quickly, or evolve over time.

The humanitarian answer is a progressive and dynamic field, guided by fundamental humanitarian principles.

4.1 The Humanitarian Reform and the Cluster Approach

In response to the increasing complexity of the humanitarian contexts, a Journal of the Humanitarian Answer was finalised in 2005 by the IASC²⁵. This Journal pointed out the significant gaps: particularly fragmented responses and an insufficient involvement of governments and national stakeholders.

The development of a **Humanitarian Reform** has been advised in order to improve the **predictability** of the financial situation, the **accountability** towards the affected populations, and the **partnership** between the UN and non-UN humanitarian actors.



figure 3: the 4 pillars of the Humanitarian Reform

4.1.1 Aims of the Cluster Approach

The development of the Cluster Approach is aimed at reinforcing the humanitarian response, through the strengthening of partnerships between organizations and ensuring that key sectors are held accountable.

- At the global level: reinforcement of the preparation and technical ability to answer humanitarian emergencies.
- At the country level: ensuring a more coherent and efficient response through mobilising agencies in such a way that they are able to respond in a more strategic manner, with a leading agent: “the cluster” (Cluster Lead Agency) designated at the level of the country.

25 Inter-Agency Standing Committee: forum involving UN and non-UN key actors, in charge of coordination, development of policies and decisions making. The IASC determines who is in charge of doing what in the humanitarian answer, identifies the gaps and makes recommendations for the setting up of international humanitarian principles. The IASC is managed by the Emergency Relief Coordinator (ERC).

The Cluster Approach allows more strategic responses and a more effective system in prioritizing available resources while clarifying how work is shared between organisations, and better defining the roles and responsibilities of the humanitarian organisations within the sector.

4.1.2 Where/When activating the Clusters?

When a humanitarian emergency exceeds the limits of an agency's mandate, when the needs are of such complexity that a multi-sectorial approach and the commitment of a large range of actors is justified.

4.1.3 Mechanism for the activation of the Clusters

The process to activate the Clusters was developed by the IASC in 2007.

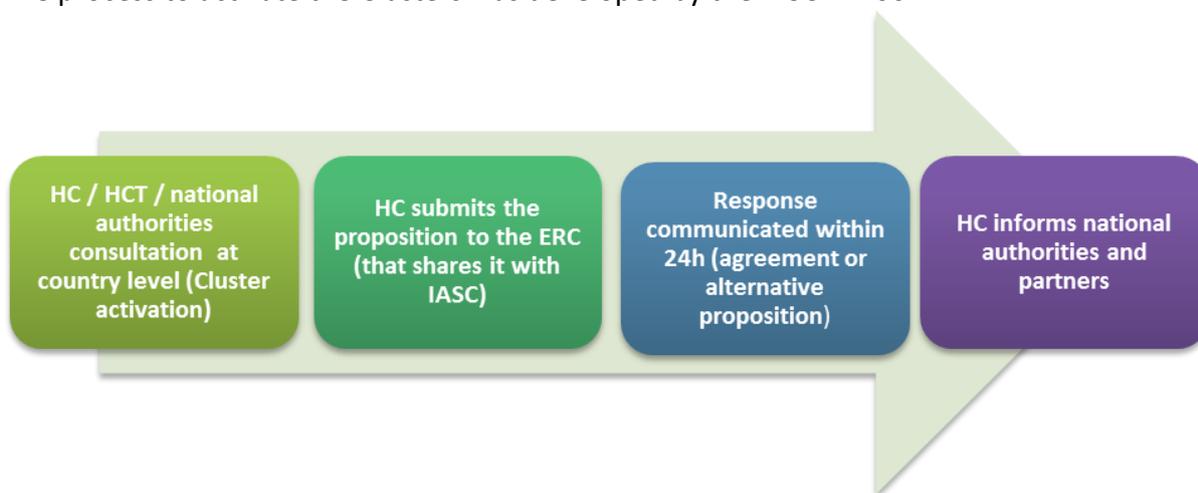


Figure 4: Mechanism for activation the Clusters

Acronyms

HC (Humanitarian Coordinator): (S)he has the responsibility to ensure that the international response is strategic, well planned, coordinated and efficient.

HCT (Humanitarian Country Team): the equivalent of the IASC at the country level; managed the HC.

ERC (Emergency Relief Coordinator): is at the head of the OCHA, manager of IASC, and reporting to the Secretary General of the United Nation, the ERC is responsible for the global coordination of the humanitarian assistance.

CLA (Cluster Lead Agency): For nutrition, UNICEF is the Cluster Lead Agency

4.1.4 When does the Nutrition Cluster need be activated?

The activation of specific clusters depends on the humanitarian emergency and on the abilities to respond at the national level. Clusters are supposed to be activated only in sectors where existing mechanisms of coordination are insufficient. The activation of a cluster will depend on the decision of the national authorities (see below).

As Cluster Lead Agency at a global level for Nutrition, UNICEF has the responsibility to facilitate the discussion, the analysis and the recommendation on whether or not to activate the nutrition cluster. At the same time, the actors in nutrition at the country level as well as the GNC-CT²⁶ can bring forth their own contributions.

Questions to ask oneself to know whether a Nutrition Cluster is necessary:

- Are there gaps between the availability of the treatment programmes and the prevention of malnutrition because of the emergency?
- Are the preparation and response to the nutrition emergency already coordinated in a proper manner by the national authorities?
- Is there a coordination mechanism in the nutrition sector that has the ability to prepare and answer emergencies?
- Do other sectors plan to activate the Cluster Approach?
- Are there indicators to measure an increase of the nutritional risk linked to the emergency, and would one surpass present capacities in order to respond?

4.2 Roles and Responsibilities

4.2.1 Government

The role of the government is defined in the resolution 46/182 of the General Assembly of the UN: “Each State has the responsibility **first and foremost** to take care of the victims of natural disasters and other emergencies occurring on its territory. Hence, the affected State has the primary role in the initiation, organization, coordination and implementation of humanitarian assistance within its territory”

Humanitarian assistance is provided in case the national authorities have the will or ability to give it themselves.

According to the will of the national authorities to take part to the Cluster, there are three possibilities of partnership:

- The government is the lead or co-lead of one cluster;
- The government wishes to coordinate, but delegates the power of coordination to the CLA, and the opportunities for taking decisions are given in a regular manner (the most common situation);
- The government cannot or does not want to coordinate and is being kept informed of the progresses of the cluster at regular intervals.

4.2.2 Cluster Lead Agency

An agency is designated as CLA in each technical sector.

At the global level, the CLA in Nutrition is UNICEF. At the country level, UNICEF, is for the most part also the CLA, although there are other relationships as well. At the country level, the CLA can be any member organization of the IASC if it has the resources and necessary expertise to qualify for the terms of reference. ACF has acted as the CLA in some countries: South Sudan, as one example.

The intervention fields of the CLA are:

- Standards and policies: development, consolidation, dissemination
- Construction of a ability to answer: trainings, stocks, HR
- Operational back up

ACF INVOLVEMENT

- ▶ **Operational presence:** it would be unrealistic for ACF to position itself as a CLA with a limited operational presence in the field.
- ▶ **HR implications:** the CLA must provide sufficient numbers of senior, experienced personnel to perform the coordination, information-management and administrative-support functions throughout the duration of the emergency and during the transitional period.
- ▶ **Financial implications:** costs of personnel and coordination activities (meetings, logistical support, administrative support, printing, etc.).
- ▶ **Working relations with the national authorities:** the different organisations (UN, NGOs, institutions) may be treated differently by the national authorities (e.g. for travelling permits and work permits). To act as a CLA would require resolution of this type of problem.
- ▶ **Accountability:** as a provider of last resort, the CLA is accountable to the humanitarian coordinator where gaps are identified.

To know more

Last resort Supplier: At country level, the CLA is responsible to supply the necessary services in order to fill any gaps during the emergency response. Conditions to consider are access, security and availability of funds.

4.2.3 The Cluster coordinator

The role of the Nutrition Cluster Coordinator (NCC) is to ensure a coherent and efficient answer to a nutrition emergency. His/her terms of reference cover 13 fields of intervention:

- ▶ Inclusion of all the key partners;
- ▶ Establishing and maintaining appropriate coordination mechanisms;
- ▶ Ensuring the link/coordination with the national authorities, the institutions and the civil society;
- ▶ Ensuring the participative approach and the involvement of the community in the assessments, analysis and answers;

- ▶ Ensuring that the transverse questions are taken into account (gender, HIV, environment, etc.);
- ▶ Ensuring the efficiency and coherence of the assessments and analysis, and involving the appropriate partners;
- ▶ Preparation for the emergencies;
- ▶ Elaboration of a strategy;
- ▶ Implementation of the standards: ensuring that the answers are in line with the national policies;
- ▶ Follow up and reporting: ensuring that the mechanism are implemented;
- ▶ Plea and mobilisation of the resources;
- ▶ Training and development of the abilities of the partners;
- ▶ Supplier in last resort: request to the CLA to fill in the gaps.

The credibility of the NCC depends on the manner in which (s)he can demonstrate his/her impartiality, autonomy and independence regarding his/her CLA.

4.2.4 Participants to the Cluster

The Nutrition Cluster is open to all organisations taking part to a nutrition response, as long as they are in line with the good practice standards and wish to take part in reinforcing nutrition resources in a specific country. They must also be committed to the Nutrition Cluster strategic priorities.

ACF INVOLVEMENT

- ▶ Approving the global objectives and coordination mechanisms of the cluster;
- ▶ A proactive approach to exchanging information, identifying needs and gaps, mobilising resources and strengthening local capacities;
- ▶ Sharing coordination responsibilities: using working groups to assess needs, develop response plans and guidelines, etc.; developing responses aligned with the defined objectives and priorities;
- ▶ Complying with principles, policies, priorities and standards.

It is important to make clear that the Cluster Nutrition participants are not accountable to the CLA, except where contractual obligations exist (e.g. as implementing partner).

4.2.5 Global Nutrition Cluster (international level)

4.2.5.1 Composition

The Global Nutrition Cluster (GNC) is made up of a large range of participants each with a different role and responsibilities:

- Coordinator of the GNC: in charge of the general management of the GNC, helped by a team (GNC-CT: GNC-Coordination Team);
- Main partners of the GNC (Core Partners): individuals or agents being formally part of the GNC, and bringing their technical expertise. (ACF is part of this);
- Resource persons of the GNC: network of NCC and regional staff of the CLA which are called on for specific contributions;
- Observers of the GNC: individuals or agencies which take part in the GNC only to share information (for example: MSF, CICR)
- Large network of the GNC: students, professionals having an interest in the information shared by the GNC but are not involved in the work.

4.2.5.2 Strategic lines of the GNC

- Coordination, plea and mobilisation of resources internationally speaking;
- Policies, standards, international guidelines;
- Development of the abilities to give a humanitarian answer;
- Preparation;
- Assessment, monitoring and management information; and
- Best practices and lessons learnt.

4.2.5.3 The GNC and country Cluster

There is no hierarchy between the GNC-CT and the NCC. The NCC shares its resources (documentation) and gives technical support to the NCC, on demand.

The GNC also ensures a link between other initiatives which deals with nutrition, such as the IFE²⁷ Core Group, SCN²⁸, SUN²⁹, NUGAG³⁰ and REACH³¹.

4.2.6 UNHCR and the Nutrition Cluster

In 2005 the UNHCR took the role of CLA for the Protection and Shelter Cluster for internally displaced persons, as well as the coordination and management of the displaced camps. On the other hand, there are no directives on how the UNHCR and the Nutrition Cluster should cooperate in the case of refugees.

In summary:

- **For displaced people, outside the camps:** nutrition is the responsibility of the Nutrition Cluster;
- **For displaced people, inside the camps:** nutrition is the responsibility of the Nutrition Cluster;
- **For refugees, inside and outside the camps:** nutrition is the responsibility of the UNHCR.

27 Infant Feeding in Emergency

28 Standing Committee on Nutrition

29 Scaling Up Nutrition

30 Nutrition Guidance expert Advisory Group

31 Ending Child Hunger and Undernutrition

4.3 Nutrition Cluster's spheres of operation

4.3.1 Information management

Managing information efficiently is fundamental to coordinating effectively. This is an essential factor for improving the planning, integration and implementation of an emergency nutrition response. Information management is comprised of four areas: collecting, processing, analysing and disseminating.

Who is involved?

- ▶ The **CLA**: provides the resources: IM staff and software required;
- ▶ The **IM manager**;
- ▶ The **NCC**: produces the data and ensures their proper use;
- ▶ **Cluster participants**: proactively exchange information and contribute to producing standards and guidelines for the IM; and
- ▶ **OCHA**: compiles the information from the various Clusters.

4.3.2 Evaluation

Information provided by evaluations represents the basis for planning, delivering and following up on the Nutrition Cluster's response. It generates a picture of the pre-emergency situation, including areas of vulnerability, as well as a picture of the situation during the crisis, highlighting the impact of the emergency and the people affected.

Who is involved?

- ▶ The **NCC** and **IM**: identify information available and any gaps;
- ▶ The **HC** and **OCHA**: coordinate inter-cluster emergency evaluations; and
- ▶ **Cluster participants** (implement evaluations and identify specific needs).

4.3.3 Cluster's strategic response

The Cluster's strategic response represents the global framework of the response to the nutrition emergency. It supplies the vision and the action plan for a collective and comprehensive response. The Nutrition Cluster strategic response:

- Defines shared objectives,
- Identifies priorities,
- Draws up a coherent and comprehensive action plan, clearly defining the roles and responsibilities, and
- Defines the mechanism for monitoring implementation of the response.

The strategic response must be based on an analysis of the information available, take account of the cross-cutting issues, establish links with other Clusters where relevant and take account of the priorities and the capacities available.

The strategy must be regularly reviewed and updated to remain relevant.

Who is involved?

- ▶ The **NCC**: facilitates development and updating of the strategy with clear quality control and revision methods; and
- ▶ **Cluster participants**: contribute via their information and ideas.

4.3.4 Promoting standards and developing capacities

Promoting standards

Standards must be put in place to promote a quality response and to ensure the Nutrition Cluster objectives are attained, by undertaking planned activities that are implemented and monitored in an appropriate way.

Who is involved?

- ▶ The **NCC**: facilitates the identification, revision, development and promotion of standards,
- ▶ **Cluster participants**: identify and prioritise areas where standards are required and undertake developing/revising,
- ▶ **Institutions or organisations** outside the Cluster: develop training materials or other aspects.

Developing capacities

The capacities of the Cluster participants are developed in such a way as to better equip them to safeguard the nutritional status of populations.

Who is involved?

- ▶ The **NCC**: supports efforts to strengthen the capacities of national authorities and civil society; and
- ▶ **Cluster participants**: help identify and prioritise capacities that need to be developed.

4.3.5 Advocacy and communication

Advocacy

In practice, advocacy in emergency situations is aimed at:

- Gaining acceptance and support for nutrition in emergency situations;
- Mobilising resources;
- Increasing awareness.

Who is involved?

- ▶ The **NCC**: ensures the Nutrition Cluster's advocacy issues are identified and facilitates the joint advocacy process);
- ▶ **IM**: collects and analyses information used in advocacy messages;
- ▶ **Cluster participants**: prioritise problems, develop evidence, implement advocacy and determine its parameters: who speaks on behalf of the Nutrition Cluster and the conditions that apply;
- ▶ The **CLA**: the representative of the CLA is responsible for advocating on behalf of the Nutrition Cluster, using every opportunity presented and basing the advocacy on input from the NCC.

Communication

Communication is an important advocacy tool particularly in relation to the media.

Who is involved?

- ▶ The **NCC**: facilitates the definition and presentation of the Nutrition Cluster's point of view and ensures that the messages represent the Nutrition Cluster's position and not that of just one partner);
- ▶ The **IM**: collects and analyses information used in communication material;
- ▶ **Cluster participants**: define the parameters of external communication based on the Cluster's Terms of Reference: who speaks on behalf of the Nutrition Cluster, the conditions that apply and how sensitive information is handled;

- ▶ The **CLA**: communicates the Nutrition Cluster’s needs and problems at higher-level forums, provides technical support and facilitates contact with the media and
- ▶ **OCHA**: important communication role for all Clusters.

4.3.6 Mobilising resources

Fundraising

Fundraising is aimed at ensuring the humanitarian partners have sufficient financial resources to enable the Nutrition Cluster’s response strategy to be implemented.

Who is involved?

- ▶ The **NCC**: ensures that the Nutrition Cluster mobilises the necessary funds to address priority needs and that the funds obtained through the Nutrition Cluster are prioritised for the most critical and underfinanced problems;
- ▶ The **CLA**: advocates on behalf of the Nutrition Cluster’s financial needs and aims this action at the HC, donors and the humanitarian community;
- ▶ **Cluster participants**: share information with the NCC to ensure that all financial needs are covered, help prioritise projects within the Cluster and mobilise funds from their side;
- ▶ **OCHA and the HC**: manage the fundraising process for Clusters; determine the process, tools, time assigned to drawing up funding priorities and project selection.

More details on funding mechanisms...

Funds	What is it?	Who is eligible?	Who prepares it?
FLASH APPEAL	Gives an overview of all urgent needs, the Cluster’s response strategies and agency projects for the first 3 to 6 months. Usually revised at the end of 1 month depending on additional information.	UN agencies NGOs NO national authorities unless as part of a UN or NGO project	Coordinated and compiled by the HC and OCHA with input from cluster coordinators and HCT. In 5 to 7 days from emergency.
CERF Rapid Response Grant (Central Emergency Response Fund)	Supplies a starting-point for launching ‘life-saving’ programmes developed in the Flash Appeal but not yet covered by other donors.	UN agencies IOM NO NGOs and national authorities except as part of a UN project	NCC in collaboration with Nutrition Cluster
CAP (Consolidated Appeal)	Developed if an emergency goes on beyond the 6 months of the Flash Appeal. Comprises the CHAP (Common Humanitarian Action Plan) which is the strategic emergency response + the package of projects needed for this strategy.	UN agencies NGOs IFRC National authorities can only be an implementing partner	HC directs the process with the HCT, cluster coordinators and the other humanitarian organisations.
Pooled Funds: ERF (Expanded Humanitarian Response Fund)	Small-scale funds covering needs not included in the CAP but in line with the CHAP objectives; short-term projects (max 6 months).	Often NGOs	
Pooled Funds: CHF (Common Humanitarian Fund)	Covers CAP priority projects.		Consultative process involving all the clusters

4.3.7 Mobilising inputs and equipment

The capacity to implement nutrition interventions requires having sufficient inputs and equipment in the right place at the right time.

The type and quantity of products required for the response should be included in the nutrition response strategy.

Inputs used to treat SAM and MAM are often categorised as foodstuffs and are subject to regulations at the national level. Establishing and respecting quality control standards associated with nutritional inputs are also crucial matters for the Nutrition Cluster.

Who is involved?

- ▶ The **NCC**: ensures that all necessary input and equipment needs relating to the emergency response are identified and that the Nutrition Cluster can identify and resolve pipeline issues;
- ▶ The **IM**: manages information relating to inputs and equipment;
- ▶ The **CLA**: advocates for all the Nutrition Cluster's resources;
- ▶ **Cluster participants**: share information concerning input needs and stocks to identify potential disruptions.

4.3.8 Monitoring and evaluation

Monitoring

The aim of monitoring within the Nutrition Cluster is to:

- ✓ Oversee changes in the emergency situation and evolving needs;
- ✓ Evaluate progress and coverage of the response;
- ✓ Facilitate accountability;
- ✓ Identify and resolve problems as they appear;
- ✓ Highlight successes.

An effective monitoring system is essential to make better use of the resources available.

Who is involved?

- ▶ The **NCC**: ensures the monitoring system is in place;
- ▶ The **IM**: designs the monitoring system and strengthens partners' capacities relating to monitoring;
- ▶ **Cluster participants**: define and use the monitoring system; and
- ▶ **OCHA**: coordinates monitoring data from all clusters.

4.3.9 Evaluation and lessons learned

Evaluations within the Nutrition Cluster may be done at two levels:

- ✓ Partners can evaluate their own programmes (no obligation to share the results with the Cluster);
- ✓ Overall evaluation of the Cluster's performances.

Who is involved?

- ▶ The **NCC**: coordinates evaluations at Cluster level and ensures information is disseminated and used;
- ▶ The **IM**: provides technical support to define the methodology and conduct the evaluation analysis);
- ▶ **Cluster participants**: identify and prioritise the need for evaluations for the Cluster and for their own agencies; and
- ▶ **OCHA**: carries out inter-cluster coordination.

4.4 Perspectives

4.4.1 Transformative Agenda

Weaknesses are always identified in the multilateral humanitarian response.

Three priority areas for improvement are the following:

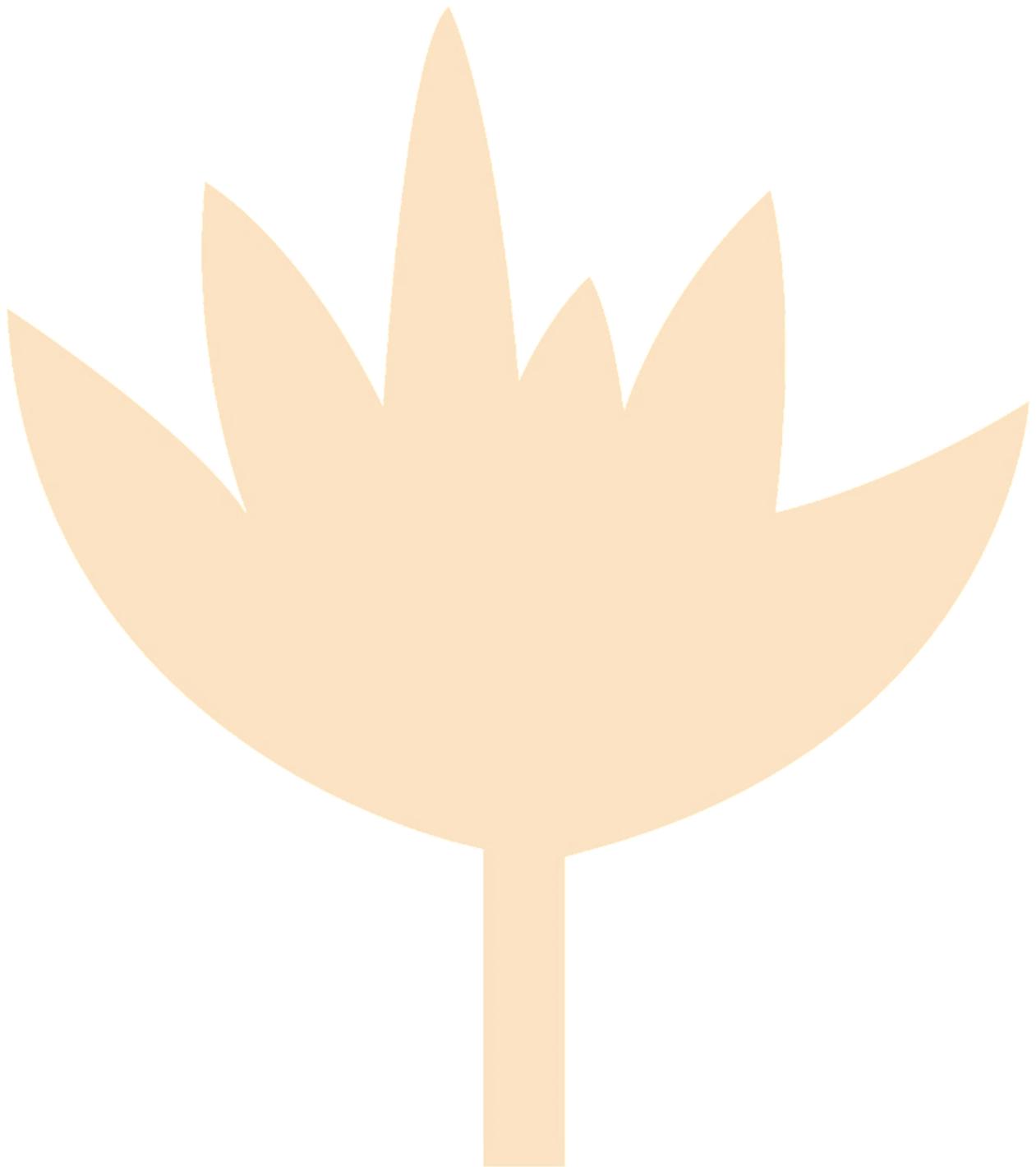
- Leadership: Rapid deployment of an experienced, top-level HC;
- Coordination: Trained and experienced Cluster coordinators and inter-cluster coordination;
- Accountability: Improvements in mutual accountability between HC/HCT/Cluster coordinators/Cluster participants.

In summary, what can bring the Nutrition Cluster

- ▶ Access to technical support, and clarity of the standard response;
- ▶ Reduced risk of duplication or conflict between agencies, or beneficiaries;
- ▶ Improved network and means to discuss with governments and donors;
- ▶ Power collective advocacy, resource mobilization, etc.. ;
- ▶ Sharing resources and expertise;
- ▶ Decreased risk of decision-making and accountability solo.



Global
NUTRITION
CLUSTER





V. TAKING THE CAUSES OF UNDERNUTRITION INTO ACCOUNT

Undernutrition is the result of the interaction of multiple complex factors. The immediate causes are linked to inadequate intake of food and diseases. Food insecurity, inappropriate care and unhealthy, inadequate environment (limited access to healthcare services and to water supply and sanitation) are the underlying causes of undernutrition.

Crises characterised by levels of acute undernutrition above emergency thresholds are predominantly managed by providing emergency food aid. However, **nutritional statuses are more likely to be improved through an integrated response based on a thorough understanding of the causes of undernutrition at local level**, and not solely as a result of food aid.

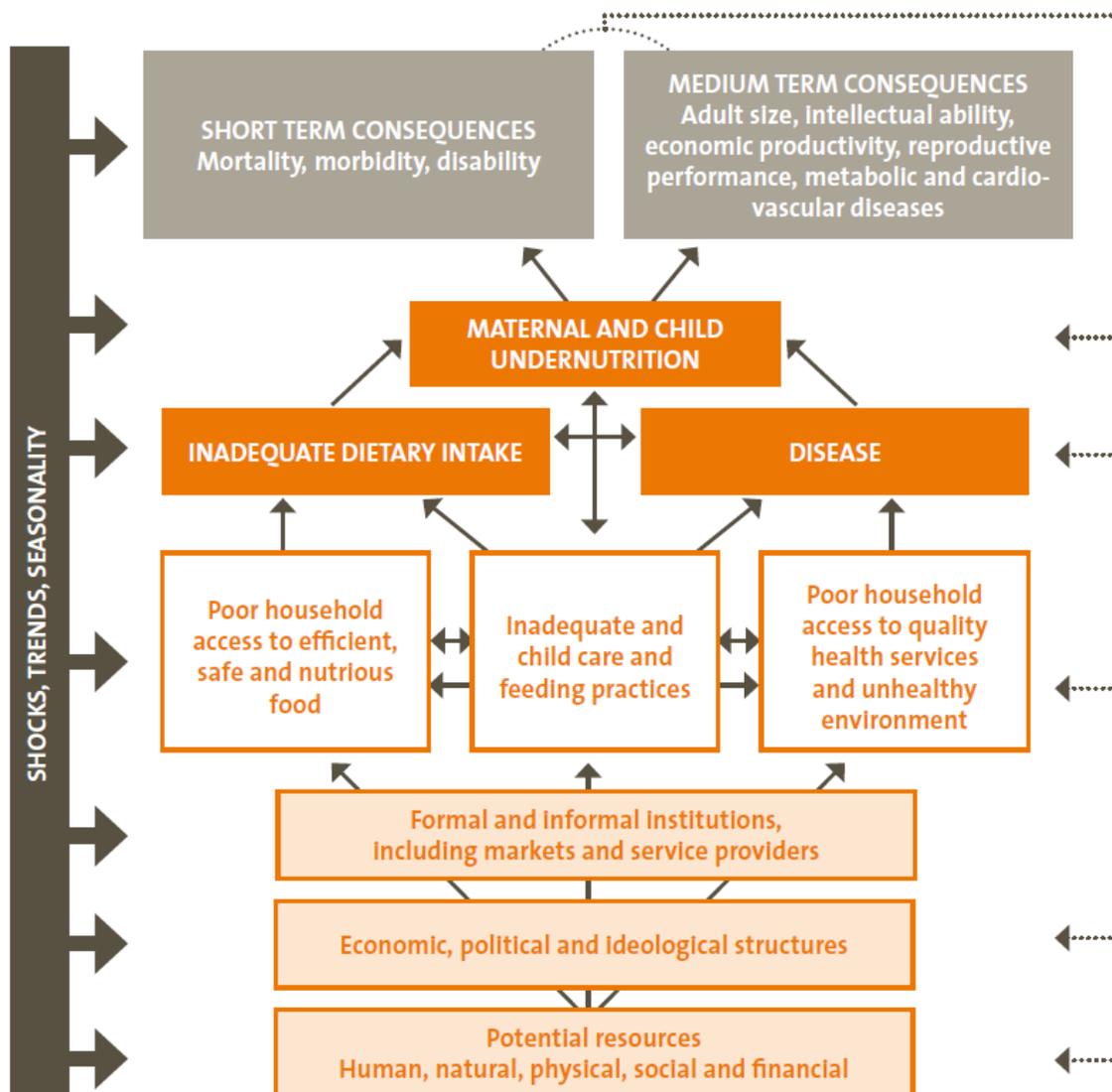


Figure: Conceptual framework of the causes of undernutrition

The fight against maternal and infant undernutrition requires a twofold approach: implementing large-scale direct nutritional interventions and 'nutrition sensitive' indirect and multi-sectoral interventions.

5.1 Health

A vicious circle: **common infectious diseases increase the probability that a weakened child will be affected by acute malnutrition** (a sick child loses appetite and weight). From the period of conception until the end of early childhood, undernutrition increases the frequency and intensity of infectious diseases. Due to this interaction, severe acute malnutrition is thus directly responsible for 1 million deaths a year, while undernutrition is now considered to cause 3.5 million deaths.

Epidemiology confirms these observations. This science allows us to quantify the link between nutrition and health. Thus, by aggregating the data obtained from several different contexts, it is now possible to estimate that a malnourished child has, due to the single aggravating factor of his/her nutritional state, about six times higher a risk of dying from diarrhea, nine times higher from pneumonia, two times higher from an acute malaria attack, and six times higher from measles. **Overall, severely malnourished children die nine times more frequently than healthy children.**

Children with a deficiency in iron, zinc, vitamin A or iodine (simple nutritional deficiencies), are more at risk of dying than others if they develop an infectious disease. The causal role of pathologies in the appearance of acute malnutrition is more complicated to demonstrate. It is very well-known with regard to chronic malnutrition. The impact of chronic undernutrition on quality of life and life expectancy is also generally recognized. The juxtaposition between the prevalence maps of chronic and acute malnutrition is also very well-known. It has also been shown that malarial episodes during pregnancy lead to acute malnutrition of the baby (low weight-for-age). Common sense tells us that in areas inhabited by poor populations who are struggling to provide themselves with good nutrition, falling ill can set off a fatal episode of malnutrition among the most vulnerable, i.e. children under the age of three.

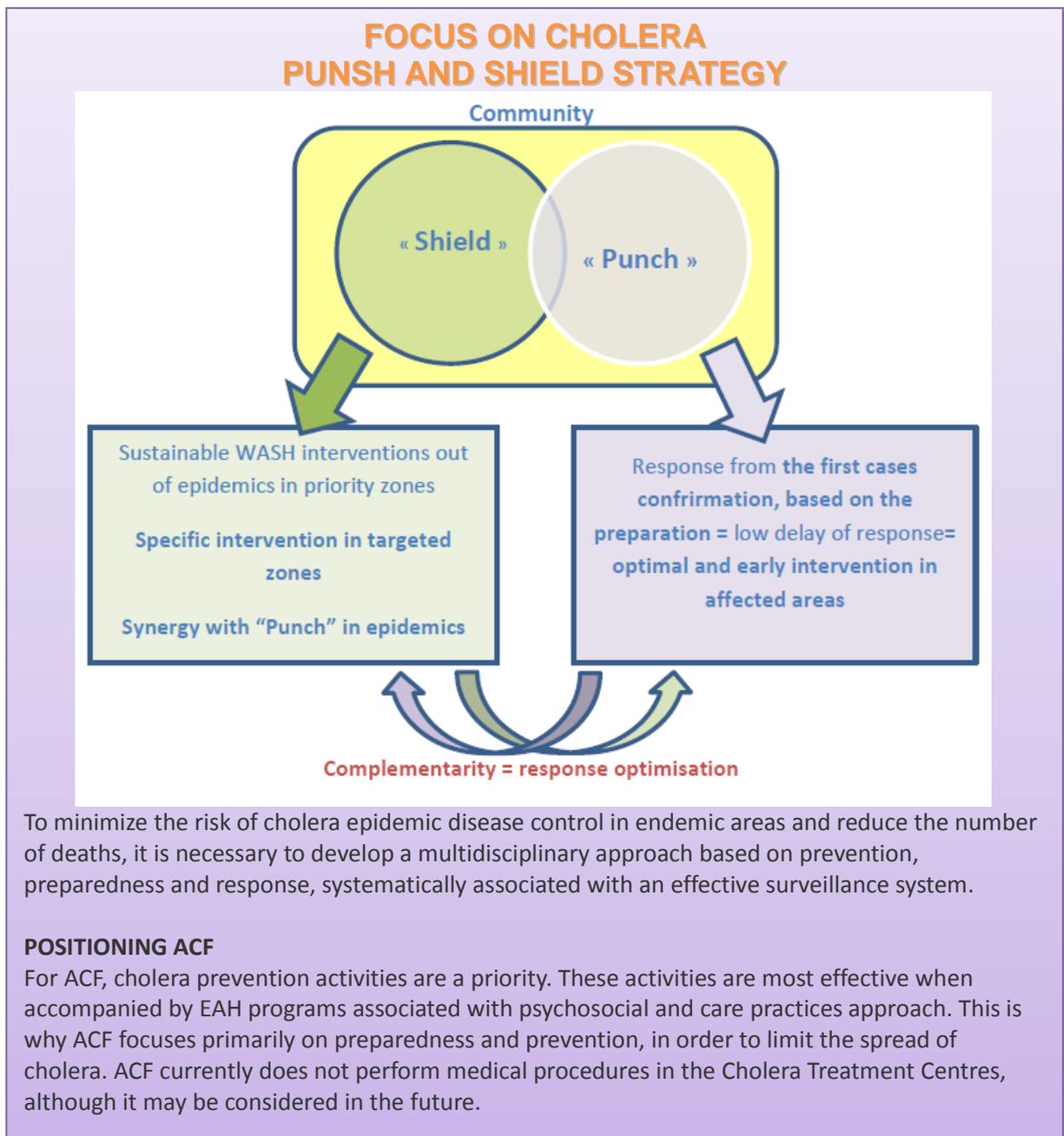
Among the medical factors contributing to undernutrition, the following are preventable:

- ▶ **Routine pediatric consultations**
 - Treatment of common pathologies before they result in weight loss
 - Early detection of nutritional problems (dynamic analysis)
- ▶ **Vaccination**
 - Against the immunizing viral childhood diseases (measles, diphtheria, polio)
 - Against particularly serious pathologies of early childhood (hemophilus)
 - Against banal viral diarrheas of childhood (rotavirus: ROTARIX; ROTATEQ)
 - Against serious diseases recurrent in a given area:
 - meningitis
 - cholera
 - yellow fever
- ▶ **Prenatal and neonatal care:**
 - Fight against nutritional deficiencies of the mother
 - Early screening of puerperal infections, including malaria
 - Prevention of vertical HIV transmission
 - Promotion of breastfeeding
- ▶ **Routine de-worming**

► Correction of latent micronutrient deficiencies

Thus, a preventive medical strategy disposes of many arms that should be used judiciously in line with the local health analysis. The following are important to consider as they will each influence the type and intensity of the prevention strategy in development:

- The annual incidence of undernutrition;
- The state of stress and capacities available for resilience of persons affected by undernutrition; and
- Results from the epidemiological analysis performed locally (and at the departure point for migrants) as well as that of the different resources available through the current healthcare system.



Further reading

ACF-International, *ACF & La Santé, L'Essentiel Nutrition et Santé*, 2012

5.2 Mental Health and Care Practices

Care practices are defined as “the behaviours and practices of persons in charge of care (mother, father, brothers and sisters, the people who take care of the child) to provide food, medical care, stimulation and emotional support necessary to allow the child to live, grow and develop in a healthy manner. These practices, combined with food security and health care, have an impact on the well-being of the child. It is not only the practices themselves, but also the ways they are carried out (with affection and receptivity towards the child), that are essential to the survival, growth and development of the child. It is impossible for people responsible for the child’s care to provide the latter without adequate resources, such as time and energy”³²

Six care practices were identified by Engle and presented in the manual published by Unicef³³ in 1997: care for women, breastfeeding practices and complementary feeding, psychosocial care, food preparation, hygiene practices and household health practices.

Adequate care practices are all the more important when the environment is poor because they make it possible to optimize available resources. Humanitarian emergencies such as natural disasters, wars or other emergency situations can cause deterioration of the environment and place the children in even more danger, since there may be deterioration not only of food security and health, but also of care practices.

Experiences such as traumatic events, the loss of loved ones, the loss of social support, displacements, deterioration of living conditions, inadequacy of food supplies, an uncertain future and the loss of possessions may impact **the capacity of the entourage to care for children, which will increase their risks of malnutrition, illness and death. Those families for whom childcare has become difficult should benefit from technical, psychosocial and psychological support** in such a way as to reinforce good practices and encourage adaptation of practices in order to promote the well-being and development of the child.

Further reading

IASC, *Directives du CPI concernant la santé mentale et le soutien psychosocial dans les situations d’urgence*, 2007

ACF-International, *Politique santé mentale et pratiques de soins*, Décembre 2009

ACF-International, *Holistic approach for pregnant, lactating women and their children in emergency (Baby friendly tent): guidelines and practical handbook*. To be published in 2013

OMS, *Santé mentale et bien-être psychosocial des enfants en situation de pénurie alimentaire sévère*

UNICEF & WHO, *Integrating early childhood development activities into nutrition programs in emergencies. Why, what and How* (2012)

5.3 Food Security and Livelihoods

The links between food security, livelihoods, nutrition and health are complex, global and subject to rapid change. Food security and livelihood programs have the potential to prevent and reduce the scourge of undernutrition. At the minimum, FSL programs should not jeopardize the nutritional status of beneficiaries. If that occurs, attenuation measures (preventive or corrective) must be implemented.

32 Engle, P.L., M. Bentley, and G. Pelto, The role of care in nutrition programmes: current research and a research agenda. *Proceedings of the Nutrition Society*, 2000. 59(1): p. 25-35.

33 Engle, P (1997) *The Care initiative : assessment, analysis and action to improve care for nutrition*. Unicef

Further reading

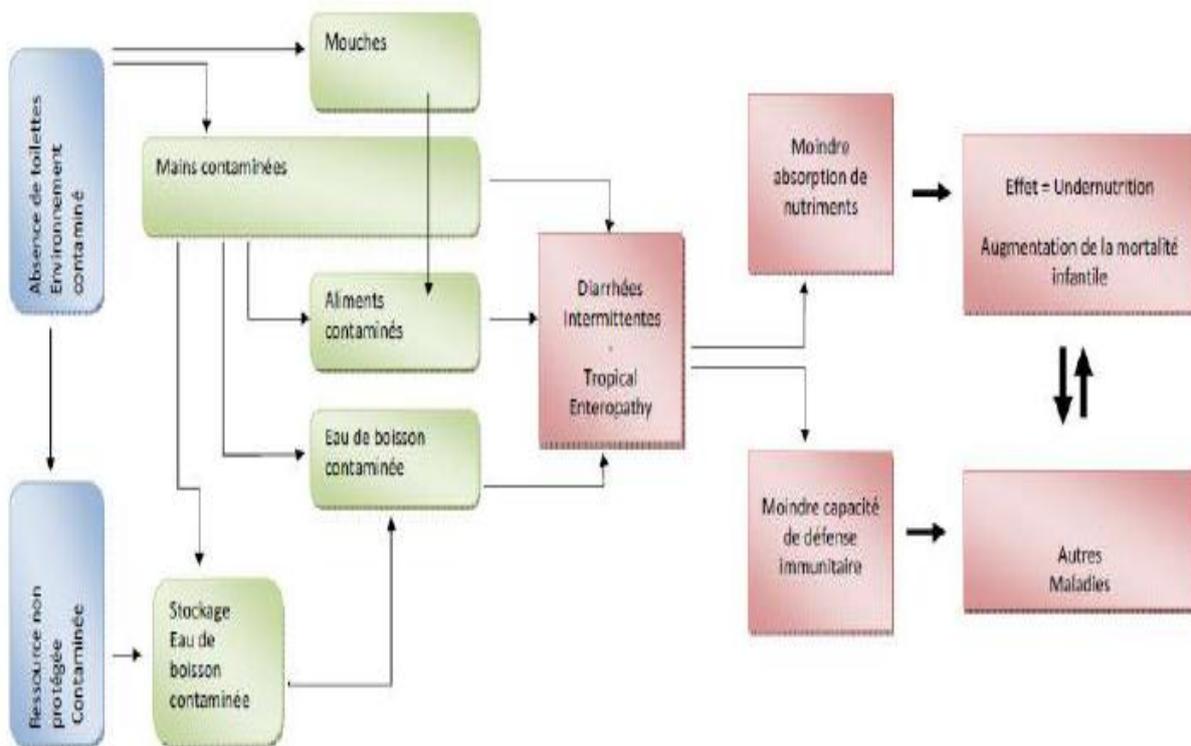
ACF-International, *Optimiser l'impact nutritionnel des interventions de sécurité alimentaire et moyens d'existence*, Décembre 2011

5.4 Water, Sanitation and Hygiene

Undernutrition is responsible for about 35% of worldwide deaths among children under five. It is thought that a high proportion of this undernutrition is associated with diarrhea or recurrent infections with intestinal nematodes because of unclean water, inadequate sanitation or unsatisfactory hygiene conditions.

Diarrhea that is already affecting patients is in itself a particularly important aggravating factor for malnutrition because it reduces the capacity to absorb nutrients by alteration of the intestinal wall, and those who suffer from malnutrition are at high risk for diarrhea. That creates a vicious circle hindering the child's growth and development.

Water supply, sanitation and improved hygiene can contribute to the fight against undernutrition by integrating the nutrition issue with improvement of the state of health. Ensuring access to drinking water, a healthy environment and good hygiene practices remains extremely important in the prevention of undernutrition, especially in contexts of survival and/or socioeconomic development.



Link between precarious WSH conditions, disease and undernutrition

Translation of text in chart

Absence de toilettes	Lack of toilets
Environnement contaminé	Contaminated environment
Ressource non protégée...	Unprotected, contaminated resource
Mouches	Flies
Mains contaminées	Contaminated hands
Aliments contaminés	Contaminated foods
Eau potable contaminée	Contaminated drinking water
Stockage Eau potable contaminée	Storage of contaminated drinking water
Diarrhées intermittentes	Intermittent diarrhea
Entéropatie tropicale	Tropical Enteropathy

Moindre absorption de nutriments	Reduced absorption of nutrients
Capacité de défense immunitaire diminuée	Reduced immune defense capacity
Effet = Sous-nutrition	Effect = Undernutrition
Augmentation de la mortalité infantile	Increase of infantile mortality
Autres maladies	Other diseases

Special attention must be given throughout the treatment chain, starting from the therapeutic feeding centres to the domicile of the “mother/accompanying person – malnourished child” couple. Interventions such as treatment of water at home to guarantee the potability of drinking water stored in the home and consumed by the malnourished child also offer the opportunity to target the most vulnerable.

Further reading

Strategy « Wash in Nut », Regional Emergency Cluster Advisor (RECA) project, WCARO



© ACF, Roselyne Monin – Ivory Coast, 2011



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- ▶ ONUG/DHA, *Glossaire international multilingue agréé de termes relatifs à la gestion des catastrophes*, 1992
- ▶ IASC Global Nutrition Cluster, *Introduction to nutrition in emergencies*, 2008
- ▶ MAM Task Force du Global Nutrition Cluster, *Moderate Acute Malnutrition : A decision tool for emergencies*, 2012
- ▶ ACF-International, *Products are not enough : putting nutrition products in their proper place in the treatment and prevention of global acute malnutrition*, 2011
- ▶ ACF-International, *L'Essentiel Nutrition-Santé*, 2012
- ▶ Kit urgence ACF : http://www.missions-acf.org/kitemergency/HTML_STATIC/homepageFR.html
- ▶ UN-SCN, *Report of the meeting of the working group on nutrition in emergencies*, Avril 1998
- ▶ ALNAP, *Slow-onset disasters: drought and food and livelihoods insecurity. Learning from previous relief and recovery responses*
- ▶ OMS, *Distribution of infant formula during the Lebanon Crisis*, Décembre 2006
- ▶ SCUK, *Infant feeding in emergencies – Indonesia & Lebanon responses*, Décembre 2006
- ▶ Fitsum Assefa, Sri Sukotjo, Anna Winoto & David Hipgrave, *Increased diarrhea following infant formula distribution in 2006 earthquake response in Indonesia*, Field Exchange n°34
- ▶ ACF-International, *Breastfeeding assessment report, Java, Indonesia, June 2006*
- ▶ Victoria Sibson, *Putting IFE guidance into practice: operational challenges in Myanmar*, Field Exchange n°36
- ▶ Karleen Gribble, *Media reports on IFE in relation to cyclone Nargis and the Wenchuan earthquake: an analysis*, September 2009
- ▶ Carmen Dolan & Mija Ververs, *The Haiti earthquake, Country and global level Cluster coordination experiences and lessons learnt*, Field Exchange n° 39
- ▶ SCUK, *Infant and young child feeding in emergencies: Why are we not implementing at scale? A review of global gaps, challenges and ways forward*, October 2012
- ▶ Peter Hailey & Daniel Tewoldeberha, *Suggested new design framework for CMAM programming*, Field Exchange n° 39
- ▶ Oxfam & SCUK, *A dangerous delay. The cost of late response to early warnings in the 2011 drought in the Horn of Africa*, January 2012
- ▶ OMS, *Strengthening health system emergency preparedness – Toolkit for assessing health system capacity for crisis management*. 2012
- ▶ Global Nutrition Cluster, *Nutrition Coordination Handbook version1*
- ▶ ACF-International, *Optimiser l'impact nutritionnel des interventions de sécurité alimentaire et moyens d'existence*, Décembre 2011
- ▶ ACF-International, *Care Practices in Emergencies Guidelines*; to be published.



ANNEXES

Annex 1 – FSAU / FAO Integrated Food Security Phase Classification

Phase classification	Key Reference Outcomes (current or imminent outcomes on lives and livelihoods; based on convergence of evidence)	Strategic Response Framework (mitigate immediate outcomes, support livelihoods, and address underlying/structural causes)
Generally food secure	<p>Crude Mortality Rate <0.5 / 10,000 / day. Acute Malnutrition <3 % (w/h <-2 z-scores). Stunting <20% (w/age <-2 z-scores). Food Access/Availability Usually adequate (>2,100 kcal ppp day), stable. Dietary Diversity Consistent quality and quantity of diversity. Water Access/Avail. Usually adequate (>15 litres ppp day), stable. Hazards Moderate to low probability and vulnerability. Civil Security Prevailing and structural peace Livelihood Assets Generally sustainable utilization (of 5 capitals).</p>	<ul style="list-style-type: none"> • Strategic assistance to pockets of food insecure groups. • Investment in food and economic production systems. • Enable development of livelihood systems based on principles of sustainability, justice, and equity. • Prevent emergence of structural hindrances to food security. • Advocacy.
Chronically food insecure	<p>Crude Mortality Rate <0.5/10,000/day; U5MR<1/10,000/day. Acute Malnutrition >3% but <10 % (w/h <-2 z-score), usual range, stable. Stunting >20% (w/age <-2 z-scores). Food Access/ Availability borderline adequate (2,100 kcal ppp day); unstable. Dietary Diversity chronic dietary diversity deficit. Water Access/Avail. Borderline adequate (15 litres ppp day). Hazards recurrent, with high livelihood vulnerability. Civil Security Unstable; disruptive tension. Coping 'insurance strategies' Livelihood Assets stressed and unsustainable utilization (of 5 capitals).</p>	<ul style="list-style-type: none"> • Design and implement strategies to increase stability, resistance. • and resilience of livelihood systems, thus reducing risk. • Provision of 'safety nets' to high risk groups. • Interventions for optimal and sustainable use of livelihood assets. • Create contingency plan. • Redress structural hindrances to food security. • Close monitoring of relevant outcome and process indicators. • Advocacy.
Acute food and livelihood crisis	<p>Crude Mortality Rate 0.5-1 /10,000/day, U5MR 1-2/10,000/dy. Acute Malnutrition 10-15 % (w/h <-2 z-score), >than usual, increasing. Disease epidemic; increasing. Food Access/ Availability lack of entitlement; 2,100 kcal ppp. Dietary Diversity acute dietary diversity deficit. Water Access/Avail. 7.5-15 litres ppp day, accessed via asset stripping Destitution/Displacement Emerging; diffuse Civil Security Limited spread, low intensity conflict. Coping 'Crisis strategies'; CSI > than reference;</p>	<ul style="list-style-type: none"> • Support livelihoods and protect vulnerable groups • Strategic and complementary interventions to immediately increase food access/availability AND support livelihoods. • Selected provision of complementary sectoral support, eg water, shelter, sanitation, health, etc. • Strategic interventions at community to national levels to create, stabilize, rehabilitate, or protect priority livelihood assets.

	<p>increasing. Livelihood Assets accelerated and critical depletion or loss of access.</p>	<ul style="list-style-type: none"> • Create or implement contingency plan. • Close monitoring of relevant outcome and process indicators. • Use 'crisis as opportunity' to redress underlying structural causes. • Advocacy.
<p>Humanitarian emergency</p>	<p>Crude Mortality Rate 1-2 / 10,000 / day, >2x reference rate, increasing; U5MR > /10,000/day. Acute Malnutrition >15 % (w/h <-2 z-score), > than usual, increasing Disease Pandemic. Food Access/ Availability Severe entitlement gap; unable to meet 2,100 kcal ppp day. Dietary Diversity Regularly 2–3 or fewer main food groups consumed. Water Access/Avail. < 7.5 litres ppp day (human usage only) r. Destitution/Displacement Concentrated; increasing. Civil Security Widespread, high intensity conflict. Coping 'Distress strategies'; CSI significantly > than reference. Livelihood Assets Near complete & irreversible depletion or loss of access.</p>	<ul style="list-style-type: none"> • Urgent protection of vulnerable groups. • Urgently increase food access through complementary interventions. • Selected provision of complementary sectoral support, eg water, shelter, sanitation, health, etc. • Protection against complete livelihood asset loss and/or advocacy for access. • Close monitoring of relevant outcome and process indicators. • Use crisis as opportunity to redress underlying structural causes. • Advocacy.
<p>Famine/ Humanitarian catastrophe</p>	<p>Crude Mortality Rate > 2/10,000 /day (example: 6,000 /1,000,000 /30 days). Acute Malnutrition > 30 % (w/h <-2 z-score) Disease Pandemic. Food Access/ Availability Extreme entitlement gap; much below 2,100 kcal ppp day. Water Access/Avail. < 4 litres ppp day (human usage only). Destitution/Displacement Large scale, concentrated. Civil Security Widespread, high intensity conflict. Livelihood Assets Effectively complete loss; collapse.</p>	<ul style="list-style-type: none"> • Critically urgent protection of human lives and vulnerable groups. • Comprehensive assistance with basic needs, eg food, water, shelter, sanitation, health, etc. • Immediate policy/legal revisions where necessary. • Negotiations with varied political-economic interests. • Use crisis as opportunity to redress underlying structural causes. • Advocacy.

Source: Food Security Analysis Unit – Somalia. Integrated Food Security and Humanitarian Phase Classification: Technical Manual Version I. Technical Series Report No. IV. 11. May 2006

Annex 2 – WHO Decision Tree for the Implementation of Nutritional Programs

Finding	Action required
Food availability at household level below 2,100 kcal per person per day.	Unsatisfactory situation <ul style="list-style-type: none"> Improve general rations until local food availability and access can be made adequate.
Malnutrition rate 15% or more or 10–14% with aggravating factors.	Serious situation <ul style="list-style-type: none"> General rations (unless situation is limited to vulnerable groups) plus Supplementary feeding generalized for all members of vulnerable groups especially children and pregnant and lactating women Therapeutic feeding programme for severely malnourished individuals.
Malnutrition rate 10-14% or 5–9% with aggravating factors.	Risky situation <ul style="list-style-type: none"> No general rations; but Supplementary feeding targeted at individuals identified as malnourished in vulnerable groups Therapeutic feeding programme for severely malnourished individuals.
Malnutrition rate under 10% with no aggravating factors	Acceptable situation <ul style="list-style-type: none"> No need for population interventions Attention for malnourished individuals through regular community services.

Aggravating factors

- General food ration below the mean energy requirement
- Crude mortality rate more than 1 per 10 000 per day
- Epidemic of measles or whooping cough (pertussis)
- High incidence of respiratory or diarrhoeal diseases

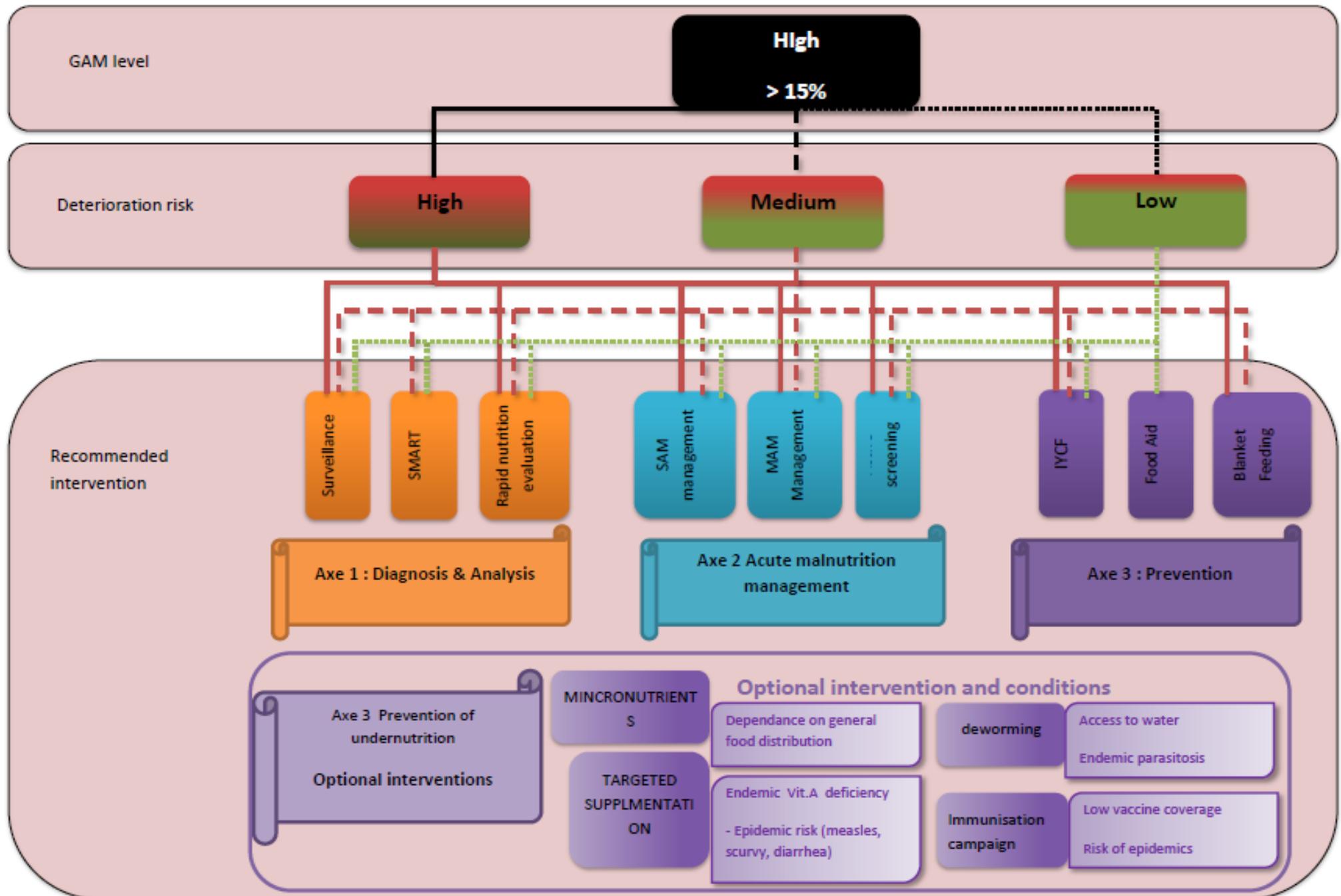
Source: WHO. The Management of Nutrition in Major Emergencies. 2000

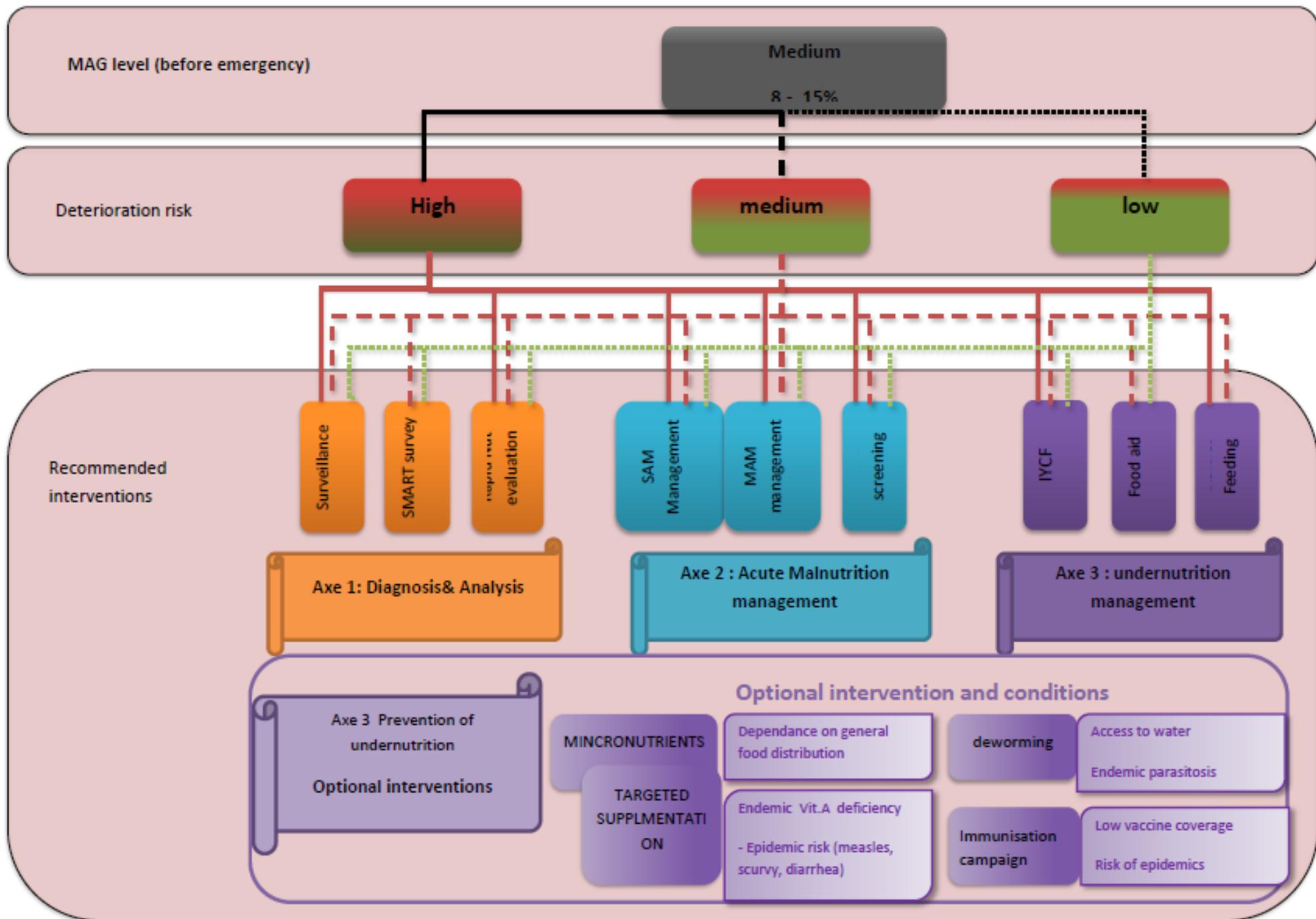
Annex 3 – Reference Table for Integrated Food Security Classification Framework

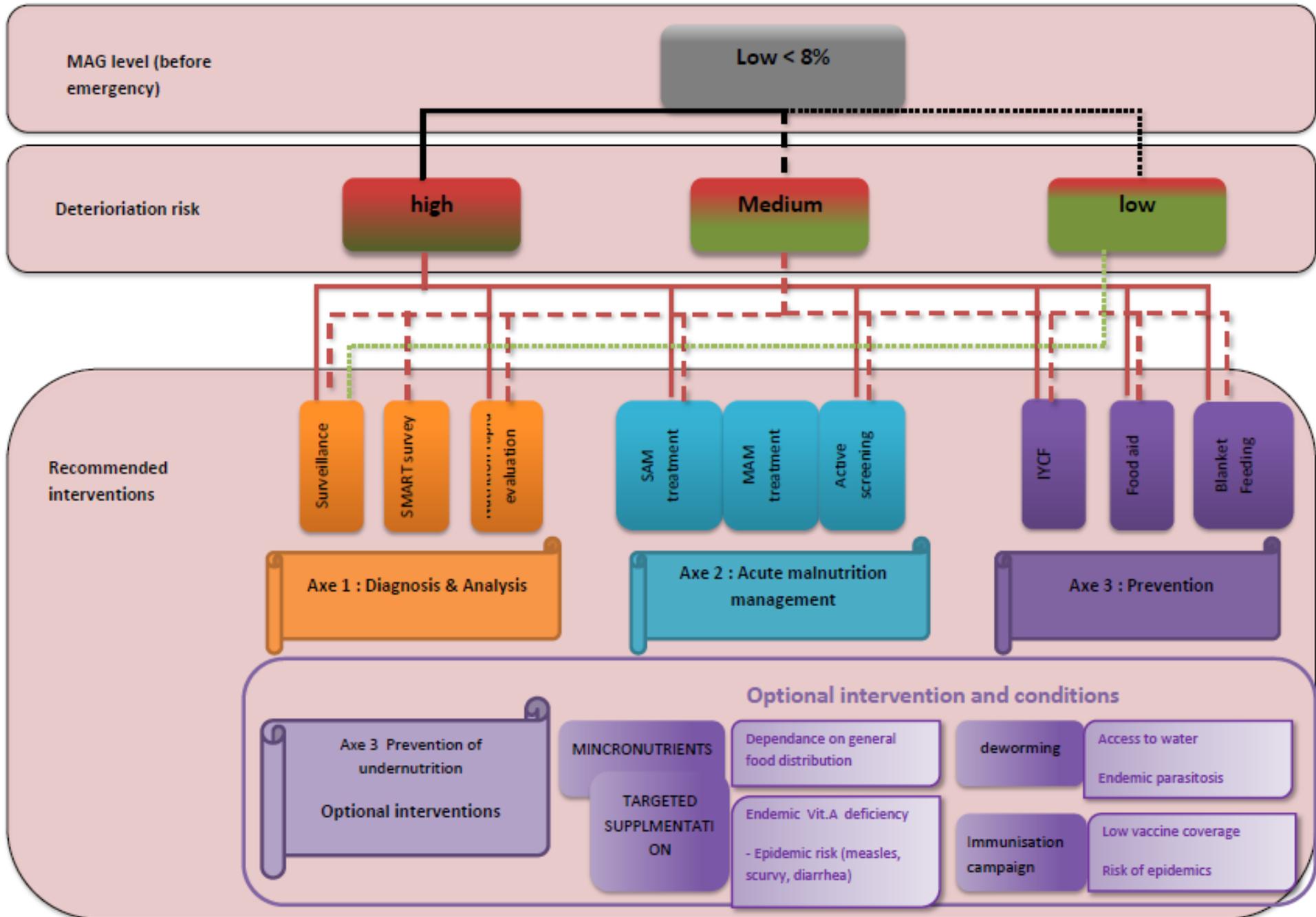
Phase Classification		Key Reference Outcomes <i>Current or imminent outcomes on lives and livelihoods. Based on convergence of direct and indirect evidence rather than absolute thresholds. Not all indicators must be present for classification..</i>	Strategic Response Framework <i>Objectives: (1) mitigate immediate outcomes, (2) support livelihoods, and (3) address underlying causes</i>
1A	Generally Food Secure	Crude Mortality Rate < 0.5 / 10,000 / day Acute Malnutrition < 3 % (w/h < -2 z-scores) Stunting < 20% (h/age < -2 z-scores) Food Access / Availability usually adequate (> 2,100 kcal ppp day), stable Dietary Diversity consistent quality and quantity of diversity Water Access / Avail. usually adequate (> 15 litres ppp day), stable Hazards moderate to low probability and vulnerability Civil Security prevailing and structural peace Livelihood Assets generally sustainable utilization (of 6 capitals)	Strategic assistance to pockets of food insecure groups Investment in food and economic production systems Enable development of livelihood systems based on principles of sustainability, justice, and equity Prevent emergence of structural hindrances to food security Advocacy
		1B Generally Food Secur	
2	Moderately / Borderline Food Insecure	Crude Mortality Rate < 0.5 / 10,000 / day; U5MR < 1 / 10,000 / day Acute Malnutrition > 3% but < 10 % (w/h < -2 z-score), usual range, stable Stunting > 20% (h/age < -2 z-scores) Food Access / Availability borderline adequate (2,100 kcal ppp day); unstable Dietary Diversity chronic dietary diversity deficit Water Access / Avail. borderline adequate (15 litres ppp day); unstable Hazards recurrent, with high livelihood vulnerability Civil Security unstable; disruptive tension Coping "insurance strategies" Livelihood Assets stressed and unsustainable utilization (of 6 capitals) Structural Pronounced underlying hindrances to food security	Design & implement strategies to increase stability, resistance and resilience of livelihood systems, thus reducing risk Provision of "safety nets" to high risk groups Interventions for optimal and sustainable use of livelihood assets Create contingency plan Redress structural hindrances to food security Close monitoring of relevant outcome and process indicators Advocacy
3	Acute Food and Livelihood Crisis	Crude Mortality Rate 0.5-1 / 10,000 / day; U5MR 1-2 / 10,000 / dy Acute Malnutrition 10-15 % (w/h < -2 z-score), > than usual, increasing Disease epidemic; increasing Food Access / Availability lack of entitlement; 2,100 kcal ppp day via asset stripping Dietary Diversity acute dietary diversity deficit Water Access / Avail. 7.5-15 litres ppp day, accessed via asset stripping Destitution / Displacement emerging; diffuse Civil Security limited spread, low intensity conflict Coping "crisis strategies"; CSI > than reference; increasing Livelihood Assets accelerated and critical depletion or loss of access	Support livelihoods and protect vulnerable groups Strategic and complimentary interventions to immediately food access / availability AND support livelihoods Selected provision of complimentary sectoral support (e.g., water, shelter, sanitation, health, etc.) Strategic interventions at community to national levels to create, stabilize, rehabilitate, or protect priority livelihood assets Create or implement contingency plan Close monitoring of relevant outcome and process indicators Use "crisis as opportunity" to redress underlying structural causes Advocacy
4	Humanitarian Emergency	Crude Mortality Rate 1-2 / 10,000 / day, > 2x reference rate, increasing; U5MR > 2 / 10,000 / day Acute Malnutrition > 15 % (w/h < -2 z-score), > than usual, increasing Disease Pandemic Food Access / Availability severe entitlement gap; unable to meet 2,100 kcal ppp day Dietary Diversity Regularly 3 or fewer main food groups consumed Water Access / Avail. < 7.5 litres ppp day (human usage only) Destitution / Displacement concentrated; increasing Civil Security widespread, high intensity conflict Coping "distress strategies"; CSI significantly > than reference Livelihood Assets near complete & irreversible depletion or loss of access	Urgent protection of vulnerable groups Urgently food access through complimentary interventions Selected provision of complimentary sectoral support (e.g., water, shelter, sanitation, health, etc.) Protection against complete livelihood asset loss and / or advocacy for access Close monitoring of relevant outcome and process indicators Use "crisis as opportunity" to redress underlying structural causes Advocacy
5	Famine / Humanitarian Catastrophe	Crude Mortality Rate > 2 / 10,000 / day (example: 6,000 / 1,000,000 / 30 days) Acute Malnutrition > 30 % (w/h < -2 z-score) Disease Pandemic Food Access / Availability extreme entitlement gap; much below 2,100 kcal ppp day Water Access / Avail. < 4 litres ppp day (human usage only) Destitution / Displacement large scale, concentrated Civil Security widespread, high intensity conflict Livelihood Assets effectively complete loss; collapse	Critically urgent protection of human lives and vulnerable groups Comprehensive assistance with basic needs (e.g. food, water, shelter, sanitation, health, etc.) Immediate policy / legal revisions where necessary Negotiations with varied political-economic interests Use "crisis as opportunity" to redress underlying structural causes Advocacy

Source: Integrated Food Security Classification Framework – Technical Manual

Annex 4 – The matrix







Annexe 5 – Nutrition product sheet (Adapted from GNC MAM Task Force Product sheet)

Objective	Treatment of Severe Acute Malnutrition			Treatment of Moderate Acute Malnutrition	
Generic Term	Therapeutic Milk F-75	Therapeutic Milk F-100	Ready-to-Use Therapeutic Foods (RUTF)	Ready-to-use Supplementary Foods (RUSF) <i>High quantity*</i>	Fortified Blended Foods
Products*					
Purpose	Treatment of complicated severe acute malnutrition with continued breastfeeding	Treatment of complicated severe acute malnutrition with continued breastfeeding	Treatment of uncomplicated severe acute malnutrition with continued breastfeeding	Supplement to treat moderate acute malnutrition with continued breastfeeding	Supplement to treat moderate acute malnutrition with continued breastfeeding
Target Group	6-59 months <i>Older children and adults including HIV+</i>	0-59 months <i>Older children and adults including HIV+</i>	6-59 months <i>Older children and adults including HIV+</i>	6-59 months <i>Others PLW including HIV+ adults</i>	6-59 months: <i>SuperCereal Plus</i> <i>Others including PLW, HIV+ adults: SuperCereal</i>
Energy /nutrient per 100g	75 kcal/100mL 0.9g protein 2g fat	100kcal/100mL	500 kcal 12.5g protein 32.9g fat	500 kcal 12.5g protein 32.9g fat	840kcal 32gprotein 18g fat
Packaging	Sachet = 410g	Sachet = 465g	Sachet = 92g	Sachet = 92g	SuperCereal: 25 kg bag SuperCereal Plus: 1.5kg bag
Shelf life	18 months	18 months	24 months	24 months	12 months
Ration/dose	According to weight: 6-59m: 100kcal/kg/day	According to weight: 6-59m: 200kcal/kg/day	According to weight: 6-59m: 200kcal/kg/day	One sachet/day 92g/day (75kcal/kg/day)	200g/day
Approximate duration of Intervention	3-4 days	21 days	6-8 weeks	3 months	3-6 months
Cost/dose/day (USD)			0.36/sachet	0.29/day	Super Cereal: 0.17 / day; Super Cereal Plus 0.15/day
Manufacturer	Nutriset (Fr)	Nutriset (Fr)	Nutriset (Fr); Vitaset (DR); JB (Mad); Nutivita (Ind), Edesia (US); Diva (SA); Com-compact (N, Ind); Tabatchnick (US); Challenge (US), Insta(Ke); local	Nutriset (Fr); Edesia (US); Compact (India & Norway); Nutrivita (India);	Michiels fabrieken (Bel); CerFar (It); ProRata, Somill, J&C (SA) ; Export Trading, Rab (Mal) ;

Objective	Prevention of Malnutrition			
Generic Term	Acute malnutrition		Micronutrient and chronic malnutrition	
	Lipid-based Nutrient Supplements (LNS) <i>Medium quantity*</i>	Fortified Blended Food	Lipid-based Nutrient Supplements (LNS) <i>Low quantity*</i>	Vitamin & Mineral Powder
Products*	 Patent IRD/Nutriset  Wawa Mum	 SuperCereal/oil/sugar  Supercereal Plus	 Patent IRD/Nutriset	 
Purpose	Supplement to the local diet for prevention of acute malnutrition with continued breastfeeding and prevent micronutrient deficiency and stunting	Supplement to the local diet for prevention of acute malnutrition with continued breastfeeding and prevent micronutrient deficiency and stunting	Supplement to the local diet with continued breastfeeding to prevent micronutrient deficiency and stunting	Fortification of home prepared foods, just before consumption, with continued breastfeeding to prevent micronutrient deficiencies
Target Group	6-23 months	6-23 months: <i>SuperCereal Plus</i> <i>PLW: SuperCereal</i>	6-23 months	6-59 months
Energy /nutrient per 100g	247kcal 5.9gprotein 16g fat	840kcal 32gprotein 18g fat	108kcal 2.5gprotein 7g fat	<u>Daily supplement: RDI:</u> A- 400ug, C- 30ug, D- 5ug, E- 5ug, B1- 0.5, B2- 0.5 ug, niacin- 6ug, B6-0.5ug, B12- 0.9ug, folic acid-150ug, Iron- 10ug, zinc- 4.1, copper- 0.56, iodine- 90ug, selenium-17ug
Packaging	325 gm pots or sachets of different quantities	SuperCereal: 25 kg bag SuperCereal Plus: 1.5kg bag	Sachet = 20g	Sachet = 1g
Shelf life	24 months	12 months	18 months	24 months
Ration/dose	47-50g/day	200g/day	20g/day	One sachet/day 1g/day or 5g/day
Approximate duration of Intervention	3-6 months	3-6 months	Up to 18 months	6-12 months Up to 59 months
Cost/dose/day (USD)	0.18/day	Super Cereal: 0.17 / day Super Cereal Plus 0.15/day		0.028/day
Manufacturer	Nutriset (Fr); Edesia (US); Compact (India, Norway); Nutrivita (India)	Michiels fabrieken (Bel); CerFar (It); ProRata, Somill, J&C (SA) ; Export Trading, Rab (Mal) ;	Nutriset (Fr); Edesia (US)	Global Health Initiative; DSM; Fortitech; Heinz; Hexagon; Piramal (India); Renata (Bangladesh)

Objective	Other									
Generic Term	High Energy Biscuit (HEB)	Ready-to-Use Infant Formula (RUIF)								
Products*										
Purpose	Temporary meal replacement; prevention for acute malnutrition and micronutrient deficiencies for vulnerable groups	Replacement of breastfeeding for infants with no possibility to be breastfed; prevention for acute malnutrition								
Target Group	General population, vulnerable groups	0-11 months non-breastfeeding infants								
Energy /nutrient per 100g	1,800 kcal/400g (biscuits) 2,300kcal/500g (BP-5, NRG-5) <table border="1" data-bbox="391 1142 622 1332"> <thead> <tr> <th>Age</th> <th>Bars</th> </tr> </thead> <tbody> <tr> <td>6 months-3 years</td> <td>3-4</td> </tr> <tr> <td>4-8 years</td> <td>5-6</td> </tr> <tr> <td>Adults</td> <td>8-9</td> </tr> </tbody> </table>	Age	Bars	6 months-3 years	3-4	4-8 years	5-6	Adults	8-9	100kcal 2.1g protein 5.3g fat
Age	Bars									
6 months-3 years	3-4									
4-8 years	5-6									
Adults	8-9									
Packaging	400g packs (HEB) 500g packs (NRG-5, BP-5)	118mL (4oz) bottle 237mL (8oz) bottle 946mL (32oz) bottle								
Shelf life	5 years	12 – 24 months								
Ration/dose	Adults: 400g/day (HEB),500g/day (NRG-5, BP-5)	According to weight 150mL/kg/day								
Approximate duration of Intervention	1 week as full diet 1 month for children	At least up to the age of 6 months								
Cost/dose/day (USD)	2.84/day									
Manufacturer	NRG-5/BP-5: MSI (D), Compact (N), Biscuits: Nuova Biscotti (I); Michiels (B); Insta (Ke)	Abbott (US)								

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